

### § 424.33

situations in which the standard adopted by the Secretary at 45 FR 162.1102 does not support all of the information necessary for payment of the claim. The Secretary may identify situations coming within this exception in guidance.

(ii) The entity submitting the claim is a small provider of services or small supplier.

(4) *Unusual cases.* The Secretary may waive the requirement of paragraph (d)(2) of this section in unusual cases as the Secretary finds appropriate. Unusual cases are deemed to exist in the following situations:

(i) The submission of dental claims.

(ii) There is a service interruption in the mode of submitting the electronic claim that is outside the control of the entity submitting the claim, for the period of the interruption.

(iii) The entity submitting the claim submits fewer than 10 claims to Medicare per month, on average.

(iv) The entity submitting the claim only furnishes services outside of the U.S. territory.

(v) On demonstration, satisfactory to the Secretary, of other extraordinary circumstances precluding submission of electronic claims.

(5) *Effective date.* This paragraph (d) is effective October 16, 2003, and applies to claims submitted on or after October 16, 2003.

[53 FR 6639, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988, as amended at 59 FR 10299, Mar. 4, 1994; 63 FR 26311, May 12, 1998; 63 FR 53307, Oct. 5, 1998; 66 FR 39601, July 31, 2001; 68 FR 48813, Aug. 15, 2003; 70 FR 71020, Nov. 25, 2005; 71 FR 48143, Aug. 18, 2006]

### § 424.33 Additional requirements: Claims for services of providers and claims by suppliers and nonparticipating hospitals.

All claims for services of providers and all claims by suppliers and nonparticipating hospitals must be—

(a) Filed by the provider, supplier, or hospital; and

(b) Signed by the provider, supplier, or hospital unless CMS instructions waive this requirement.

### 42 CFR Ch. IV (10–1–06 Edition)

### § 424.34 Additional requirements: Beneficiary's claim for direct payment.

(a) *Basic rule.* A beneficiary's claim for direct payment for services furnished by a supplier, or by a nonparticipating hospital that has not elected to claim payment for emergency services, must include an itemized bill or a "report of services", as specified in paragraphs (b) and (c) of this section.

(b) *Itemized bill from the hospital or supplier.* The itemized bill for the services, which may be receipted or unpaid, must include all of the following information:

(1) The name and address of—

(i) The beneficiary;

(ii) The supplier or nonparticipating hospital that furnished the services; and

(iii) The physician who prescribed the services if they were furnished by a supplier other than the physician.

(2) The place where each service was furnished, e.g., home, office, independent laboratory, hospital.

(3) The date each service was furnished.

(4) A listing of the services in sufficient detail to permit determination of payment under the fee schedule for physicians' services; for itemized bills from physicians, appropriate diagnostic coding using ICD–9–CM must be used.

(5) The charges for each service.

(c) *Report of services furnished by a supplier.* For Medicare Part B services furnished by a supplier, the beneficiary claims may include the "Report of Services" portion of the appropriate claims form, completed by the supplier in accordance with CMS instructions, in lieu of an itemized bill.

[53 FR 6634, Mar. 2, 1988, as amended at 59 FR 10299, Mar. 4, 1994; 59 FR 26740, May 24, 1994]

### § 424.36 Signature requirements.

(a) *General rule.* The beneficiary's own signature is required on the claim unless the beneficiary has died or the provisions of paragraph (b), (c), or (d) of this section apply.

(b) *Who may sign when the beneficiary is incapable.* If the beneficiary is physically or mentally incapable of signing the claim, the claim may be signed on

his or her behalf by one of the following:

- (1) The beneficiary's legal guardian.
- (2) A relative or other person who receives social security or other governmental benefits on the beneficiary's behalf.
- (3) A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs.
- (4) A representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the beneficiary.
- (5) A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished if the provider or nonparticipating hospital is unable to have the claim signed in accordance with paragraph (b) (1), (2), (3), or (4) of this section.

(c) *Who may sign if the beneficiary was not present for the service.* If a provider, nonparticipating hospital, or supplier files a claim for services that involved no personal contact between the provider, hospital, or supplier and the beneficiary (for example, a physician sent a blood sample to the provider for diagnostic tests), a representative of the provider, hospital, or supplier may sign the claim on the beneficiary's behalf.

(d) *Claims by entities that provide coverage complementary to Medicare.* A claim by an entity that provides coverage complementary to Medicare Part B may be signed by the entity on the beneficiary's behalf.

(e) *Acceptance of other signatures for good cause.* If good cause is shown, CMS may honor a claim signed by a party other than those specified in paragraphs (a) through (c) of this section.

[53 FR 6640, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988, as amended at 53 FR 28388, July 28, 1988]

**§ 424.37 Evidence of authority to sign on behalf of the beneficiary.**

(a) *Beneficiary incapable.* When a party specified in § 424.36(b) signs a claim or request for payment statement, he or she must also submit a brief statement that—

- (1) Describes his or her relationship to the beneficiary; and

(2) Explains the circumstances that make it impractical for the beneficiary to sign the claim or statement.

(b) *Beneficiary not present for services.* When a representative of the provider, nonparticipating hospital, or supplier signs a claim or request for payment statement under § 424.36(c), he or she must explain why it was not possible to obtain the beneficiary's signature. (For example: "Patient not physically present for test.")

[53 FR 6640, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

**§ 424.40 Request for payment effective for more than one claim.**

(a) *Basic procedure.* A separate request for payment statement prescribed by CMS and signed by the beneficiary (or by his or her representative) may be included in claims by reference, in the circumstances specified in paragraphs (b) through (d) of this section.

(b) *Claims filed by a provider or nonparticipating hospital—(1) Inpatient services.* A signed request for payment statement, included in the first claim for Part A services furnished by a facility (a participating hospital or SNF, or a nonparticipating hospital that has elected to claim payment) during a beneficiary's period of confinement, may be effective for all claims for Part A services the facility furnishes that beneficiary during that confinement.

(2) *Home health services and outpatient physical therapy or speech pathology services.* A signed request for payment statement, included in the first claim for home health services or outpatient physical therapy or speech pathology services furnished by a provider under a plan of treatment, may be effective for all claims for home health services or outpatient physical therapy or speech pathology services furnished by the provider under that plan of treatment.

(c) *Signed statement in the provider record—(1) Services to inpatients.* A signed request for payment statement in the files of a participating hospital or SNF may be effective for all claims for services furnished to the beneficiary during a single inpatient stay in that facility—

- (i) By the hospital or SNF;