

(1) The person who claims payment must meet the following requirements:

(i) Submit a claim on a HCFA-prescribed form and an itemized bill in accordance with the requirements of this subpart. (See paragraph (g) of this section for an exception.)

(ii) Provide evidence that the services were furnished if the intermediary or carrier requests it.

(iii) Provide evidence of payment of the bill and of the identity of the person who paid it.

(2) If a person claims payment as the legal representative of the deceased beneficiary's estate, he or she must also submit a copy of the papers showing appointment as legal representative.

(3) If a person claims payment as a survivor of the beneficiary, he or she must also submit evidence, if the intermediary or carrier requests it, that he or she is highest on the priority list of paragraph (c)(3) of this section.

(f) *Evidence of payment.* Evidence of payment may be—

(1) A receipted bill, or a properly completed "Report of Services" section of a claim form, showing who paid the bill;

(2) A cancelled check;

(3) A written statement from the provider or supplier or an authorized staff member; or

(4) Other probative evidence.

(g) *Exception: Claim submitted before beneficiary died.* If a claim and itemized bill has been submitted by or on behalf of the beneficiary before he or she died, submission of another claim form and itemized bill is not required; any written request by the person seeking payment is sufficient.

§ 424.64 Payment after beneficiary's death: Bill has not been paid.

(a) *Scope.* This section specifies whom Medicare pays, and the conditions for payment when the beneficiary has died and the bill has not been paid.

(b) *Situation.* (1) The beneficiary has received covered Part B services furnished by a physician or other supplier.

(2) The beneficiary died without making an assignment to the physician or other supplier or receiving Medicare payment.

(3) The bill has not been paid.

(c) *To whom payment is made.* In the situation described in paragraph (b) of this section, Medicare pays as follows:

(1) *Payment to the supplier.* Medicare pays the physician or other supplier if he or she—

(i) Files a claim on a HCFA-prescribed form in accordance with the applicable requirements of this subpart;

(ii) Upon request from the carrier, provides evidence that the services for which it claims payment were, in fact, furnished; and

(iii) Agrees in writing to accept the reasonable charge as the full charge for the services.

(2) *Payment to a person who assumes legal obligation to pay for the services.* If the physician or other supplier does not agree to accept the reasonable charge as full charge for the service, Medicare pays any person who submits to the carrier all of the following:

(i) A statement indicating that he or she has assumed legal obligation to pay for the services.

(ii) A claim on a HCFA-prescribed form in accordance with the requirements of this subpart. (If a claim had been submitted by or on behalf of the beneficiary before he or she died, submission of another claim form is not required; a written request by the person seeking payment meets the requirement for a claim.)

(iii) An itemized bill that identifies the claimant as the person to whom the physician or other supplier holds responsible for payment. (If such an itemized bill had been submitted by or on behalf of the beneficiary before he or she died, submission of another itemized bill is not required.)

(iv) If the intermediary or carrier requests it, evidence that the services were actually furnished.

[53 FR 6634, Mar. 2, 1988, as amended at 53 FR 28388, July 28, 1988]

§ 424.66 Payment to entities that provide coverage complementary to Medicare Part B.

(a) *Conditions for payment.* Medicare may pay an entity for Part B services furnished by a physician or other supplier if the entity meets all of the following requirements:

(1) Provides coverage of the service under a complementary health benefit

plan (this is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).

(2) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.

(3) Has the written authorization of the beneficiary (or of a person authorized to sign claims on his behalf under § 424.36) to receive the Part B payment for the services for which the entity pays.

(4) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his or her survivors or estate.

(5) Submits any information HCFA or the carrier may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

(b) *Services paid for by the entity.* An entity is not required to pay and claim reimbursement for all Part B services furnished to members of its plans. However, if it does not pay and claim reimbursement for all those services, it must establish in advance precise criteria for identifying the services for which it will pay and claim reimbursement.

[53 FR 28388, July 28, 1988; 53 FR 40231, Oct. 14, 1988]

Subpart F—Limitations on Assignment and Reassignment of Claims

§ 424.70 Basis and scope.

(a) *Statutory basis.* This subpart implements sections 1815(c) and 1842(b)(6) of the Act, which establish limitations on who may receive payments due a provider or supplier of services or a beneficiary.

(b) *Scope.* This subpart—

(1) Prohibits the assignment, reassignment, or other transfer of the right

to Medicare payments except under specified conditions;

(2) Sets forth the sanctions that HCFA may impose on a provider or supplier that violates this prohibition, or on a supplier that violates the conditions to which it agreed in accepting assignment from the individual; and

(3) Specifies the conditions for payment under court-ordered assignments or reassignments.

§ 424.71 Definitions.

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

Court of competent jurisdiction means a court that has jurisdiction over the subject matter and the parties before it.

Facility means a hospital or other institution that furnishes health care services to inpatients.

Health care delivery system or *system* means a public or private organization for delivering health services. The term includes, but is not limited to, clinics and health care prepayment plans.

Power of attorney means any written documents by which a principal authorizes an agent to—

(1) Receive, in the agent's name, any payments due the principal;

(2) Negotiate checks payable to the principal; or

(3) Receive, in any other manner, direct payment of amounts due the principal.

§ 424.73 Prohibition of assignment of claims by providers.

(a) *Basic prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement.

(b) *Exceptions to the prohibition*—(1) *Payment to a government agency or entity.* Subject to the requirements of the Assignment of Claims Act (31 U.S.C. 3727), Medicare may pay a government agency or entity under an assignment by the provider.

(2) *Payment under assignment established by court order.* Medicare may pay under an assignment established by, or in accordance with, the order of a court