This publication offers providers and suppliers the following information:

- Applying for a National Provider Identifier (NPI) and enrolling in the Medicare Program;
- Filing Medicare claims;
- Private contracts with Medicare beneficiaries; and
- Resources.

**APPLYING FOR A NATIONAL PROVIDER IDENTIFIER AND ENROLLING IN THE MEDICARE PROGRAM**

In order to enroll in and obtain reimbursement from Medicare, you must apply for a NPI and enroll in the Medicare Program.

These two requirements are discussed in more detail below.

1) **Applying for the National Provider Identifier**

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

You can apply for a NPI using one of the following methods:

- Visiting [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do) and completing the web-based application;
- Requesting Form CMS-10114, the NPI Application/Update Form, by calling (800) 465-3203, sending an e-mail to customerservice@npienumerator.com or sending a letter to:
  - NPI Enumerator
  - P. O. Box 6059
  - Fargo, ND 58108-6059; or
- Requesting that an Electronic File Interchange Organization submit application data on your behalf.


2) **Enrolling in the Medicare Program**

In the enrollment process, CMS collects information about the applying provider or supplier 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 paper enrollment process via an enrollment application (Form CMS-855).

**Provider Enrollment, Chain and Ownership System Enrollment**

PECOS can be used to complete the following via the Internet:

- Submit an initial Medicare enrollment application;
- View or change enrollment information;

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Track the enrollment application through the web submission process;
Add or change a reassignment of benefits;
Submit changes to existing Medicare enrollment information;
Reactivate an existing enrollment record; and
Withdraw from the Medicare Program.

After the enrollment application is submitted, the signed and dated Certification Statement and any supporting documentation is then mailed to the designated Medicare Contractor. The enrollment application cannot be processed until the Medicare Contractor receives these documents.

**Paper Enrollment**

Alternatively, you may apply for enrollment by completing and signing a paper enrollment form, which is mailed along with any supporting documentation to the designated Medicare Contractor. Depending upon the provider or supplier type, one of the following enrollment forms is completed to enroll in the Medicare Program:

- **Form CMS-855A/Medicare Enrollment Application for Institutional Providers:** Application used by institutional providers to initiate the Medicare enrollment process or to change Medicare 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 initiate the Medicare enrollment process or to change Medicare 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 initiate the Medicare enrollment process or to change Medicare enrollment information;
- **Form CMS-855R/Medicare Enrollment Application for Reassignment of Medicare Benefits:** Application used by individual physicians or NPPs to initiate reassignment of a right to bill the Medicare Program and receive Medicare payments or to terminate a reassignment of benefits; and
- **Form CMS-855S/Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Suppliers:** Application used by DMEPOS suppliers to initiate the Medicare enrollment process or to change Medicare enrollment information.

**Additional Forms and Documentation That May Be Required**

The following forms are often required in addition to the Medicare Enrollment Application:

- **Form CMS-588/Electronic Funds Transfer (EFT) Authorization Agreement:** Medicare authorization agreement for EFTs (to have payments sent directly to your financial institution); and
- **CMS Standard Electronic Data Interchange (EDI) Enrollment and Registration Forms:** Agreements executed when you intend to 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 EMC or other EDI transactions to Medicare.

Form CMS-460, the Medicare Participating Physician or Supplier Agreement, is also submitted if you wish to enroll as a Part B participating provider or supplier.
To access the enrollment applications and EFT and EDI forms, visit http://www.cms.gov/CMSForms/CMSForms/list.asp on the CMS website. The EDI forms are also available from Medicare Carriers, Fiscal Intermediaries, A/B Medicare Administrative Contractors (MAC), and Durable Medical Equipment MACs. To find information about where to send Medicare enrollment forms, visit http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

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

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

**FILING MEDICARE CLAIMS**

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

**Timely Filing Requirement**

Before payment can be made for Medicare-covered services, claims must be filed timely. Claims with dates of service on or after January 1, 2010, must be received no later than one calendar year from the claim’s date of service. Fee-For-Service claims with service dates from October 1, 2009, through December 31, 2009, must be received no later than December 31, 2010. Claims that are 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.

There are four exceptions to the timely filing requirement, if certain conditions are met:

- Administrative error, if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare Contractor, 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.

**Exceptions to Mandatory 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 items or services furnished outside the U.S., except in limited cases;
- The claim is for services initially paid by third-party insurers who then file Medicare claims to recoup what Medicare pays as the primary insurer (e.g., indirect payment provisions);
- The claim is for other unusual services, which are evaluated by Medicare Contractors on a case-by-case basis;
The claim is for excluded services, unless the beneficiary requests submission of a claim to Medicare (some supplemental insurers who pay for these services may require a Medicare claim denial notice prior to making payment);
The beneficiary has signed Form CMS-R-131, the Advance Beneficiary Notice of Noncoverage, indicating that no claim should be filed for a specific item or service;
You have opted-out of the Medicare Program and entered into a private contract with the beneficiary; or
You have been excluded or debarred from the Medicare Program.

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 and doctors of 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 two 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 two-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 services.”

When you have opted-out, Medicare will make payment 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.
RESOURCES


This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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