

CMS 1135 Waiver / Flexibility Request and Inquiry Form

Organization Workflow

CMS 1135 Waiver / Flexibility Request

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Under **Section 1135 or 1812(f) of the Social Security Act**, CMS can issue several blanket waivers when there's a disaster or emergency. Blanket waivers prevent gaps in the access to care for beneficiaries affected by the emergency.

When a blanket waiver is issued, providers don't have to apply for an individual waiver. If there's no blanket waiver, providers can ask for an individual Section 1135 waiver.

If you have a request or inquiry, please use this form to submit your request to CMS.

Who are you? ?

An Organization / Provider

A Beneficiary

What would you like to do?

I want to submit a waiver / flexibility request

I want to submit an inquiry request

Submit a waiver / flexibility request

1 Select a Public Health Emergency

Select the Public Health Emergency (PHE) that applies to your waiver request

Public Health Emergency (PHE) (required) * ?

| Please select one | | |
|----------------------------|-----------------------------|-----------|
| COVID-19 | 3/13/20 - 10/31/2020 | |
| California Wildfire | 3/13/20 - 10/31/2020 | CA |
| Hurricane Laura | 8/15/20 - 11/15/2020 | |
| Hurricane Revelation | 9/13/19 - 12/13/2019 | |

2 Provide Your Contact Information

Some explanatory text on what's in the step

Point of Contact ?

Who should CMS contact in response to this waiver request?

Email address (required) *

First name (required) *

Last name (required) *

Phone number

Organization Information ?

Who is the organization making this request?

Organization name (required) *

State/US Territory/Federal District (required) *

| Alaska | California | Ne |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nebraska | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nevada | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| New York | | |

Organization Categories ?

Who is the organization making this request?

| General | Emergency Provider / Supplier Types | Other |
|--|---|-------|
| <input type="checkbox"/> Association | <input type="checkbox"/> Part D Prescription Plan | |
| <input type="checkbox"/> Advocacy Group | <input type="checkbox"/> State Government | |
| <input type="checkbox"/> Congressional Office | <input type="checkbox"/> State Medicaid Agency | |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> State Survey Agency | |
| <input type="checkbox"/> Department of Health and Human Services | <input type="checkbox"/> Tribal Nation | |

| General | Emergency Provider / Supplier Types | Other |
|--|--|-------|
| <input type="checkbox"/> Ambulatory Surgical Center (ASC) | <input type="checkbox"/> Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) | |
| <input type="checkbox"/> Community Mental Health Center (CMHC) | <input type="checkbox"/> Nursing Homes (SNF/NF) | |
| <input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility (CORF) | <input type="checkbox"/> Organ Procurement Organization | |
| <input type="checkbox"/> Critical Access Hospital (CAH) | <input type="checkbox"/> Outpatient Physical Therapy/Speech Therapy (OPT/ST) | |
| <input type="checkbox"/> Community Mental Health Center (CMHC) | <input type="checkbox"/> Programs of All-Inclusive Care for Elderly (PACE) | |
| <input type="checkbox"/> End Stage Renal Disease (ESRD) | <input type="checkbox"/> Psychiatric Residential Treatment Facility (PRTF) | |
| <input type="checkbox"/> Home Health Agencies (HHA)(OPO) | <input type="checkbox"/> Religious Non-Medical Health Care Institution (RNCHI) | |
| <input type="checkbox"/> Hospice(OPO) | <input type="checkbox"/> Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC) | |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Transplant Center | |

| General | Emergency Provider / Supplier Types | Other |
|--|-------------------------------------|-------|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Palliative | |
| <input type="checkbox"/> Durable Medical Equipment (DME) | <input type="checkbox"/> Physician | |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Other | |

Organization Identification Numbers ?

What are the identification numbers for your organization?

These numbers will be different, depending on the categories you have selected for your organization including: CCN/Provider, Medicare Contract Number, or NPI.

For the categories selected above, use:

NAME-OF-IDENTIFICATION-NUMBER

3 Describe your 1135 Waiver / Flexibility Request ?

Select the type of information you are making. Depending on your request type, we may ask you for additional information.

Request #1

Waiver Request Type (required) *

Regulation Related to this Request ?

Regulation Description (required) * ?

[+ Add another waiver request](#)

4 Submit your request

Submit

Confirmation Message (need content)

Case #

WARNING: Individually identifiable health information in this system is subject to the Health Information Portability and Accountability Act of 1996 and the Privacy Act of 1974. Submission to the 1135 Waivers System that contains Protected Health Information (PHI) is a violation of these Acts. **Questions containing PHI will be deleted from the system and not processed.** For detailed information regarding transmitting or receiving healthcare information or data read the [QualityNet System Security Policy](#) (PDF).

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A Beneficiary

What would you like to do?

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I want to submit an inquiry request

Submit an inquiry

1 Select a Public Health Emergency

Select the Public Health Emergency (PHE) that applies to your inquiry request

Public Health Emergency (PHE) (required) * ?

California Wildfire 3/13/20 - 10/31/20 CA ▼

2 Provide Your Contact Information

Some explanatory text on what's in the step

Point of Contact ?

Who should CMS contact in response to this inquiry request?

Email address (required) *

First name (required) *

Last name (required) *

Phone number

3 Inquiry

Inquirer Type (required) *

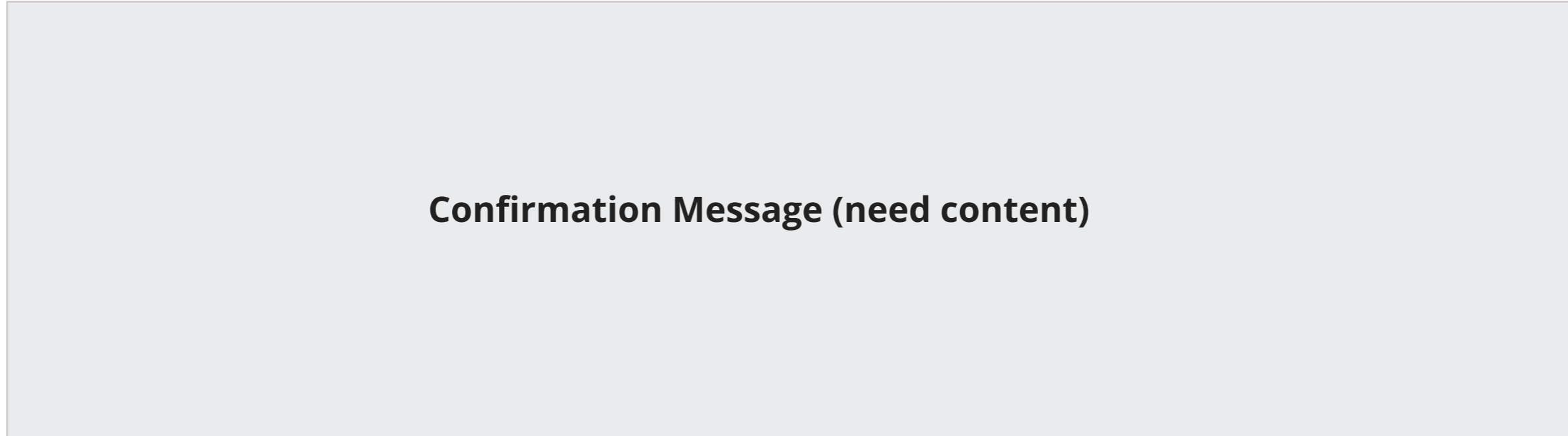
Please select an option ▼

Inquiry Topic (required) *

Please select an option ▼



Submit



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Beneficiary Workflow

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Public Health Emergency (PHE) ?
California Wildfire 3/13/20 - 10/31/20 CA ▼

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3 Inquiry

Inquirer Type (required) *

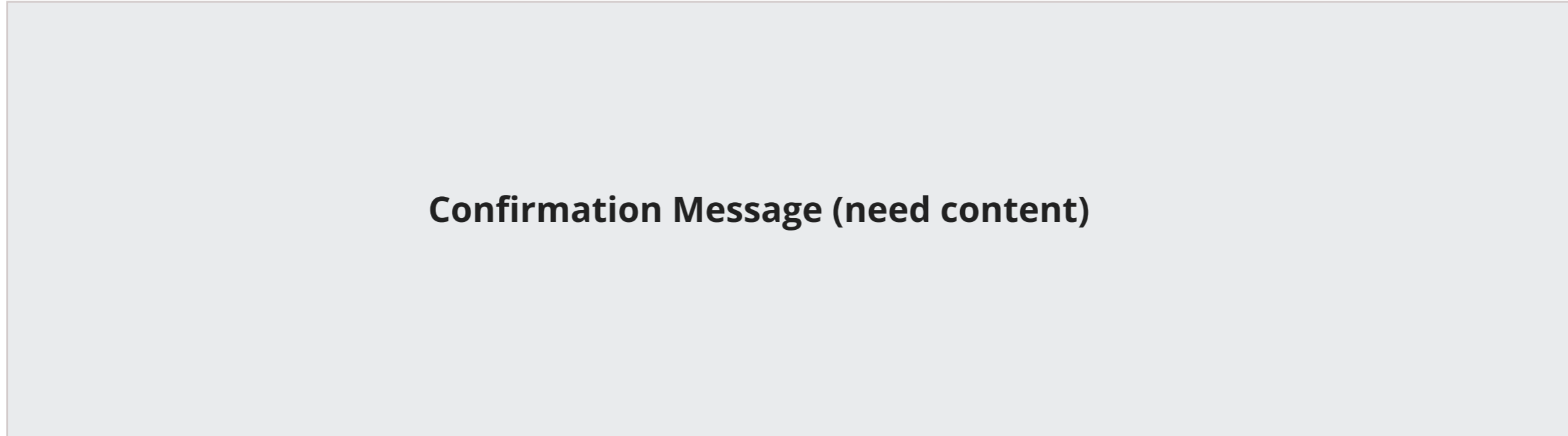
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Please select an option ▼



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