



**CMS Office of Financial Management/Financial Services Group**

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May 26, 2009

**The Medicare Secondary Payer Mandatory Reporting Provisions in  
Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (the MMSEA)  
(See 42 U.S.C. 1395y(b)(7)&(b)(8))**

**ALERT: Compliance Guidance Regarding Obtaining  
Individual HICNs and/or SSNs for Group Health Plan (GHP) Reporting  
Under 42 U.S.C. 1395v(b)(7)**

Persons with Medicare need to be aware that certain group health plan insurers (GHPs) and/or their claim processors (GHP Responsible Reporting Entities (RREs)) are now required to report data necessary to identify Medicare beneficiaries for whom the GHP is responsible for paying primary to Medicare. RREs also have access to a query function which can assist them in: 1) verifying a Medicare Health Insurance Claim Number (or HICN) for a given Medicare beneficiary, or 2) determining whether or not an individual is a Medicare beneficiary if the individual furnishes his/her Social Security Number (SSN).

Some GHP RREs have advised CMS that they are having difficulties in obtaining either the HICN or SSN from some of their insured. CMS is providing the attached model questions (with a picture of a Medicare card), to assist RREs in obtaining this information and being compliant with Section 111.

Subscribers and dependents should routinely cooperate in furnishing either their HICN (or SSN if they do not have a HICN available) as requested by their group health plan RRE. If an individual refuses to furnish a HICN or SSN, and the GHP RRE chooses to use the attached model language, CMS will consider the RRE compliant for purposes of its next Section 111 file submission if:

- A signed copy of the model language in the format provided is obtained (even if the individual is later discovered to be a Medicare beneficiary).
- With respect to that same individual, the RRE has the model language (with the picture of the Medicare ID card) re-signed and dated at least once every 12 months.
- The RRE should retain this documentation.

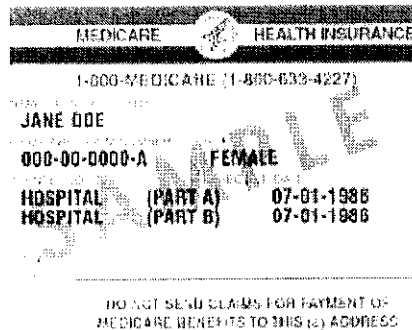
**NOTE:** This process does not provide a “safe harbor” to any RRE attempting to use it to avoid reporting MSP data about an individual known to the RRE to be a Medicare beneficiary. Also note that RREs are not required to use the specific model language provided by CMS.

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 insurance 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 insurance plans, certain 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 the picture of the Medicare card below 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.*

<b><u>Full Name:</u></b> <i>(Please print the name exactly as it appears on your SSN or Medicare card if available.)</i>
<b><u>Medicare Claim Number:</u></b>
<b><u>Date of Birth:</u></b>
<b><u>Sex:</u></b>
<b><u>Social Security Number:</u></b> <i>(If Medicare Claim Number is Unavailable)</i>

**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.*

<b><u>Full Name:</u></b> <i>(Please print the name exactly as it appears on the SSN or Medicare card if available.)</i>
<b><u>Medicare Claim Number:</u></b>
<b><u>Date of Birth:</u></b>
<b><u>Sex:</u></b>
<b><u>Social Security Number:</u></b> <i>(If Medicare Claim Number is Unavailable)</i>

**Section III**

Do you have another covered 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.*

<b><u>Full Name:</u></b> <i>(Please print the name exactly as it appears on the SSN or Medicare card if available.)</i>
<b><u>Relationship:</u></b> <i>(Dependent child, domestic partner, other.)</i>
<b><u>Medicare Claim Number:</u></b>
<b><u>Date of Birth:</u></b>
<b><u>Sex:</u></b>
<b><u>Social Security Number:</u></b> <i>(If Medicare Claim Number is Unavailable)</i>

**Full Name:**

*(Please print the name exactly as it appears on the SSN or Medicare card if available.)*

**Relationship:**

*(Dependent child, domestic partner, other)*

**Medicare Claim Number:**

**Date of Birth:**

**Sex:**

**Social Security Number:**

*(If Medicare Claim Number is Unavailable)*

**Full Name:**

*(Please print the name exactly as it appears on the SSN or Medicare card if available.)*

**Relationship:**

*(Dependent child, parent, domestic partner, etc.)*

**Medicare Claim Number:**

**Date of Birth:**

**Sex:**

**Social Security Number:**

*(If Medicare Claim Number is Unavailable)*

**Full Name:**

*(Please print the name exactly as it appears on the SSN or Medicare card if available.)*

**Relationship:**

*(Dependent child, parent, domestic partner, etc.)*

**Medicare Claim Number:**

**Date of Birth:**

**Sex:**

**Social Security Number:**

*(If Medicare Claim Number is Unavailable)*

**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 Providing This Information (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

<p><b><u>Reason(s) for Refusal to Provide Requested Information:</u></b></p> <p>_____</p> <p>_____</p>
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\_\_\_\_\_  
**Name of Individual Providing This Information (Please Print)**

\_\_\_\_\_  
**Signature of Individual Providing This Information**

\_\_\_\_\_  
**Date**