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 the 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.

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?



□Yes

□No

Section I:

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 - -														
Social Security Number:														
(If Medicare Claim Number is Unavailable)														
Coation II.														
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 their SSN or Medicare card if available.)														
Medicare Claim Number: - - Date of Birth - - -														
Mo/Day/Year)														
Social Security Number:														
(If Medicare Claim Number is Unavailable)														
Section III:														
Do you have another covered family member that is presently, or has ever been, enrolled in □Yes □No														
Medicare Part A or Part B?														
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 their SSN or Medicare card if available.)														
Relationship (Dependent child, domestic partner, etc.):														
Medicare Claim Number:														
Medicare Claim Number: (Mo/Day/Year)														

Social Security Number:				-			-					Sex		□Female					□Male			
(If Medicare Claim Number is Unavailable)	<u> </u>												`									
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Relationship (Dependent child, domestic partner,	etc.,	<i>)</i> :																				
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Signature of Person Completing This Form				Date)																	
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Section V:																						
Subscriber Name (Please Print)	_		Ś	Sub	scri	ber	's F	Plar	า ID													
For the reason(s) listed below, I have not provided a look not provide the requested information, I may be benefits to pay my claims correctly and promptly.						•															•	
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