The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insuranace pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you, a spouse, or other family members covered by your group health plan have, or has ever had, a similar Medicare card.

Section I:

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No

If yes, please complete the following. If no, proceed to Section II.

Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available).

Medicare Claim Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth (Mo/Day/Year) ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number: (Only If Medicare Claim Number is Unavailable) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Sex ☐ Female ☐ Male

Section II:

Do you have a spouse that is presently, or has ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No

If yes, please complete the following. If no, proceed to Section III.

Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available).

Medicare Claim Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth (Mo/Day/Year) ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number: (Only If Medicare Claim Number is Unavailable) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Sex ☐ Female ☐ Male

Section III:

Do you have another family member that is presently, or has ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No

If yes, please complete the following. If no, proceed to Section IV. If additional space is needed for completion of this section, please attach another sheet.

Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available).

Relationship: (Dependent child, domestic partner, etc.)

Medicare Claim Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth (Mo/Day/Year) ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number: (Only If Medicare Claim Number is Unavailable) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Sex ☐ Female ☐ Male

Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available).

Relationship: (Dependent child, domestic partner, etc.)

Medicare Claim Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ - ___ Date of Birth (Mo/Day/Year) ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number: (Only If Medicare Claim Number is Unavailable) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Sex ☐ Female ☐ Male

Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available).

Relationship: (Dependent child, domestic partner, etc.)

Medicare Claim Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ - ___ Date of Birth (Mo/Day/Year) ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number: (Only If Medicare Claim Number is Unavailable) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Sex ☐ Female ☐ Male

Section IV:

I understand that the information requested is to assist my insurer, third-party administrator or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Subscriber Name (Please Print) _____ **Subscriber's Plan ID** _____

Name of Person Completing This Form (Please Print) _____

Signature of Person Completing This Form _____ **Date** _____

If you have completed Sections I - IV above, stop here. If you are refusing to provide the information requested in Sections I - IV, proceed to Section V.

Section V:

Subscriber Name (Please Print) _____ **Subscriber's Plan ID** _____

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

Name of Person Completing This Form (Please Print) _____ **Signature of Person Completing This Form / Date** _____