Complete Medicare Beneficiary Signature Regulations for Ambulance Services - Effective January 1, 2009

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Unofficial Summary Prepared by Page, Wolfberg & Wirth, LLC
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TITLE 42 -- PUBLIC HEALTH
CHAPTER IV -- CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCHAPTER B -- MEDICARE PROGRAM
PART 424 -- CONDITIONS FOR MEDICARE PAYMENT
SUBPART C -- CLAIMS FOR PAYMENT

§ 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 paragraphs (b), (c), or (d) of this section apply. For purposes of this section, "the claim" includes the actual claim form or such other form that contains adequate notice to the beneficiary or other authorized individual that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary.

(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 after making reasonable efforts to locate and obtain the signature of one of the individuals specified in paragraph (b)(1), (2), (3), or (4) of this section.

(6) An ambulance provider or supplier with respect to emergency or nonemergency ambulance transport services, if the following conditions and documentation requirements are met.

(i) None of the individuals listed in paragraph (b)(1), (2), (3), or (4) of this section was available or willing to sign the claim on behalf of the

beneficiary at the time the service was provided;

(ii) The ambulance provider or supplier maintains in its files the following information and documentation for a period of at least four years from the date of service:

(A) A contemporaneous statement, signed by an ambulance employee present during the trip to the receiving facility, that, at the time the service was provided, the beneficiary was physically or mentally incapable of signing the claim and that none of the individuals listed in paragraph (b)(1), (2), (3), or (4) of this section were available or willing to sign the claim on behalf of the beneficiary, and

(B) Documentation with the date and time the beneficiary was transported, and the name and location of the facility that received the beneficiary, and

(C) Either of the following:

(1) A signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the date and time the beneficiary was received by that facility; or

(2) The requested information from a representative of the hospital or facility using a secondary form of verification obtained at a later date, but prior to submitting the claim to Medicare for payment. Secondary forms of verification include a copy of any of the following:

(i) The signed patient care/trip report;

(ii) The facility or hospital registration/admission sheet;

(iii) The patient medical record;

(iv) The facility or hospital log; or

(v) Other internal facility or hospital records.

(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.

§ 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.")

§ 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;

(ii) By physicians, if their services are billed by the hospital or SNF in its name; or

(iii) By physicians who bill separately, if the services were furnished in the hospital or SNF.

(2) Services to outpatients: Providers and renal dialysis facilities. A signed request for payment statement retained in the provider's or facility's files may be effective indefinitely, for all claims for services furnished to that beneficiary on an outpatient basis --

(i) By the provider or facility;

(ii) By physicians whose services are billed by the provider or facility in its name; or

(iii) By physicians who bill separately, if the services were furnished in the provider or facility.

(3) Services to outpatients: Independent rural health clinics and Federally qualified health centers. A signed request for payment statement retained in the clinic's or center's files may be effective indefinitely for all claims for services furnished to that beneficiary by the clinic.

(d) Signed statement in the supplier's record. A signed request for payment statement retained in the supplier's file may be effective indefinitely subject to the following restrictions:

(1) This policy does not apply to unassigned claims for rental of durable medical equipment (DME).

(2) With respect to assigned claims for rental or purchase of DME, a new statement is required if another item of equipment is rented or purchased.