proprietors must be signed by the enrolling or enrolled individual. Each delegation of authority to a delegated official must—

(A) Be assigned by the authorized official currently on file with CMS;

(B) Be submitted to CMS using the appropriate enrollment application or CMS established electronic enrollment process;

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

(D) Be an individual that 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.

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

(5) *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.

(6) *Ability to furnish Medicare covered items or services.* The provider or supplier must be operational to furnish Medicare covered items or services before being granted Medicare billing privileges.

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

(8) *On-site review.* CMS reserves the right, when deemed 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 do not affect those site visits performed for establishing compliance with conditions of participation.

(i) *Medicare Part A providers.* CMS determines, upon on-site review, that the provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) *Medicare Part B suppliers.* CMS determines, upon review that the supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

(9) In order to obtain enrollment and to maintain enrollment for the first three months after Medicare billing privileges are conveyed, a home health agency must satisfy the home health ''initial reserve operating funds'' requirement as set forth in § 489.28 of this chapter.

(e) Providers and suppliers must—

(1) Agree to receive Medicare payment via electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors where the provider or supplier was already receiving payments via EFT or submission of an enrollment change request; and

(2) Submit the CMS–588 form to receive Medicare payment via electronic funds transfer.

[71 FR 20776, Apr. 21, 2006, as amended at 73 FR 36461, June 27, 2008; 75 FR 50418, Aug. 16, 2010; 75 FR 70464, Nov. 17, 2010; 75 FR 73628, Nov. 29, 2010; 77 FR 29030, July 16, 2012; 79 FR 72531, Dec. 5, 2014]

§ 424.514 Application fee.

(a) *Application fee requirements for prospective institutional providers.* Beginning on or after March 25, 2011, prospective institutional providers that are submitting an initial application or currently enrolled institutional providers that are submitting an application to establish a new practice location must submit either or both of the following:

(1) The applicable application fee.

(2) A request for a hardship exception to the application fee at the time of filing a Medicare enrollment application.

(b) *Application fee requirements for revalidating institutional providers.* Beginning March 25, 2011, institutional providers that are subject to CMS revalidation efforts must submit either or both of the following:

(1) The applicable application fee.

(2) A request for a hardship exception to the application fee at the time of filing a Medicare enrollment application.

(c) *Hardship exception for disaster areas.* CMS will assess on a case-by-case basis whether institutional providers enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5206 (Stafford Act) should receive an exception to the application fee.

(d) *Application fee.* The application fee and associated requirements are as follows:

(1) For 2010, $500.00.

(2) For 2011 and subsequent years—

(i) Is adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year;

(ii) Is effective from January 1 to December 31 of a calendar year;

(iii) Is based on the submission of an initial application, application to establish a new practice location or the submission of an application in response to a CMS revalidation request;

(iv) Must be in the amount calculated by CMS in effect for the year during which the application for enrollment is being submitted;

(v) Is nonrefundable, except if submitted with one of the following:

(A) A request for hardship exception that is subsequently approved;

(B) An application that is rejected prior to initiation of screening processes;

(C) An application that is subsequently denied as a result of the imposition of a temporary moratorium;

(e) *Denial or revocation based on application fee.* A Medicare contractor may deny or revoke Medicare billing privileges of a provider or supplier based on noncompliance if, in the absence of a written request for a hardship exception from the application fee that accompanies a Medicare enrollment application, the bank account on which the check that is submitted with the enrollment application is drawn does not contain sufficient funds to pay the application fee.

(f) *Information needed for submission of a hardship exception request.* A provider or supplier requesting an exception from the application fee must include with its enrollment application a letter that describes the hardship and why the hardship justifies an exception.

(g) *Failure to submit application fee or hardship exception request.* A Medicare contractor may—

(1) Reject an enrollment application from a newly-enrolling institutional provider that, with the exceptions described in §424.514(b), is not accompanied by the application fee or by a letter requesting a hardship exception from the application fee.

(2) Revoke the billing privileges of a currently enrolled institutional provider that, with the exceptions described in §424.514(b), is not accompanied by the application fee or by a letter requesting a hardship exception from the application fee.

(3)(i) Notwithstanding the foregoing, the contractor must first inform the provider that the application fee was not submitted in accordance with this section.

(ii) Within 30 days after the date of the notification, the contractor may reject the application of the newly-enrolling institutional provider or revoke the billing privileges of the currently enrolled institutional provider that has not submitted the fee.

(h) *Consideration of hardship exception request.* CMS has 60 days in which to approve or disapprove a hardship exception request. If a provider submits a request for hardship exception to the fee and the provider or supplier has not already submitted the fee consistent with provisions in §424.514(a) and (b), and the request for hardship exception is not approved, CMS notifies the provider or supplier that the hardship exception request was not approved and allows the provider or supplier 30 days

from the date of notification to submit the application fee.

(1) A Medicare contractor does not—

(i) Begin processing an enrollment application that is accompanied by a hardship exception request until CMS has made a decision to approve or disapprove the hardship exception request; and

(ii) Deny an enrollment application that is accompanied by a hardship exception request unless the hardship exception request is denied by CMS and the provider or supplier fails to submit the required application fee within 30 days of being notified that the request for a hardship exception was denied.

(2) A hardship exception determination made by CMS is appealable using § 405.874 of this chapter.

[76 FR 5962, Feb. 2, 2011]

§ 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 (other than a DMEPOS supplier) must resubmit and recertify the accuracy of its enrollment information every 5 years. All providers and suppliers currently billing the Medicare program or initially enrolling in the Medicare program are required to complete the applicable enrollment application. The provider or supplier then enters a 5-year revalidation cycle once a completed enrollment application is submitted and validated. (Ambulance service providers must continue to resubmit enrollment information in accordance with § 410.41(c)(2) of this chapter and DMEPOS suppliers must continue to renew enrollment in accordance with § 424.57(g)). The requirements for the resubmission, recertification and reverification of enrollment information include the following:

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

(1) CMS contacts each provider or supplier directly when it is time to revalidate their enrollment information.

(2) A provider or supplier must submit to CMS the applicable enrollment application 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.

(b) *Completion of any applicable State surveys, certifications and provider agreements.* A new 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 chapter, or any currently established supplier agreement, if applicable.

(c) *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 do not affect those site visits performed for establishing compliance with conditions of participation.

(1) *Medicare Part A providers.* CMS determines, upon on-site review, that the provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(2) *Medicare Part B suppliers.* CMS determines, upon review that the supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

(d) *Off Cycle revalidations.* (1) CMS reserves the right to perform off cycle revalidations in addition to the regular 5-year revalidations and may request that a provider or supplier recertify the accuracy of the enrollment information when warranted to assess and confirm the validity of the enrollment information maintained by CMS. Off cycle revalidations may be triggered as a result of random checks, information indicating local health care fraud problems, national initiatives, complaints,