

disbursing center responsible for issuing checks.

(3) *Action by the Treasury Department.* The Treasury Department will replace and begin reclamation of Treasury checks in accordance with Treasury Department regulations (31 CFR parts 235, 240, and 245).

(b) *Intermediary and carrier benefit checks.* Checks issued by intermediaries and carriers are drawn on commercial banks and are not subject to the Federal laws and Treasury Department regulations that govern Treasury checks. Replacement procedures are carried out in accordance with § 424.352 under applicable State law (including any Federal banking laws or regulations that may affect the relevant State proceedings).

[58 FR 65129, Dec. 13, 1993]

**§ 424.352 Intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed or paid on forged endorsements.**

(a) When an intermediary or carrier is notified by a payee that a check has been lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsement, the intermediary or carrier contacts the commercial bank on whose paper the check was drawn and determines whether the check has been negotiated.

(b) If the check has been negotiated—

(1) The intermediary or carrier provides the payee with a copy of the check and other pertinent information (such as a claim form, affidavit or questionnaire to be completed by the payee) required to pursue his or her claim in accordance with State law and commercial banking regulations.

(2) To pursue the claim, the payee must examine the check and certify (by completing the claim form, questionnaire or affidavit) that the endorsement is not the payee's.

(3) The claim form and other pertinent information is sent to the intermediary or carrier for review and processing of the claim.

(4) The intermediary or carrier reviews the payee's claim. If the intermediary or carrier determines that the claim appears to be valid, it forwards the claim and a copy of the check to the issuing bank. The intermediary or

carrier takes further action to recover the proceeds of the check in accordance with the State law and regulations.

(5) Once the intermediary or carrier recovers the proceeds of the initial check, the intermediary or carrier issues a replacement check to the payee.

(6) If the bank of first deposit refuses to settle on the check for good cause, the payee must pursue the claim on his or her own and the intermediary or carrier will not reissue the check to the payee.

(c) If the check has not been negotiated—

(1) The intermediary or carrier arranges with the bank to stop payment on the check; and

(2) Except as provided in paragraph (d), the intermediary or carrier reissues the check to the payee.

(d) No check may be reissued under (c)(2) unless the claim for a replacement check is received by the intermediary or carrier no later than 1 year from the date of issuance of the original check, unless State law (including any applicable Federal banking laws or regulations that may affect the relevant State proceeding) provides a longer period which will control.

[58 FR 65130, Dec. 13, 1993]

**Subparts N–O [Reserved]**

**Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges**

SOURCE: 71 FR 20776, Apr. 21, 2006, unless otherwise noted.

**§ 424.500 Scope.**

The provisions of this subpart contain the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers except for physicians and practitioners who have entered into a private contract with a beneficiary as described in part 405, subpart D of this chapter. Providers and suppliers must meet and maintain

**§ 424.502**

**42 CFR Ch. IV (10–1–06 Edition)**

these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies.

**§ 424.502 Definitions.**

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

*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.

*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.

*Enroll/Enrollment* means the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. The process includes—

- (1) Identification of a provider or supplier;
- (2) Validation of the provider's 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) Granting the provider or supplier Medicare billing privileges.

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

*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.

*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.

*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.

**§ 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. 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