

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Official Information Health Care
Professionals Can Trust

Medicare Enrollment and Claim Submission Guidelines



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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

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This publication provides the following information:

- ❖ Enrolling in the Medicare Program;
- ❖ Private contracts with Medicare beneficiaries;
- ❖ Medicare claims;
- ❖ Deductibles, coinsurance, and copayments;
- ❖ Beneficiary Notices of Noncoverage;
- ❖ Billing requirements; and
- ❖ Resources.

When “you” is used in this publication, we are referring to Medicare Fee-For-Service (FFS) providers and suppliers.

ENROLLING IN THE MEDICARE PROGRAM

To enroll in and obtain payment from Medicare, you must apply for:

- 1) A National Provider Identifier (NPI); and
- 2) Enrollment in the Medicare Program.

More details about applying for a NPI and enrollment in the Medicare Program are provided below.

1) Applying for a National Provider Identifier (NPI)

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard and a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions adopted under HIPAA. Health care providers

can apply for an NPI in one of three ways:

- ❖ Online – For the most efficient application processing and to get your NPI the fastest, you may apply using the web-based application process by logging onto the National Plan and Provider Enumeration System (NPPES) at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> on the NPPES website;
- ❖ Paper Application – You may obtain Form CMS-10114/National Provider Identifier (NPI) Application/Update Form and mail the completed and signed form to the NPI Enumerator. Staff at the NPI Enumerator will enter application data into the NPPES. You may access this form at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You may also request the form from the NPI Enumerator by calling (800) 465-3203 or TTY (800) 692-2326, sending an e-mail to customerservice@npienumerator.com, or sending a letter to:

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059; or
- ❖ Electronic File Interchange (EFI) – You may agree to have an EFI Organization (EFIO) submit application data on your behalf (through a bulk enumeration process) if an EFIO requests permission to do so.

2) Applying for Enrollment in the Medicare Program

CMS collects information about you and secures documentation to ensure that



you are qualified and eligible to enroll in the Medicare Program. You can apply for enrollment by using either:

- ❖ The Internet-based Provider Enrollment, Chain and Ownership System (PECOS); or
- ❖ The appropriate Form CMS-855 to complete the paper enrollment application process.

More details about the methods to apply for enrollment are provided below.

Internet-Based Provider Enrollment, Chain and Ownership System (PECOS) Enrollment Process

You can use Internet-based PECOS to:

- ❖ Submit and electronically sign a Medicare enrollment application;
- ❖ Revalidate Medicare enrollment information;
- ❖ View or update existing enrollment information;
- ❖ Track the status of an enrollment application;

- ❖ Add or terminate a reassignment of benefits;
- ❖ Reactivate an existing enrollment record; and
- ❖ Voluntarily withdraw from the Medicare Program.

If you do not choose to electronically sign the enrollment application, after you submit the application, mail the signed and dated Certification Statement and any supporting documentation to your designated Medicare Administrative Contractor (MAC). To find MAC contact information, refer to <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Provider-Compliance-Interactive-Map> on the CMS website.

Paper Enrollment Application Process

Alternatively, you can apply for enrollment by completing and signing a paper enrollment application form, which is mailed along with any supporting documentation to your designated MAC. Depending upon the provider or supplier type and the enrollment scenario, complete one of the following six CMS enrollment application forms to enroll in the Medicare Program:

- ❖ Form CMS-855A/Medicare Enrollment Application for Institutional Providers: Application used by institutional providers to apply for enrollment in the Medicare Program or make a change in their enrollment information;
- ❖ Form CMS-855B/Medicare Enrollment Application for Clinics/Group Practices and Certain Other Suppliers: Application used by group practices and other organizational suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, to apply for enrollment in the Medicare Program or to make a change in their enrollment information;



- ❖ Form CMS-855I/Medicare Enrollment Application for Physicians and Non-Physician Practitioners: Application used by individual physicians or non-physician practitioners (NPP) to apply for enrollment in the Medicare Program or to make a change in their enrollment information;
- ❖ Form CMS-855O/Medicare Enrollment Application – Registration for Eligible Ordering and Referring Physicians and Non-Physician Practitioners: Application used by physicians and NPPs to apply to register in the Medicare Program for the sole purpose of ordering and referring items and/or services for beneficiaries in the Medicare Program or to make a change in their registration information;
- ❖ Form CMS-855R/Medicare Enrollment Application for Reassignment of Medicare Benefits: Application used by individual physicians or NPPs to reassign Medicare payments or terminate a reassignment of Medicare benefits after enrollment in the Medicare Program or to make a change in their reassignment of Medicare benefit information; or
- ❖ Form CMS-855S/Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers: Application used by suppliers of DMEPOS to apply for enrollment in the Medicare Program or to make a change in their enrollment information.

Additional Required Form and Information

The following form/information is required in addition to the Medicare Enrollment Application:

- ❖ Form CMS-588/Electronic Funds Transfer (EFT) Authorization

Agreement: Medicare authorization agreement to have payments sent directly to your financial institution through EFT; and

- ❖ Your Tax Identification Number and Legal Business Name as reported/on file with the Internal Revenue Service.

Additional Forms and Documentation That May Be Required

The following forms may be required in addition to the Medicare Enrollment Application:

- ❖ Electronic Data Interchange (EDI) Enrollment Form and Centers for Medicare & Medicaid Services EDI Registration Form: Agreements executed when you submit electronic media claims (EMC) or use EDI, either directly with Medicare or through a billing service or clearinghouse. These forms must be completed prior to submitting EMCs or other EDI transactions to Medicare; and
- ❖ Form CMS-460/Medicare Participating Physician or Supplier Agreement: Agreement you will submit if you wish to enroll as a Part B participating provider or supplier. The Participating and Nonparticipating Providers and Suppliers Section on pages 4 – 7 provides additional information about participating in the Medicare Program.

For more information about the forms discussed above, visit <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html> on the CMS website. The EDI enrollment and registration forms are also available from MACs and Durable Medical Equipment Medicare Administrative

Contractors (DME MAC). Refer to the Medicare Fee-For-Service Provider Enrollment Contact List located at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf on the CMS website for information about where to send Medicare enrollment forms.

Additional documentation, which may vary from State to State, may also be required to enroll in the Medicare Program. This documentation may include:

- ❖ A State medical license;
- ❖ An Occupational or Business license; and
- ❖ A Certificate of Use.

Additional Requirements for Institutional Providers

Institutional providers must simultaneously contact their local State Survey Agency (SA), which determines Medicare participation requirements (certain provider types may elect voluntary accreditation by a CMS-recognized accrediting organization in lieu of a SA survey).

Reporting Changes to Information in Enrollment Records

You must report changes to information in your Medicare enrollment records within 30 – 90 days of a reportable event. In most cases, you must report an event within 90 days. The following events must be reported within 30 days:

- ❖ A change in ownership;
- ❖ A change in practice location; and
- ❖ Final adverse actions that include:
 - Medicare-imposed revocation of any Medicare billing privileges;
 - Suspension or revocation of a license to provide health care by any State licensing authority;

- Suspension or revocation by an accrediting organization;
- Conviction of a Federal or State felony offense within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
- Exclusion or debarment from participation in a Federal or State health care program.


Participating and Nonparticipating Providers and Suppliers

There are two types of Part B providers and suppliers: participating and nonparticipating.

1) Participating Providers and Suppliers:

- ❖ Accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries;
- ❖ Receive higher Medicare Physician Fee Schedule (PFS) allowances than nonparticipating providers and suppliers;
- ❖ Accept the Medicare-allowed amount as payment in full (limiting charge provisions are not applicable); and
- ❖ Are included in the Medicare Participating Physicians and Suppliers Directory (MEDPARD).





When you complete and sign Form CMS-460/Medicare Participating Physician or Supplier Agreement, you:

- ❖ Are formally notifying CMS that you wish to participate in the Medicare Program; and
- ❖ Agree to accept assignment on all Part B claims for all covered services for all Medicare beneficiaries.

Assignment means that you are paid the Medicare-allowed amount as payment in full for all Part B claims for all covered services for all Medicare beneficiaries. You may not collect from the beneficiary any amount other than the unmet deductible and coinsurance. The following are always subject to assignment:

- ❖ Clinical diagnostic laboratory services and physician laboratory services;
- ❖ Physician services to individuals dually entitled to Medicare and Medicaid;
- ❖ Services furnished by the following providers:
 - Anesthesiologist assistants;
 - Certified nurse-midwives;
 - Certified registered nurse anesthetists;
 - Clinical nurse specialists;
 - Clinical psychologists;
 - Clinical social workers;
 - Medical nutrition therapists;
 - Nurse practitioners; and
 - Physician assistants;
- ❖ Ambulatory Surgical Center facility services;
- ❖ Services of mass immunization roster billers;
- ❖ Drugs and biologicals; and
- ❖ Ambulance services.

Participation is valid for a yearlong period from January 1 through December 31.

Active participants get a postcard during the Medicare Participation Open Enrollment Period, which usually begins in mid-November of each year. During this period, you can change your participation status, and that change will be effective on January 1 of the following year. If you wish to continue participating in the Medicare Program, you do not need to sign an agreement each year. The Medicare Participating Physician or Supplier Agreement will remain in effect through December 31 of the calendar year and automatically renews each year unless you decide to terminate the agreement during the open enrollment period. Once you sign the Medicare Participating Physician or Supplier Agreement, CMS will rarely honor your decision to change participation status during the year.

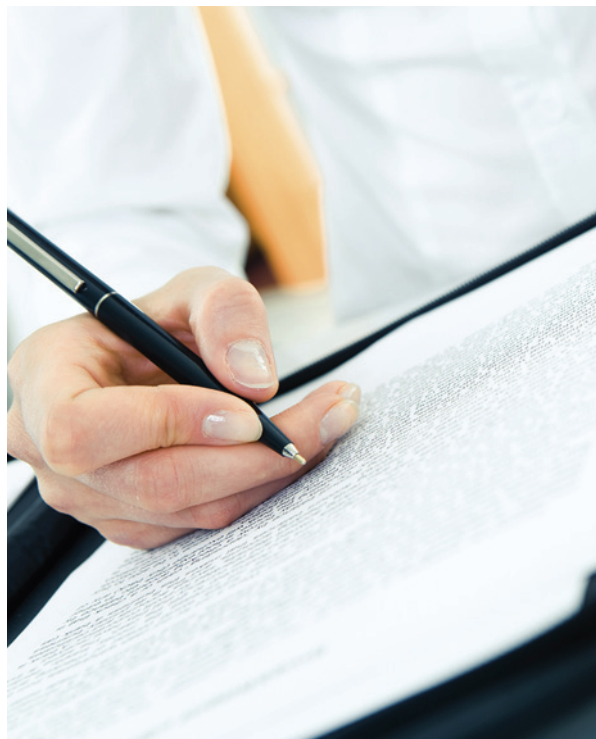
2) Nonparticipating Providers and Suppliers:

- ❖ May accept assignment of Medicare claims on a claim-by-claim basis;
- ❖ Receive lower PFS allowances than participating providers and suppliers for assigned or nonassigned claims;
- ❖ May not submit charges for nonassigned claims that are in excess of the limiting charge amount (with the exception of pharmaceuticals, equipment, and supplies) and may collect up to the limiting charge amount at the time services are furnished, which is the maximum that can be charged for the services furnished (unless prohibited by an applicable State law); and
- ❖ Are not included in the MEDPARD.

The chart below provides an example of a limiting charge (when a provider or supplier does not accept assignment).

Limiting Charge Example

Amount	Example
PFS Allowed Amount for Procedure “X”	\$200.00
Nonparticipating Provider or Supplier Allowed Amount for Procedure “X”	\$190.00 ($\$200.00 \times .95 = 5\%$ lower than PFS allowed amount)
Limiting Charge for Procedure “X”	\$218.50 ($\$190.00 \times 1.15 = 115\%$ of PFS allowed amount)
Beneficiary Coinsurance	\$ 38.00 ($\$190.00 \times 0.2 = 20\%$ of PFS allowed amount)
Limiting Charge Portion	\$ 28.50 ($\$218.50 - \$190.00 =$ limiting charge less nonparticipating provider/supplier allowed amount)
Beneficiary Coinsurance Plus Limiting Charge Due to Provider or Supplier	\$ 66.50 ($\$38.00 + \28.50)



Limiting charges apply to the following regardless of who furnishes or bills for them:

- ❖ Physicians’ services;
- ❖ Services and supplies commonly furnished in physicians’ offices that are incident to physicians’ services;
- ❖ Outpatient physical and occupational therapy services furnished by an independently practicing therapist;
- ❖ Diagnostic tests; and
- ❖ Radiation therapy services, including x-ray, radium, radioactive isotope therapy, materials, and technician services.

The chart on page 7 illustrates the payment amounts that participating and nonparticipating providers and suppliers receive.



Payment Amounts – Participating and Nonparticipating Providers and Suppliers

Amount	Participating Provider/Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/Supplier Who Does Not Accept Assignment
Submitted Amount	\$250.00	\$250.00	\$250.00
PFS Allowed Amount	\$200.00	\$190.00	\$190.00
80 Percent of PFS Allowed Amount	\$160.00	\$152.00	\$152.00
Beneficiary Amount Due to Provider/Supplier (after deductible has been met)	\$ 40.00 Coinsurance	\$ 38.00 Coinsurance	\$ 66.50 Coinsurance + Limiting Charge Portion
Total Payment to Provider/Supplier (payment for nonassigned claims goes to the beneficiary, who is responsible for paying provider/supplier)	\$200.00	\$190.00	\$218.50

PRIVATE CONTRACTS WITH MEDICARE BENEFICIARIES

The following physicians who are legally authorized to practice medicine, surgery, dentistry, podiatry, or optometry by the State in which such function or action is performed may opt-out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- ❖ Doctors of medicine or osteopathy;
- ❖ Doctors of dental surgery or dental medicine;

- ❖ Doctors of podiatry; and
- ❖ Doctors of optometry.

The following practitioners who are legally authorized to practice by the State and otherwise meet Medicare requirements may also opt-out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- ❖ Certified nurse-midwives;
- ❖ Certified registered nurse anesthetists;

- ❖ Clinical nurse specialists;
- ❖ Clinical psychologists;
- ❖ Clinical social workers;
- ❖ Nurse practitioners;
- ❖ Nutrition professionals;
- ❖ Physician assistants; and
- ❖ Registered dietitians.

The opt-out law does not define “physician” to include chiropractors; therefore, chiropractors may not opt-out of Medicare and provide services under private contract. Physical therapists and occupational therapists in independent practice cannot opt-out because they are not within the opt-out law’s definition of either a “physician” or “practitioner.”

The opt-out period is for 2 years and can only be terminated early (no later than 90 days after the effective date of the opt-out affidavit) by a physician or practitioner who has not previously opted out. Opt-outs may be renewed for subsequent 2-year periods.

You must opt-out of Medicare for all beneficiaries and all items or services, with the exception of emergency or urgent care situations, in which case you may treat a beneficiary with whom you do not have a private contract and bill Medicare for the treatment. Claims for emergency or urgent care require modifier GJ, “Opt-out physician or practitioner emergency or urgent service.”



If you have opted out of Medicare, payment will be made for covered medically necessary items or services that you order if:

- ❖ You have acquired a provider identifier; and
- ❖ The items or services are not furnished by a physician or practitioner who has also opted out of Medicare.

MEDICARE CLAIMS

A claim is defined as a request for payment for benefits or services received by a beneficiary. When you furnish covered services to Medicare beneficiaries, you are required to submit claims for your services and cannot charge beneficiaries for completing or filing a Medicare claim. MACs monitor compliance with these requirements. Offenders may be subject to a Civil Monetary Penalty of up to \$10,000 for each violation.

Exceptions to Mandatory Claim Filing

You are not required to file claims on behalf of Medicare beneficiaries when:

- ❖ The claim is for services for which:
 - Medicare is the secondary payer;
 - The primary insurer’s payment is made directly to the beneficiary; and
 - The beneficiary has not furnished the primary payment information needed to submit the Medicare secondary claim;
- ❖ The claim is for services furnished outside the United States (U.S.);
- ❖ The claim is for services initially paid by a third-party insurer who then files a Medicare claim to recoup what Medicare pays as the primary insurer (for example, indirect payment provisions);



- ❖ The claim is for other unusual services, which are evaluated by MACs on a case-by-case basis;
- ❖ The claim is for non-covered services, unless the beneficiary requests submission of a claim to Medicare (a supplemental insurer who pays for these services may require a Medicare claim denial notice prior to making payment);
- ❖ The beneficiary signed a Beneficiary Notice of Noncoverage, indicating that no claim should be filed for a specific item or service;
- ❖ You opted-out of the Medicare Program and entered into a private contract with the beneficiary (when you opt-out of Medicare and privately contract with a beneficiary for the purpose of furnishing items or services that would otherwise be covered, you cannot submit a claim for such); or
- ❖ You have been excluded or debarred from the Medicare Program (when you have been excluded or debarred from the Medicare Program, you cannot submit a claim for your services).

Timely Filing Requirement

Before payment can be made for Medicare-covered services, claims must be filed timely. Claims must be received no later than 1 calendar year from the claim's date of service. Claims filed after the specified timeframe will be denied with no appeal rights. For claims that include span dates of service, claims filing timeliness is determined as follows:

- ❖ The "Through" date is used to determine the date of service for institutional claims; and

- ❖ The "From" date is used to determine the date of service for professional claims.

Exceptions to the timely filing requirement include the following:

- ❖ Administrative error, if failure to meet the filing deadline was caused by error or misrepresentation of an employee, MAC, or agent of the U.S. Department of Health and Human Services that was performing Medicare functions and acting within the scope of its authority;
- ❖ Retroactive Medicare entitlement;
- ❖ Retroactive Medicare entitlement involving State Medicaid Agencies and dually-eligible beneficiaries; and
- ❖ Retroactive disenrollment from a Medicare Advantage Plan or Program of All-Inclusive Care for the Elderly provider organization.

Electronic Claims

You must submit claims electronically via EDI in the HIPAA format, except in limited situations.

You must complete the Electronic Data Interchange (EDI) Enrollment Form and send it to your designated MAC prior to submitting EMCs. A submitter number, which is required to submit electronic claims, will then be issued. An organization comprised of multiple components that have been assigned more than one Medicare provider identifier may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these identifiers have been assigned.

Electronic Media Claim (EMC) Submissions

Claims are electronically transmitted to the MAC's system, which verifies claim data. This information is then electronically checked or edited for required information. Claims that pass these initial edits, also called front-end or pre-pass edits, are processed in the claims processing system according to Medicare policies and guidelines. Claims with inadequate or incorrect information may:

- ❖ Be returned to you for correction;
- ❖ Be suspended in the MAC's system; or
- ❖ Be corrected by the system (in some cases).

A confirmation or acknowledgment report, which indicates the number of claims accepted and the total dollar amount transmitted, is generated to you. This report also indicates the claims that have been rejected and reason(s) for the rejection.

Electronic Media Claim (EMC) Submission Alternatives

If you do not submit electronic claims using EMC, you may alternatively choose to submit claims through an electronic billing software vendor or clearinghouse, billing agent, or by using Medicare's free billing software. You can obtain a list of electronic billing software vendors and clearinghouses as well as billing software from your MAC.

Paper Claims

In limited situations, you may submit paper claims to Medicare. To find more information about when you may submit paper claims, visit <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html> on the CMS website.

Practitioners (physicians and non-physicians) and suppliers use Form CMS-1500 to bill MACs and DME MACs. You can order Form CMS-1500 from printing companies, office supply stores, and the U.S. Government Printing Office (GPO), U.S. Government Bookstore. U.S. Government Bookstore orders can be placed by calling (866) 512-1800 or visiting <http://bookstore.gpo.gov/agency/346> on the GPO website.

Institutional providers use Form CMS-1450, also known as the UB-04, to bill MACs. You can order UB-04 claim forms from the National Uniform Billing Committee (NUBC) at <http://www.nubc.org> on the NUBC website.


Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) Claims

DME MACs have jurisdiction for the following claims:

- ❖ Nonimplantable DMEPOS (including items for home use);
- ❖ PEN products (other than items furnished to inpatients covered under Part A);
- ❖ Certain oral drugs billed by pharmacies; and
- ❖ Medications delivered through infusion pumps.

DEDUCTIBLES, COINSURANCE, AND COPAYMENTS

You must collect unmet deductibles, coinsurance, and copayments from the beneficiary. The deductible is the amount a beneficiary must pay before Medicare begins to pay for covered services and supplies. These amounts can change every year. Under FFS Medicare and Medicare



Advantage Private Fee-For-Service Plans, coinsurance is a percentage of covered charges that the beneficiary may pay after he or she has met the applicable deductible. You should determine whether the beneficiary has supplemental insurance that will pay for the deductible and coinsurance before billing him or her for them. In some Medicare health plans, a copayment is the amount that the beneficiary pays for each medical service.

If a beneficiary is unable to pay these charges, he or she should sign a waiver that explains the financial hardship. If a waiver is not assigned, the beneficiary's medical record should reflect normal and reasonable attempts to collect the charges before they are written off. The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries. Consistently waiving deductibles, coinsurance, and copayments may be interpreted as program abuse.

On assigned claims, the beneficiary is responsible for:

- ❖ Unmet deductibles;
- ❖ Applicable coinsurance and copayments; and
- ❖ Charges for services and supplies that are not covered under the Medicare Program.

BENEFICIARY NOTICES OF NONCOVERAGE

You must give written notice to a FFS Medicare beneficiary before you provide items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance (for example, lack of medical necessity).

The following CMS notices are approved for this purpose:

- ❖ Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131;
- ❖ Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form CMS-10055;
- ❖ Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296; and
- ❖ Hospital-Issued Notice of Noncoverage (HINN).

These notices allow the beneficiary to make an informed decision about whether or not to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. If you do not issue the ABN or a similar notice when notice is required, the beneficiary cannot be held financially liable if Medicare denies payment. If you properly notify the beneficiary that the item or service may not be covered, you may seek payment from the beneficiary.

You are not required to notify the beneficiary before you provide items or services that are never covered by Medicare (for example, statutorily non-covered services). You may, however, choose to issue a voluntary ABN or a similar notice as a courtesy to the beneficiary to alert him or her about their forthcoming financial liability.

If you furnish items or services to the beneficiary based on the referral or order of another provider or supplier, you are responsible for notifying the beneficiary that the services may not be covered by Medicare and that he or she can be held financially liable for them if payment is denied. A copy of the ABN or a similar notice must be kept in the medical record.

BILLING REQUIREMENTS

Medicare Secondary Payer (MSP) Provisions

MSP provisions apply to situations when Medicare is not the beneficiary's primary health insurance coverage. Before you submit a claim, you must determine whether Medicare is the primary or secondary payer for all inpatient admissions and outpatient encounters, thereby assisting in ensuring the appropriate use of Medicare funds. If another plan, insurer, or program is the primary payer, you must identify such on the claim you submit to Medicare. A primary payer has the primary responsibility for paying a claim. You can determine who the primary payer is by asking the beneficiary about their other health insurance or coverage or referring to the Common Working File (CWF). However, you should not rely on CWF information alone since MSP health care insurance coverage can change quickly. The following secondary payer information can be found via the MSP Auxiliary File in the CWF:

- ❖ MSP effective date;
- ❖ MSP termination date;
- ❖ Patient relationship;
- ❖ Subscriber name;
- ❖ Subscriber policy number;
- ❖ Insurer type;
- ❖ Insurer information (name, group number, address, city, State, and ZIP code);
- ❖ MSP type;
- ❖ Remarks code;
- ❖ Employer information (name, address, city, State, and ZIP code); and
- ❖ Employee information (identification number).

Coordination of Benefits Contractor (COBC)

The COBC performs activities that support the collection, management, and reporting of other health insurance or coverage for Medicare beneficiaries. The COBC can assist you with:

- ❖ Verifying Medicare's primary or secondary payer status;
- ❖ Reporting changes to a beneficiary's health coverage;
- ❖ Reporting a beneficiary's accident or injury;
- ❖ Reporting potential MSP situations; and
- ❖ Obtaining information about Medicare development letters and questionnaires.

The COBC does not process claims for primary or secondary payment or handle any mistaken payment recoveries, claims-specific inquiries, claim or service denials and adjustments, or billing issues. MACs complete these responsibilities.

Claims Processing

After a claim has been submitted and a reimbursement decision has been made, you or your billing agent receive a Remittance Advice (RA). The RA is a notice of payments





and adjustments that the MAC produces as a companion to claim payments or an explanation when there is no payment. It features valid codes and specific values that make up the claim payment. Some of these codes may identify adjustments, which refer to any changes that relate to how a claim is paid differently from the original billing. There are seven general types of adjustments:

- 1) Denied claim;
- 2) Zero payment;
- 3) Partial payment;
- 4) Reduced payment;
- 5) Penalty applied;
- 6) Additional payment; and
- 7) Supplemental payment.

Both assigned and non-assigned claims may be returned as unprocessable before a reimbursement decision is made if they contain claim errors (for example, incomplete or invalid information). You will receive a

letter of explanation or a RA that provides information about claim errors. After the claim has been corrected, you must resubmit it as a new claim within the timely filing period. A claim that has been returned as unprocessable may not be appealed.

You may appeal initial claim determinations, including denials, if you are dissatisfied with the claim determination and file a timely appeal request that contains the necessary information needed to process the request.

If a denial is due to a minor error or omission you made in filing a claim, you may request a reopening to correct such clerical errors. A reopening is separate and distinct from the appeals process. After the claim has been corrected, you must resubmit it within the timely filing period.

1500 HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE PICA MEDICAID TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY M F

4. INSURED'S NAME (Last Name)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
 Self Spouse Child Other

7. INSURED'S ADDRESS (City)

8. PATIENT STATUS
 Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT? (Current or Previous) YES NO
 b. AUTO ACCIDENT? YES NO PLACE (State)
 c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY OR GROUP NUMBER

12. IS THERE ANOTHER INSURED'S DATE OF BIRTH DD MM YY M F

13. INSURANCE POLICY NUMBER

14. RESERVED FOR LOCAL USE

RESOURCES


The chart below provides Medicare enrollment and claim submission resources.

Enrollment and Claim Submission Resources

For More Information About...	Resource
Enrolling in the Medicare Program	<p>Chapters 1 and 24 of the “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website</p> <p>Chapters 10 and 15 of the “Medicare Program Integrity Manual” (Publication 100-08) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html on the CMS website</p> <p>http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll on the CMS website</p> <p style="text-align: center;">National Provider Identifier</p> <p>Chapter 14 of the “Medicare Program Integrity Manual” (Publication 100-08) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c14.pdf on the CMS website</p> <p>Medicare Learning Network® (MLN) publication titled “The National Provider Identifier (NPI): What You Need to Know” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPIBooklet.pdf on the CMS website</p> <p>http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand on the CMS website</p> <p style="text-align: center;">Institutional Provider Participation Requirements</p> <p>http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo on the CMS website</p> <p style="text-align: center;">Provider Enrollment & Certification Frequently Asked Questions</p> <p>https://questions.cms.gov/faq.php?id=5005&rtopic=1889 on the CMS website</p>

For More Information About...	Resource
Private Contracts With Medicare Beneficiaries	Chapter 15 of the “Medicare Benefit Policy Manual” (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website
Medicare Claims	Chapter 1 of the “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf on the CMS website Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and Parenteral and Enteral Nutrition Claims http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html on the CMS website
Deductibles, Coinsurance, and Copayments	Chapter 3 of the “Medicare General Information, Eligibility, and Entitlement Manual” (Publication 100-01) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf on the CMS website
Beneficiary Notices of Noncoverage	Chapter 30 of the “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf on the CMS website http://www.cms.gov/Medicare/Medicare-General-Information/BNI on the CMS website



For More Information About...	Resource
Billing Requirements	<p>“Medicare General Information, Eligibility, and Entitlement Manual” (Publication 100-01) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS050111.html on the CMS website</p> <p style="text-align: center;">Medicare Secondary Payment Provisions</p> <p>“Medicare Secondary Payer Manual” (Publication 100-05) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html on the CMS website</p> <p>MLN publication titled “Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MSP_Fact_Sheet.pdf on the CMS website</p> <p style="text-align: center;">Coordination of Benefits Contractor</p> <p>http://cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html on the CMS website</p> <p style="text-align: center;">Claims Processing</p> <p>Chapters 1, 29, and 34 of the “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website</p>
All Available MLN Products	<p>“Medicare Learning Network® Catalog of Products” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLN_Catalog.pdf on the CMS website or scan the Quick Response (QR) code on the right with your mobile device</p> 
Provider-Specific Medicare Information	<p>MLN publication titled “MLN Guided Pathways to Medicare Resources Provider Specific Curriculum for Health Care Professionals, Suppliers, and Providers” booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website</p>
Medicare Information for Beneficiaries	<p>http://www.medicare.gov on the CMS website</p>



The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official information health care professionals can trust. For additional information, visit the MLN's web page at <http://go.cms.gov/MLNGenInfo> on the CMS website.

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