CMS.gov

CMS 1135 Waiver / Flexibility Request and Inquiry Form

Organization Workflow

CMS 1135 Waiver / Flexibility Request

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Under the authority granted by Section 1135 of the Social Security Act, as amended, CMS is authorized to waive or modify certain requirements of Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) in order to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in these programs during emergency periods. This form is used by providers and suppliers to request waivers and flexibilities under Section 1135 of the Social Security Act, as implemented by CMS. Requests may be submitted by providers, suppliers, or their representatives using this form. Complete all required sections and submit to the appropriate CMS Regional Office or, for Medicaid waivers, to the State Medicaid Agency. Incomplete or illegible forms may delay processing. Keep a copy of your completed form for your records.

Who are you? (required)

- I work for a state or federal agency
- I work for a provider or supplier
- I want to submit an inquiry
- I want to submit a waiver or flexibility request on behalf of a provider/supplier or healthcare facility

Under **Section 1135 of 1935 of the Social Security Act**, CMS can issue several broad waivers and flexibilities in response to an emergency. Waiver requests are limited to providers and suppliers in areas affected by an emergency declared by a governor or tribal leader. Flexibilities are more narrow, generally not tied to an emergency declaration, but they're meant to apply for an extended waiver. If there's no waiver overall, providers can ask for an individual flexibility (1135 waiver).

Submit a waiver / flexibility request

1 Select a Public Health Emergency

Are you requesting a waiver or flexibility for a public health emergency or your waiver request

Public Health Emergency (PHE) (required) *

Please select one

Effective Date (required) *

01/27/2020 - 04/26/2021

Expiration Date (required) *

05/11/2023 - 10/31/2023

2 Provide Your Contact Information

Your contact information will be added to your request's progress.

Point of Contact (required)

Who should CMS contact in response to this waiver request?

Email address (required) *

Confirm email address (required) *

First name (required) *

Last name (required) *

Phone number

(555)555-5555

Organization Name (required) *

Search/Select Provider/Supplier (required) *

Search... Cardiac C... ×

- Nebraska
- Texas
- New York

Organization Categories (required) *

Who is the organization/entity filing for?

General	Emergency Provider / Supplier Types	Other
Primary Group	State Government	Tribal Nation
Association	Qualified Health Plan	
Corporation	State Medicaid Agency	
Medicare Advantage / Part D Plan	State Public Health Agency	

General	Emergency Provider / Supplier Types	Other
Ambulatory Surgical Center (ASC)	Nursing Homes (SNF/NF)	
Community Mental Health Center (CMHC)	Organ Procurement Organizations (OPO)	
Comprehensive Outpatient Rehabilitation Facility (CORF)	Outpatient Physical Therapy/Speech Therapy (OPT/ST)	
Critical Access Hospital (CAH)	Prospective Payment Hospital Inpatient Psychiatric Facility (PPS-IPF)	
End Stage Renal Disease (ESRD)	Psychiatric Residential Treatment Facility (PRTF)	
Home Health Agencies (HHA)	Religious Non-Medical Health Care Institution (RNHCI)	
Hospice	Rural Health Clinic/Federally Qualified Health Center (RHC/FQHC)	
Hospital	Outpatient Center	
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)		

General	Emergency Provider / Supplier Types	Other
Ambulance	Fallabrae	
Durable Medical Equipment (DME)	Physician	
Lab	Other	

Other Organization Category

Organization Identification Numbers (required) *

What are the identification numbers for your organization?

Please contact us for efficiency, depending on which organization you have selected for your organization including: CCN/Provider, Medicare Contract Number, or NPI.

For the categories selected above, add

IDENTIFICATION NUMBER

Separate multiple identification numbers with a comma.

3 Describe your 1135 Waiver / Flexibility Request

Request #1

Waiver Request Type (required) *

Click here if you do not see your Waiver Request Type

Regulation Related to this Request *

Request Description (required) *

Detail a brief summary of why the waiver is needed (for example: CMS is under community-based testing for a waiver to address a specific need, or CMS is considering a waiver to address a specific need, or CMS is currently considering a waiver for a similar request) and how it number of beds or 1 hospital or 1 ambulance) the specific and the age of what you are seeking

+ Add another waiver request

4 Submit your request

Submit

Thank You! Your request has been successfully submitted.

Your case number is: Capitol

You can also expand an email confirmation summarizing your request and providing you with additional guidance.

WARNING: Knowingly deactivate health information in this system is subject to the Health Information Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act (HITECH) and Federal Information Security Management Act (FISMA) is subject to the Federal Trade Commission (FTC) and/or Federal Trade Commission (FTC) and/or Federal Communications Commission (FCC) and/or Federal Communications Commission (FCC) and/or Federal Communications Commission (FC

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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
- I want to provide a status update on my beneficiaries and/or healthcare facility

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) *

COVID-19 — 01/27/2020 - 04/20/2021

2 Provide Your Contact Information

This will help help you updated on your request's progress

Point of Contact

Who should CMS contact in response to this inquiry request?

Email address (required) *

Confirm email address (required) *

First name (required) *

Last name (required) *

Zip Code (required) *

XXXXX

Phone number

2202202-XXXX

Organization Information

Who is the organization making this request?

Organization Name (required) *

Organization Categories (required) *

Who is the organization making this request?

General | Emergency Provider / Supplier Types | Other

- Advocacy Group
- Association
- Corporation
- Medicare Advantage / Part D Plan
- State Government
- Qualified Health Plan
- State Medicaid Agency
- State Survey Agency
- Tribal Nation

General | Emergency Provider / Supplier Types | Other

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

General | Emergency Provider / Supplier Types | Other

- Ambulance
- Durable Medical Equipment (DME)
- Lab
- Palliative
- Physician
- Other — Other Organization Category

Organization Identification Numbers

What are the identification numbers for your organization?

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

For the categories selected above, use:

IDENTIFICATION NUMBER

Separate multiple identification numbers with a comma.

3 Inquiry

Request #1

Topic (required) *

Please select an option

Type (required) *

Please select an option

Click here if you do not see your type

Description (required) *

Provide a comprehensive description of your inquiry (including regulation citations if applicable).

Add another inquiry request

4 Submit Your Inquiry

Submit

Thank You! Your inquiry has been successfully submitted.

Your case number is <Case#>

You will also receive an email confirmation summarizing your request and providing you with additional guidance.

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 safeguarding protected healthcare information or data, please refer to the "HIPAA Security Rule" https://www.hhs.gov/hipaa/for-professionals/index.html.

INFORMATION NOT TO BE RELEASED TO PUBLIC UNLESS AUTHORIZED BY LAW: This information is for internal Government use only and has not been publicly disclosed. It may contain information that is privileged, confidential, or otherwise protected from disclosure under public laws. Do not share Publicly Identifiable Information (PII) and/or Public Health Information (PHI). Unauthorized disclosure may result in prosecution to the full extent of the law.

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Drop down options

PHE

COVID-19 — 01/27/2020 - 04/20/2021

Topic

Medicaid/CHIP
Original Medicare (Part A or B)
Medicare Advantage/Prescription Drug Plan
Qualified Health Plans

Type

638 Tribal Clinics
Original Medicare (Part A or B)
Academia
Medicare Advantage/Prescription Drug Plan
Access To Care
Qualified Health Plans
Advocate
Ambulance
Ambulatory Care Center
Appeals
Appendix K
Association/Society for Provider/Facility
Attorney for Provider/Facility
Billing Agency
Consultant for Provider/Facility
Critical Access Hospital
Denials
Dialysis Facility
Eligibility
Employer
Facility
Fair Hearings
Federal/State Government Agency
Federally Qualified Health Center (FQHC)
General Public
HCBS Waivers
Home Health
Hospice
Hospital
Insurance Company
Long Term Care Services And Supports
Managed Care
Medical Supplier/DME
Nurse/Nurse Practitioner
Nursing Home
Other
Payment Methodology/Rates
Pharmacist/Pharmacy
Physical/Occupational Therapy
Physician
Physician Assistant
Provider - Mental Health
Provider - Other
Provider Enrollment
Respite
Retainer Payments
Rural Health Clinic
Rural Health Clinic (RHC)
Skilled Nursing Facility
State Agency
Telehealth

Help Tooltips

Who are you?

This information helps CMS understand who you are so we can better assist you.

What would you like to do?

Choose the applicable option below.

I want to submit a waiver / flexibility request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people as possible. Waivers and flexibilities can free helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

"Waiver" refers to a waiver or modification of a statutory requirement of the Social Security Act (SA) or its implementing regulations that may be waived or modified under the authority of § 1135 of the Act or § 1812(f). A "flexibility" is an agency policy or procedure that can be adjusted under current authority - and generally speaking, can be adjusted without reprogramming CMS's systems. CMS will implement these waivers and flexibilities as necessary and appropriate to accommodate the needs of those impacted by an emergency or disaster.

I want to submit an inquiry request option

When there's a disaster or emergency, waivers and flexibilities help health care facilities give timely care to as many people as possible. Waivers and flexibilities can free helping States, Federal Districts and U.S. territories to make sure people with Medicare and/or Medicaid continue to have access to care.

I want to provide a status update on my patients and/or healthcare facility residents

You may use this option to report any impact on normal operations.

Select a Public Health Emergency

Select the applicable Public Health Emergency from the dropdown list.

Point of Contact

CMS uses your contact information to send responses and ask follow up questions.

Organization Information

An organization is an organized body of people with a particular purpose (e.g., State, Corporation, Health System, etc.). Please provide the required information for your organization.

Zip Code

Please enter your 5 digit zip code.

Organization Categories

This provides CMS additional information on the type of organization requesting a inquiry. Please select all applicable organizations by reviewing the data on all three tabs (At least one category must be selected).

Organization Identification Numbers

Indicate all applicable identification numbers for the healthcare facilities/providers affiliated with your organization impacted by the PHE.

Inquiry - Type dropdown

Choose your inquiry type from the dropdown list.

Inquiry - Topic dropdown

Choose from the dropdown list which category your inquiry would fall under.

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Beneficiary Workflow

CMS 1135 Inquiry Request

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CMS 1135 Waiver / Flexibility Request and Inquiry Form

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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
- I want to provide a status update on my beneficiaries and/or healthcare facility

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) *

COVID-19 — 01/27/2020 - 04/20/2021

2 Provide Your Contact Information

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Point of Contact

Who should CMS contact in response to this inquiry request?

Email address (required) *

Confirm email address (required) *

First name (required) *

Last name (required) *

Zip Code (required) *

XXXXX

Phone number

XXX(XXX-XXXX

Organization Information

Who is the organization making this request?

Organization Name (required) *

Organization Categories (required) *

Who is the organization making this request?

General | Emergency Provider / Supplier Types | Other

- Advocacy Group
- Association
- Corporation
- Medicare Advantage / Part D Plan
- State Government
- Qualified Health Plan
- State Medicaid Agency
- State Survey Agency
- Tribal Nation

General | Emergency Provider / Supplier Types | Other

- Ambulatory Surgical Center (ASC)
- Community Mental Health Center (CMHC)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
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- Home Health Agencies (HHA)
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3 Inquiry

Request #1

Topic (required) *

Please select an option

Type (required) *

Please select an option

Click here if you do not see your type

Description (required) *

Provide a comprehensive description of your inquiry (including regulation citations if applicable).

Add another inquiry request

4 Submit Your Inquiry

Submit

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Drop down options

PHE

COVID-19 — 01/27/2020 - 04/20/2021

Topic

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Original Medicare (Part A or B)
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Type

638 Tribal Clinics
Original Medicare (Part A or B)
Academia
Medicare Advantage/Prescription Drug Plan
Access To Care
Qualified Health Plans
Advocate
Ambulance
Ambulatory Care Center
Appeals
Appendix K
Association/Society for Provider/Facility
Attorney for Provider/Facility
Billing Agency
Consultant for Provider/Facility
Critical Access Hospital
Denials
Dialysis Facility
Eligibility
Employer
Facility
Fair Hearings
Federal/State Government Agency
Federally Qualified Health Center (FQHC)
General Public
HCBS Waivers
Home Health
Hospice
Hospital
Insurance Company
Long Term Care Services And Supports
Managed Care
Medical Supplier/DME
Nurse/Nurse Practitioner
Nursing Home
Other
Payment Methodology/Rates
Pharmacist/Pharmacy
Physical/Occupational Therapy
Physician
Physician Assistant
Provider – Mental Health
Provider – Other
Provider Enrollment
Respite
Retainer Payments
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Rural Health Clinic (RHC)
Skilled Nursing Facility
State Agency
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