**CARRIER OR INTERMEDIARY REQUEST FOR SSO ASSISTANCE**

<table>
<thead>
<tr>
<th>2a. BENEFICIARY NAME</th>
<th>b. SEX</th>
<th>c. HEALTH INSURANCE CLAIM NUMBER</th>
<th>d. PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ M</td>
<td></td>
<td>□ F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. ADDRESS OF BENEFICIARY</th>
<th>4a. NAME AND ADDRESS OF PERSON TO BE CONTACTED IF OTHER THAN BENEFICIARY</th>
<th>b. PHONE NUMBER</th>
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<tr>
<th>5. TO (Assisting SSO Office) (Send through parallel SSO unless direct contact permitted.)</th>
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**PART I – CARRIER OR INTERMEDIARY REQUEST**

<table>
<thead>
<tr>
<th>7. CLAIMS MATERIAL ATTACHED</th>
<th>□ YES</th>
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<tr>
<th>8. DEVELOPMENT REQUEST (Please obtain)</th>
<th>9. INFORMATION REQUEST (Please verify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. □ COMPLETION OF (Form CMS-1490) (CMS-ITEM(S));</td>
<td>a. □ HI CLAIM NUMBER</td>
</tr>
<tr>
<td>b. □ UNDERPAYMENT DEVELOPMENT (Contact is shown in 6 above if known.) MEDICAL EXPENSES PAID □ YES □ NO OBTAIN:</td>
<td>b. □ BENEFICIARY NAME</td>
</tr>
<tr>
<td>c. □ EOMB UNDELIVERABLE. NO BETTER ADDRESS AVAILABLE.</td>
<td>c. □ ADDRESS OF BENEFICIARY</td>
</tr>
<tr>
<td>d. □ CODE REJECT. SEE SPECIFIC INSTRUCTIONS FOR DO HANDLING OF THIS TYPE OF REJECT. IF NECESSARY, TAKE STEPS TO ENTER OR CORRECT INFORMATION ON HI TAPE.</td>
<td>d. □ OTHER</td>
</tr>
<tr>
<td>e. □ BENEFICIARY NEEDS SPECIAL ASSISTANCE. CONTACT IS SHOWN IN 6 ABOVE</td>
<td></td>
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<tr>
<td>f. □ OTHER</td>
<td>10. □ FOLLOW-UP TO ORIGINAL REQUEST</td>
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</tbody>
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11. REMARKS

**PART II – SSO REPLY (Return through parallel SSO unless direct return permitted.)**

12. □ REPLY (Continue on reverse if necessary) OR □ IS ATTACHED

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Form CMS-1980 (3-78)
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5. TO (Assisting SSO Office) (Send through parallel SSO unless direct contact permitted.)

6. FROM

### PART I – CARRIER OR INTERMEDIARY REQUEST

7. CLAIMS MATERIAL ATTACHED □ YES □ NO

8. DEVELOPMENT REQUEST (Please obtain)
   a. □ COMPLETION OF (Form CMS-1490) (CMS-ITEM(S));
   b. □ UNDERPAYMENT DEVELOPMENT (Contact is shown in 6 above if known.)
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      OBTAIN:
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   e. □ BENEFICIARY NEEDS SPECIAL ASSISTANCE. CONTACT IS SHOWN IN 6 ABOVE IF KNOWN
   f. □ OTHER

9. INFORMATION REQUEST (Please verify)
   a. □ HI CLAIM NUMBER
   b. □ BENEFICIARY NAME
   c. □ ADDRESS OF BENEFICIARY
   d. □ OTHER

10. FOLLOW-UP TO ORIGINAL REQUEST

11. REMARKS

### PART II – SSO REPLY (Return through parallel SSO unless direct return permitted.)

12. REPLY (Continue on reverse if necessary) OR □ IS ATTACHED
**CARRIER OR INTERMEDIARY REQUEST FOR SSO ASSISTANCE**

1. DATE

2a. BENEFICIARY NAME □ M □ F

2b. SEX

3. ADDRESS OF BENEFICIARY

3a. NAME AND ADDRESS OF PERSON TO BE CONTACTED IF OTHER THAN BENEFICIARY

3b. PHONE NUMBER

3c. RELATIONSHIP TO BENEFICIARY

4. PHONE NUMBER

4a. HEALTH INSURANCE CLAIM NUMBER

5. TO (Assisting SSO Office) (Send through parallel SSO unless direct contact permitted.)

6. FROM

7. CLAIMS MATERIAL ATTACHED □ YES □ NO

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   a. □ COMPLETION OF (Form CMS-1490) (CMS-ITEM(S):

   b. □ UNDERPAYMENT DEVELOPMENT (Contact is shown in 6 above if known.)

   MEDICAL EXPENSES PAID □ YES □ NO

   OBTAIN:

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