The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program.

Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other 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 have, or have ever had, a similar Medicare card.



## Section I

e you presently, or have you ever been, enrolled in Medicare Part A or Part B?									] No	)								
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 Number:						Date (Mo				d)		/			/			
**Social Security Number:			-			-	, <u> </u>	<b>,,</b> .		Sex	H	 ] F∉	ema	ale		$\vdash$	] N	lale
(If Medicare Number is Unavailable)										JCX		٠,٢	21110	aic.			۷ ۱۷	iaic

<sup>\*\*</sup>Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

## **Section II**

coordinate benefits with Medicare and to meet its ma	andatory reporting obligations under Medicare law.
Claimant Name (Please Print)	Medicare Number
Name of Person Completing This Form If Claimant i	is Unable (Please Print)
Signature of Person Completing This Form	Date
If you have completed Sections I and II above, stop here. If y I and II, proceed to Section III.	you are refusing to provide the information requested in Sections
Section III	
Claimant Name (Please Print)	Medicare Number
	I the information requested. I understand that if I am a quested information, I may be violating obligations as a tests to pay my claims correctly and promptly.
Reason(s) for Refusal to Provide Requested Informa	<u>tion</u> :
Signature of Person Completing This Form	Date