DMERC
MEDICARE ADVISORY

Durable Medical Equipment Regional Carrier PO Box 100141 Columbia SC 29202-3141

Summer 1997
Page 97-45

In This Issue

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General user log on procedures</td>
<td>97-75</td>
</tr>
<tr>
<td>HCFA Internet homepage</td>
<td>97-74</td>
</tr>
<tr>
<td>Offset/overpayment through CSI</td>
<td>97-75</td>
</tr>
<tr>
<td>Publications via BBS</td>
<td>97-76</td>
</tr>
<tr>
<td>Glossary</td>
<td>97-92</td>
</tr>
<tr>
<td>Inherent reasonableness final notice</td>
<td>97-79</td>
</tr>
<tr>
<td>Medical affairs bulletin</td>
<td></td>
</tr>
<tr>
<td>Nebulizer</td>
<td>97-86</td>
</tr>
<tr>
<td>Immunosuppressive</td>
<td>97-86</td>
</tr>
<tr>
<td>Infusion therapy</td>
<td>97-86</td>
</tr>
<tr>
<td>Oral anti-cancer</td>
<td>97-87</td>
</tr>
<tr>
<td>Therapeutic shoes</td>
<td>97-87</td>
</tr>
<tr>
<td>Electronic crossover services</td>
<td>97-71</td>
</tr>
<tr>
<td>Electronic Data interchange</td>
<td></td>
</tr>
<tr>
<td>Bulletin Board System</td>
<td>97-75</td>
</tr>
<tr>
<td>Electronic remittance</td>
<td>97-77</td>
</tr>
<tr>
<td>Enrollment form</td>
<td>97-74</td>
</tr>
<tr>
<td>Medicare secondary payer</td>
<td>97-69</td>
</tr>
<tr>
<td>New ombudsman for</td>
<td></td>
</tr>
<tr>
<td>Arkansas/Oklahoma</td>
<td>97-78</td>
</tr>
<tr>
<td>Ombudsmen</td>
<td></td>
</tr>
<tr>
<td>and their territories</td>
<td>97-90</td>
</tr>
<tr>
<td>Place of service reminder</td>
<td>97-68</td>
</tr>
<tr>
<td>POV repairs</td>
<td>97-88</td>
</tr>
<tr>
<td>Recertification</td>
<td>97-68</td>
</tr>
<tr>
<td>Region C Directory</td>
<td>97-91</td>
</tr>
<tr>
<td>Sales tax</td>
<td>97-68</td>
</tr>
<tr>
<td>Seat lift mechanism</td>
<td></td>
</tr>
<tr>
<td>Physician information sheet</td>
<td>97-85</td>
</tr>
<tr>
<td>Wheelchair cushions</td>
<td>97-70</td>
</tr>
<tr>
<td>Workshop Wizard</td>
<td>97-88</td>
</tr>
<tr>
<td>ZZ001-ZZ011 billing</td>
<td>97-89</td>
</tr>
</tbody>
</table>

CMN Revisions Finalized

Included in this issue are revisions to five Certificate of Medical Necessity forms. The revised forms may be submitted with claims received by Palmetto GBA on or after October 1, 1997. These forms, however, will be required with claims received by Palmetto GBA on or after April 1, 1998.

Palmetto GBA also is releasing loose leaf originals of the revised CMNs in this issue of the Summer 1997 DMEPOS Supplier Manual Revisions.

Contact your ombudsman with questions regarding the finalized CMNs. A directory of Region C ombudsmen can be found on page 97-90.

Alabama
Arkansas
Colorado
Florida

Georgia
Kentucky
Louisiana
Mississippi

New Mexico
North Carolina
Oklahoma
Puerto Rico

South Carolina
Tennessee
Texas
Virgin Islands

Comments and suggestions are welcome. Please direct them to Communications Specialists in the Professional Relations Department at the address listed above.
CERTIFICATES OF MEDICAL NECESSITY

Revisions

Revisions have been made to several Certificates of Medical Necessity (CMNs), and one new form has been added:

<table>
<thead>
<tr>
<th>HCFA Form Number</th>
<th>New DMERC Form Number</th>
<th>Items Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>484</td>
<td>484.2</td>
<td>Oxygen</td>
</tr>
<tr>
<td>843</td>
<td>02.03A</td>
<td>Motorized Wheelchairs</td>
</tr>
<tr>
<td>844</td>
<td>02.03B</td>
<td>Manual Wheelchairs</td>
</tr>
<tr>
<td>846</td>
<td>04.03B</td>
<td>Lymphedema Pumps</td>
</tr>
<tr>
<td>847</td>
<td>04.03C</td>
<td>Osteogenesis Stimulators</td>
</tr>
<tr>
<td>854</td>
<td>11.01</td>
<td>Section C Continuation Form</td>
</tr>
</tbody>
</table>

The following pages contain camera ready copies of the revised/added CMNs.

The revised/added forms may be submitted with claims received by the DMERC on or after October 1, 1997. Existing versions of all CMNs may be submitted with claims received prior to March 31, 1998. However, DMERC Forms 484.2, 02.03A, 02.03B, 04.03B, and 04.03C will be required with claims received by the DMERC on or after April 1, 1998. Existing versions of these CMNs will not be acceptable for certifying medical necessity with claims received on or after April 1, 1998.

There is no change to the following forms:

<table>
<thead>
<tr>
<th>HCFA Form Number</th>
<th>DMERC Form Number</th>
<th>Items Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>841</td>
<td>01.02A</td>
<td>Hospital Beds</td>
</tr>
<tr>
<td>842</td>
<td>01.02B</td>
<td>Support Surfaces</td>
</tr>
<tr>
<td>845</td>
<td>03.02</td>
<td>Continuous Positive Airway Pressure (CPAP) Devices</td>
</tr>
<tr>
<td>848</td>
<td>06.02</td>
<td>Transcutaneous Electrical Nerve Stimulators (TENS)</td>
</tr>
<tr>
<td>849</td>
<td>07.02A</td>
<td>Seat Lift Mechanisms</td>
</tr>
<tr>
<td>850</td>
<td>07.02B</td>
<td>Powered Operated Vehicles</td>
</tr>
<tr>
<td>851</td>
<td>09.02</td>
<td>Infusion Pumps</td>
</tr>
<tr>
<td>852</td>
<td>10.02A</td>
<td>Parenteral Nutrition</td>
</tr>
<tr>
<td>853</td>
<td>10.02B</td>
<td>Enteral Nutrition</td>
</tr>
</tbody>
</table>
CERTIFICATES OF MEDICAL NECESSITY

Revisions (continued)

The Oxygen CMN, HCFA Form 484, has undergone a major revision to make the format consistent with the other DMERC CMNs and to collect minimal additional information. This revision includes the addition of Section C, which lists the supplier's charge and Medicare fee schedule allowance for the equipment that is provided as required by legislation. Section C contains an area for a narrative description of the delivery system provided, whether compressed gas, liquid, or concentrator. It also allows for a narrative description of whether the delivery system is stationary and/or portable. In addition, suppliers should use the space in Section C for a written confirmation of other details of the oxygen order, which after review, the physician should confirm with a signature in Section D if he/she agrees. If the information in Section C does not accurately represent the order, the CMN should be returned unsigned by the physician to the supplier for correction. The additional order information confirmed in Section C should include the means of oxygen delivery, e.g. cannula, mask, etc., and the specifics of varying oxygen flow rates and/or noncontinuous use of oxygen as appropriate. Additional explanation concerning the revised HCFA Form 484 is found on page 97-61 of this advisory under the Medical Affairs Bulletin.

The wheelchair CMNs, HCFA Forms 843 and 844, have been revised to single page CMNs. Section C will continue to accommodate the descriptions, charges and Medicare allowances for the wheelchair base and from four to six options/accessories. If additional space is needed to list options/accessories, these can be itemized on HCFA Form 854. If HCFA Form 854 is used, the wheelchair base and the most costly options/accessories must be listed on HCFA Form 843 or 844. At the present time, HCFA Form 854 may only be used as an addendum to HCFA Forms 843 or 844. It may not be used in conjunction with any other CMN. If HCFA Form 854 is used, it must be signed and dated by the physician (in addition to a signature and date on HCFA Form 843 or 844) and kept on file by the supplier. If the claim is submitted hard copy, a copy of HCFA Form 854 must be submitted along with the copy of HCFA Form 843 or 844. For electronic claims, the supplier does not send data from HCFA Form 854, but is required to keep this form on file.

The CMNs for lymphedema pumps, HCFA Form 846, and osteogenesis stimulators, HCFA Form 847, have been revised to reflect changes in the medical policies for these items which occurred after the existing CMNs were developed/implemented.

In all the revised/added CMNs, the attestation statement in Section D has been modified to clarify that the physician who signs the CMN should be the physician who is actively/presently treating the patient.

Please note that loose leaf originals of the revised CMNs are enclosed in the Summer 1997 DMEPOS Supplier Manual Revisions for photocopying.
CERTIFICATE OF MEDICAL NECESSITY

MOTORIZED WHEELCHAIRS

SECTION A

Certification Type/Date: INITIAL / / REVISED / /

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

S U P P L I E R NAME, ADDRESS, TELEPHONE and NSC NUMBER

( _ _ )  _ _ - _ _ _ _ HICN

HCPCS CODE

PLACE OF SERVICE

NAME and ADDRESS of FACILITY if applicable (See Reverse)

PT DOB / / : Sex (M/F) : HT. (in.) : WT. (lbs.)

PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER

( _ _ )  _ _ - _ _ _ _ UPIN #

SECTION B

Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9):

ITEM ADDRESSED ANSWERS

ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES.

(Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)

Motorized Wheelch & All Accessories

Motorized Wheelch Base

Reclining Back

Elevating Legrest

Adjustable Height Armrest

Reclining Back; adjustable Height Armrest

Motorized Wheelch Base

Motorized Wheelch Base

1. Does the patient require and use a wheelchair to move around in their residence?

2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?

3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?

4. Does the patient have a need for arm height different than that available using non-adjustable armrests?

5. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)

6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?

7. Is the patient unable to operate any type of manual wheelchair?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME:

TITLE:

EMPLOYER:

SECTION C

Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See instructions on back.) If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

☐ CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA FORM 854

SECTION D

Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE ______________________ DATE / / / (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

FORM HCFA 843 (6/97)
SECTION A:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HCIN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE: Indicate the place in which the item is being used. i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERG supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the physician's name and complete mailing address.

UPIN: Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B:

(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C:

(To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.
CERTIFICATE OF MEDICAL NECESSITY

MANUAL WHEELCHAIRS

SECTION A

Certification Type/Date: INITIAL / / REVISED / / /

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

(____) _____ - _____ HICN

PLACE OF SERVICE

NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODE

PT DOB / / ; Sex (M/F); HT. (in.); WT. (lbs.)

PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER

(____) _____ - _____ NSC #

(____) _____ - _____ UPC #

SECTION B

Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9):

ITEM ADDRESSED | ANSWERS | ANSWER QUESTIONS 1, 5, 8 AND 9 FOR MANUAL WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)

Manual Whlchr Base And All Accessories | Y N D | 1. Does the patient require and use a wheelchair to move around in their residence?

Reclining Back | Y N D | 2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?

Elevating Legrest | Y N D | 3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?

Adjustable Height Armrest | Y N D | 4. Does the patient have a need for arm height different than that available using non-adjustable arms?

Reclining Back; Adjustable Ht. Armrest; Any Type Lwt. Whlchr | | 5. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)

Any Type Lwt. Whlchr | Y N D | 8. Is the patient able to adequately self-propel (without being pushed) in a standard weight manual wheelchair?

Any Type Lwt. Whlchr | Y N D | 9. If the answer to question #8 is "No," would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: ________________________ TITLE: ________________________ EMPLOYER: ________________________

SECTION C

Narrative Description of Equipment and Cost

1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See instructions on back.) If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

☐ CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA FORM 854

SECTION D

Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN’S SIGNATURE ________________________ DATE / / /

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

FORM HCFA 844 (5/07)
SECTION A:

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:
If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked “INITIAL.” If this is a revised certification (to be completed when the physician changes the order, based on the patient’s changing clinical needs), indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “REVISED.” If this is a recertification, indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “RECERTIFICATION.” Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:
Indicate the patient’s name, permanent legal address, telephone number and his/her health insurance claim number (HCIN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:
Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:
Indicate the place in which the item is being used, i.e., patient’s home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:
If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES:
List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:
Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS:
Indicate the physician’s name and complete mailing address.

UPIN:
Accurately indicate the ordering physician’s Unique Physician Identification Number (UPIN).

PHYSICANS TELEPHONE NO:
Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B:

(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED:
Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:
In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:
This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling “Y” for yes, “N” for no, “D” for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS:
If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C:

(To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST:
Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier’s charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(To be completed by the physician)

PHYSICIAN ATTESTATION:
The physician’s signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE:
After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician’s signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: HCFA, P.O. Box 200684, Baltimore, Maryland 21207- and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20020-0684.