Small Employer Exception (SEE) Package

Version 1.3

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Revision History

Date	Version	Reason for Change
June 2015	1.0	Previous publication date.
April 2, 2018	1.1	Change Request (CR) 29485: Updated the CMS Confidentiality Statement and the CMS logo per CMS branding guidelines. Document format has been updated and standardized.
January 21, 2019	1.2	Change Request (CR) 31239: The BCRC contact address for mailing SEE requests has been updated.
November 26, 2025	1.3	Updated the BCRC fax number and mailing address.

Confidentiality Statement

The collection of this information is authorized by Section 1862(b) of the Social Security Act (codified at 42 U.S.C 1395y(b)) (see also 42, C.F.R. 411.24). The information collected will be used to identify and recover past conditional and mistaken Medicare primary payments and to prevent Medicare from making mistaken payments in the future for those Medicare Secondary Payer situations that continue to exist. The Privacy Act (5 U.S.C. 552a(b)), as amended, prohibits the disclosure of information maintained by the Centers for Medicare & Medicaid Services (CMS) in a system of records to third parties, unless the beneficiary provides a written request or explicit written consent/authorization for a party to receive such information. Where the beneficiary provides written consent/proof of representation, CMS will permit authorized parties to access requisite information.

Summary of Version 1.2 Updates

The following represents a change to the Small Employer Exception (SEE) Package:

The Benefits Coordination & Recovery Center (BCRC) fax number and mailing address have been updated.

Instructions for Small Employer Exception (SEE) Submittal Certification

The certification document is required for any new SEE request. This certification should be completed by the employer and contain signatures both from the employer and the submitter.

Note: The signatures cannot be dated more than one calendar year prior to the date of the exception request. This document must accompany each new SEE request, and all information is required. This document is not needed when requesting an update or delete of an existing, previously approved SEE.

Table 1: SEE Submittal Certification Fields

Field	Description
Employer Name	Printed name of the employer certifying less than 20 employees
Employer Address	Printed address of the employer certifying less than 20 employees
Number of Employees Statement	Number of employees employed by the certifying employer
Employer Identification Number (EIN)	EIN *Required if no TIN
Tax Identification Number (TIN)	TIN of employer *Required if no EIN
Employer Representative Name	Printed name of the employer's representative
Signature of Employer Representative	Signature of the employer's representative
Date	Date of the employer's representative signature
Submitter's Representative Name	Printed name of the submitter's representative
Signature of Submitter's Representative	Signature of the submitter's representative
Date	Date of the submitter's representative signature

Small Employer Exception Submittal Certification

Employer Name: _____

Employer Address: _____

Address Line 2: _____

We certify that we have not had 20 or more employees on each working day in 20 or more calendar weeks in the current or preceding calendar year.

We employ _____ employees.

Employer Identification Number (EIN): _____

Employer Tax Identification Number (TIN): _____

_____

Employer Representative Name

_____

Signature of Employer Representative Date

_____

Submitter's Representative Name

_____

Signature of Submitter's Representative Date

Instructions for Completing the Small Employer Exception (SEE) Request

This document may be used to request a SEE, or to request a change or update to a previously approved SEE.

Note: For new requests, a certification must be submitted along with the SEE Document.

A change request should only be submitted when the original conditions of a previously approved SEE no longer apply or because a previously approved SEE was submitted in error and must be withdrawn.

If the request is being made by an authorized insurer, the insurer must provide evidence, such as a signed authorization, that it is authorized to act on behalf of the multi or multiple employer plan.

Table 2: SEE Request Fields

Field	Description
Date	Current date
Name of Submitter	Name of company submitting request
TIN/EIN	Employer Tax Identification Number (TIN) or Employer Identification Number (EIN) *Required for change request
Name of Medicare Beneficiary	Medicare beneficiary name
Name of Employee	*Required if Medicare beneficiary's name differs from employee's name
Medicare ID/SSN	Beneficiary's Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) or Social Security Number (SSN) if Medicare ID is not available.
DOB	Medicare beneficiary's date of birth
Coverage Type	Coverage Type: A = Medical and Hospital J = Hospital Only K = Medical Only *Required for new SEE requests
Coverage Effective Date	Date the employer sponsored health insurance coverage began *Required for new SEE request
Submitter's Representative Signature	Signature of the submitter's representative
Name of Submitter's Representative	Printed name of the submitter's representative

Field	Description
Action Code	Action Code: A – Add C – Change D – Delete
Employer Name	Employer name *Required for change requests
Effective Date of Change	The date the specified change takes place *Required for change requests
Change Request Reason Code	Reason for the change request: A – Employee no longer works for employer on SEE B – Spouse no longer works for employer on SEE C – Employer no longer qualifies for SEE (More than 20 employees.) D – Withdrawal of SEE (Submitted in error.) *Required for change requests

Small Employer Exception (SEE) Request

Request for Exception for Working Aged Individuals and Spouses Aged 65 and Over

Date: _____ Submitter: _____

TIN/EIN: _____

Employer Name: _____

The above referenced employer participates in a multiple employer plan as defined by 42 CFR 411.101.

Employees who have coverage under the group employee health benefit plan are eligible for coverage either by virtue of their current employment status with the above referenced employer or as a spouse of a covered employee.

The above listed employer hereby requests the exception of the Medicare Secondary Payer status for the following working aged employee(s) and/or spouse(s) aged 65 or over who is/are employed by the employer listed above.

Table 3: Request for Exception for Working Aged Individuals and Spouses Aged 65 and Over Details

Medicare Beneficiary	Employee Name	Medicare ID/SSN	DOB	Coverage Type: A, J, K	Coverage Effective Date	Action Code: A, C, D	Effective Date of Change	Reason Code: A, B, C, D

Submitter's Representative Name: _____

Submitter's Representative Signature: _____

Date: _____

Submission

Requests must be submitted via mail or fax. Below is the mailing address and fax number for your submission:

Mailed Requests

Small Employer Exception Request
P.O. Box 138897
Oklahoma City, OK 73113

Faxed Requests

Medicare
Benefits Coordination & Recovery Center
Attention: Small Employer Exception Request
Fax #: 1-833-844-1427

The BCRC will provide the plan administrator/insurer with written confirmation via letter after completion of its review and, if applicable, processing of the request. Approved requests will include a listing of the individual(s) for whom the SEE, with respect to a specific plan and a specific employer, has been approved.

It is important that the plan/insurer notify each Medicare beneficiary in writing of the date Medicare will become the primary payer and when the employer GHP will pay secondary to Medicare. If the beneficiary is not enrolled in Medicare Part B and wishes to do so, the plan/insurer should advise the beneficiary to contact his/her local Social Security district office as soon as possible, and supply the affected beneficiary with the information required to apply for Part B benefits.