**§ 424.502 Definitions.**

As used in this subpart, unless the context indicates otherwise—

*Affiliation* means, for purposes of applying § 424.519, any of the following:

(1) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.

(2) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.

(3) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of this paragraph (3), sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W–2 employee of the organization.

(4) An interest in which an individual is acting as an officer or director of a corporation.

(5) Any reassignment relationship under § 424.80.

*Approve/Approval* means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.

*Authorized official* means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

*Change in majority ownership* occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sale, stock transfer, merger, and consolidation). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

*Deactivate* means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

*Delegated official* means an individual who is delegated by the ''Authorized Official,'' the authority to report changes and updates to the enrollment record. The delegated official must be an individual with ownership or control interest in, or be a W–2 managing employee of the provider or supplier.

*Deny/Denial* means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries.

*Director* means a director of a corporation, regardless of whether the provider or supplier is a non-profit entity. This includes any member of the corporation's governing body irrespective of the precise title of either the board or the member.

*Disclosable event* means, for purposes of § 424.519, any of the following:

(1) Currently has an uncollected debt to Medicare, Medicaid, or CHIP, regardless of—

(i) The amount of the debt;

(ii) Whether the debt is currently being repaid (for example, as part of a repayment plan); or

(iii) Whether the debt is currently being appealed;

(2) Has been or is subject to a payment suspension under a federal health care program (as that latter term is defined in section 1128B(f) of the Act), regardless of when the payment suspension occurred or was imposed;

(3) Has been or is excluded by the OIG from participation in Medicare, Medicaid, or CHIP, regardless of whether the exclusion is currently being appealed or when the exclusion occurred or was imposed; or

(4) Has had its Medicare, Medicaid, or CHIP enrollment denied, revoked, or terminated, regardless of—

(i) The reason for the denial, revocation, or termination;

(ii) Whether the denial, revocation, or termination is currently being appealed; or

(iii) When the denial, revocation, or termination occurred or was imposed.

*Enroll/Enrollment* means the process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services. The process includes—

(1) Identification of a provider or supplier;

(2) Except for those suppliers that complete the CMS–855O form, CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services, validating the provider or supplier's eligibility to provide items or services to Medicare beneficiaries;

(3) Identification and confirmation of the provider or supplier's practice location(s) and owner(s); and

(4) Except for those suppliers that complete the CMS–855O form, CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services, granting the Medicare provider or supplier Medicare billing privileges.

*Enrollment application* means a CMS-approved paper enrollment application or an electronic Medicare enrollment process approved by OMB.

*Final adverse action* means one or more of the following actions:

(1) A Medicare-imposed revocation of any Medicare billing privileges;

(2) Suspension or revocation of a license to provide health care by any State licensing authority;

(3) Revocation or suspension by an accreditation organization;

(4) A conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or

(5) An exclusion or debarment from participation in a Federal or State health care program.

*Institutional provider* means any provider or supplier that submits a paper Medicare enrollment application using the CMS–855A, CMS–855B (not including physician and nonphysician practitioner organizations), CMS–855S, or an associated internet-based PECOS enrollment application.

*Managing employee* means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W–2 employee of the provider or supplier.

*Managing organization* means an entity that exercises operational or managerial control over, or that directly or indirectly conducts, the day-to-day operations of the provider or supplier, either under contract or through some other arrangement.

*NPI* stands for National Provider Identifier.

*Officer* means an officer of a corporation, regardless of whether the provider or supplier is a non-profit entity.

*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 items being rendered), to furnish these items or 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 sections 1124 and 1124A(A) of the Act.

*PECOS* stands for Internet-based Provider Enrollment, Chain, and Ownership System.

*Physician or nonphysician practitioner organization* means any physician or nonphysician practitioner entity that enrolls in the Medicare program as a

sole proprietorship or organizational entity.

*Reject/Rejected* means that the provider or supplier's enrollment application was not processed due to incomplete information, or that additional information or corrected information was not received from the provider or supplier in a timely manner.

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

*State oversight board* means, for purposes of §§ 424.530(a)(15) and 424.535(a)(22) only, any State administrative body or organization, such as (but not limited to) a medical board, licensing agency, or accreditation body, that directly or indirectly oversees or regulates the provision of health care within the State.

*Voluntary termination* means that a provider or supplier, including an individual physician or nonphysician practitioner, submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

[71 FR 20776, Apr. 21, 2006, as amended at 73 FR 69939, Nov. 19, 2008; 75 FR 70464, Nov. 17, 2010; 75 FR 73628, Nov. 29, 2010; 76 FR 5962, Feb. 2, 2011; 79 FR 72531, Dec. 5, 2014; 82 FR 53368, Nov. 15, 2017; 84 FR 47852, Sept. 10, 2019; 84 FR 63203, Nov. 15, 2019; 86 FR 65682, Nov. 19, 2021; 87 FR 70231, Nov. 18, 2022]

### § 424.505 Basic enrollment requirement.

To receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim), a provider or supplier must be enrolled in the Medicare program. Except for those suppliers that complete the CMS–855O form or CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services; once enrolled the provider or supplier receives billing privileges and is issued a valid billing number effective for the date a claim was submitted for an item that was furnished or a service that was rendered. (See 45 CFR part 162 for information on the National Provider Identifier and its use as the Medicare billing number.)

[71 FR 20776, Apr. 21, 2006, as amended at 79 FR 72531, Dec. 5, 2014]

### § 424.506 National Provider Identifier (NPI) on all enrollment applications and claims.

(a) *Definition. Eligible professional* means any of the professionals specified in section 1848(k)(3)(B) of the Act.

(b) *Enrollment requirements.* (1) A provider or a supplier that is eligible for an NPI must do the following:

(i) Report its NPI on its Medicare enrollment application.

(ii) If the provider or supplier was in the Medicare program before obtaining an NPI and the provider's or the supplier's NPI is not in the provider's or supplier's Medicare enrollment record, the provider or supplier must update its Medicare enrollment record by submitting its NPI using either of the following:

(A) The applicable paper CMS–855 form.

(B) Internet-based PECOS.

(2) A physician or eligible professional who has validly opted-out of the Medicare program is not required to submit a Medicare enrollment application for any reason, including to order or certify.

(c) *Claims reporting requirements.* (1) A provider or supplier that is enrolled in Medicare and submits a paper or an electronic claim must include its NPI and the NPI(s) of any other provider(s) or supplier(s) identified on the claim.

(2) A Medicare beneficiary who submits a claim for service to Medicare—

(i) Must include the legal name of any provider or supplier who is required to be identified in that claim; and

(ii) May, if known to the beneficiary, include the National Provider Identifier (NPI) of any provider or supplier who is required to be identified in that claim.

(3) A Medicare contractor will reject a claim from a provider or a supplier if the required NPI(s) is not reported.

[75 FR 24448, May 5, 2010, as amended at 77 FR 25317, Apr. 27, 2012]