

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 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?														<input type="checkbox"/> Yes		<input type="checkbox"/> No					
<i>If yes, please complete the following. If no, proceed to Section II.</i>																					
Full Name: <i>(Please print the name exactly as it appears on your SSN or Medicare card if available.)</i>																					
[Grid for name entry]																					
Medicare Claim Number:						-	-	-	Date of Birth						-	-					
									(Mo/Day/Year)												
Social Security Number:								-									Sex	<input type="checkbox"/> Female	<input type="checkbox"/> Male		
<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?														<input type="checkbox"/> Yes		<input type="checkbox"/> No					
<i>If yes, please complete the following. If no, proceed to Section III.</i>																					
Full Name: <i>(Please print the name exactly as it appears on their SSN or Medicare card if available.)</i>																					
[Grid for name entry]																					
Medicare Claim Number:						-	-	-	Date of Birth						-	-					
									(Mo/Day/Year)												
Social Security Number:								-									Sex	<input type="checkbox"/> Female	<input type="checkbox"/> Male		
<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?														<input type="checkbox"/> Yes		<input type="checkbox"/> No					
<i>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.</i>																					
Full Name: <i>(Please print the name exactly as it appears on their SSN or Medicare card if available.)</i>																					
[Grid for name entry]																					
Relationship <i>(Dependent child, domestic partner, etc.):</i>																					
Medicare Claim Number:						-	-	-	Date of Birth						-	-					
									(Mo/Day/Year)												

