

§ 405.2472

it determines that the clinic or center does not maintain records that provide an adequate basis to determine payments under Medicare.

(2) The suspension continues until the clinic or center demonstrates to the intermediary's satisfaction that it does, and will continue to, maintain adequate records.

(c) *Reporting requirements*—(1) *Initial report*. At the beginning of its initial reporting period, the clinic or center must submit an estimate of budgeted costs and visits for rural health clinic or Federally qualified health center services for the reporting period, in the form and detail required by CMS, and such other information as CMS may require to establish the payment rate.

(2) *Annual reports*. Within 90 days after the end of its reporting period, the clinic or center must submit, in such form and detail as may be required by CMS, a report of:

(i) Its operations, including the allowable costs actually incurred for the period and the actual number of visits for rural health clinic or Federally qualified health center services furnished during the period; and

(ii) The estimated costs and visits for rural health clinic services or Federally qualified health center services for the succeeding reporting period and such other information as CMS may require to establish the payment rate.

(3) *Late reports*. If the clinic or center does not submit an adequate annual report on time, the intermediary may reduce or suspend payments to preclude excess payment to the clinic or center.

(4) *Inadequate reports*. If the clinic or center does not furnish a report or furnishes a report that is inadequate for the intermediary to make a determination of program payment, CMS may deem all payments for the reporting period to be overpayments.

(5) *Postponement of due date*. For good cause shown by the clinic or center, the intermediary may, with CMS's approval, grant a 30-day postponement of the due date for the annual report.

(6) *Reports following termination of agreement or change of ownership*. The report from a clinic or center which voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change in ownership (see

42 CFR Ch. IV (10–1–05 Edition)

§§ 405.2436–405.2438) is due no later than 45 days following the effective date of the termination of agreement or change of ownership.

§ 405.2472 Beneficiary appeals.

A beneficiary may request a hearing by an intermediary (subject to the limitations and conditions set forth in subpart H of this part) if:

(a) The beneficiary is dissatisfied with an intermediary's determination denying a request for payment made on his or her behalf by a rural health clinic or Federally qualified health center; or

(b) The beneficiary is dissatisfied with the amount of payment; or

(c) The beneficiary believes the request for payment is not being acted upon with reasonable promptness.

[43 FR 8261, Mar. 1, 1978. Redesignated and amended at 57 FR 24978, June 12, 1992]

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

Subpart A—General Provisions

Sec.

406.1 Statutory basis.

406.2 Scope.

406.3 Definitions.

406.5 Basis of eligibility and entitlement.

406.6 Application or enrollment for hospital insurance.

406.7 Forms to apply for entitlement under Medicare Part A.

Subpart B—Hospital Insurance Without Monthly Premiums

406.10 Individual age 65 or over who is entitled to social security or railroad retirement benefits, or who is eligible for social security benefits.

406.11 Individual age 65 or over who is not eligible as a social security or railroad retirement benefits beneficiary, or on the basis of government employment.

406.12 Individual under age 65 who is entitled to social security or railroad retirement disability benefits.

406.13 Individual who has end-stage renal disease.

406.15 Special provisions applicable to Medicare qualified government employment.

Subpart C—Premium Hospital Insurance

406.20 Basic requirements.

406.21 Individual enrollment.

- 406.22 Effect of month of enrollment on entitlement.
- 406.24 Special enrollment period.
- 406.26 Enrollment under State buy-in.
- 406.28 End of entitlement.
- 406.32 Monthly premiums.
- 406.33 Determination of months to be counted for premium increase: Enrollment.
- 406.34 Determination of months to be counted for premium increase: Reenrollment.
- 406.38 Prejudice to enrollment rights because of Federal Government error.

Subpart D—Special Circumstances That Affect Entitlement to Hospital Insurance

- 406.50 Nonpayment of benefits on behalf of certain aliens.
- 406.52 Conviction of certain offenses.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 48 FR 12536, Mar. 25, 1983, unless otherwise noted. Redesignated at 51 FR 41338, Nov. 14, 1986.

Subpart A—General Provisions

§ 406.1 Statutory basis.

Sections 226, 226A, 1818 and 1818A of the Social Security Act and section 103 of Public Law 89-97 establish the conditions for entitlement to hospital insurance benefits. Sections 202 (t) and (u) of the Act specify limitations that apply to certain aliens and to persons convicted of certain offenses.

[48 FR 12536, Mar. 25, 1983. Redesignated at 51 FR 41338, Nov. 14, 1986, as amended at 56 FR 38078, Aug. 12, 1991]

§ 406.2 Scope.

Subparts A through D of this part specify the conditions of eligibility for hospital insurance and set forth certain specific conditions that affect entitlement to benefits. Hospital insurance is authorized under Part A of title XVIII and is also referred to as Medicare Part A. It includes inpatient hospital care, posthospital SNF care, home health services, and hospice care.

[48 FR 56026, Dec. 16, 1983, as amended at 50 FR 33033, Aug. 16, 1985. Redesignated and amended at 51 FR 41338, Nov. 14, 1986]

§ 406.3 Definitions.

First month of eligibility means the first month in which an individual meets all the requirements for entitlement to hospital insurance except ap-

plication or enrollment if that is required.

First month of entitlement means the first month for which the individual meets all the requirements for entitlement to Part A benefits.

Insured individual means an individual who has the number of quarters of coverage required for monthly social security benefits.

Quarter of coverage means a calendar quarter that is counted toward the number of covered quarters required to make the individual eligible for monthly social security benefits. A quarter is counted if during that quarter (or that calendar year) the individual earned a required minimum amount of money. (For details, see 20 CFR part 404, subpart B.)

§ 406.5 Basis of eligibility and entitlement.

(a) *Hospital insurance without premiums.* Hospital insurance is available to most individuals without payment of a premium if they:

- (1) Are age 65 or over, or
- (2) Have received social security or railroad retirement disability benefits for 25 months; or
- (3) Have end-stage renal disease. Subpart B of this part explains the requirements such individuals must meet to obtain hospital insurance without premiums.

(b) *Premium hospital insurance.* Many individuals who are age 65 or over, but do not meet the requirements set forth in subpart B of this part, and certain individuals under age 65, may obtain the benefits by paying a premium. Section 406.20 of this part explains the requirements individuals must meet to obtain premium hospital insurance.

[48 FR 12536, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985; 56 FR 38078, Aug. 12, 1991]

§ 406.6 Application or enrollment for hospital insurance.

(a) *Basic provision.* In most cases, eligibility for Medicare Part A is a result of entitlement to monthly social security or railroad retirement cash benefits or eligibility for monthly social security cash benefits. This section specifies the individuals who need not file an application to become entitled to