United States of America
Railroad Retirement Board

CURRENT

Form Approved
OMB No. 3220-0086

APPLICATION FOR CANADIAN HOSPITAL BENEFITS UNDER MEDICARE - PART A

1. Your Provincial Hospital Insurance Number

Copy From Your Health Insurance Card

2. Name of Beneficiary (Patient)

3. Claim Number with Prefix

4. Sex ☐ Male ☐ Female

5.a. Were you an inpatient in a hospital, nursing home, or convalescent hospital in the 60-day period before the first day you were furnished the services covered by this claim?

☐ Yes - **Go to Item 5b**
☐ No - **Go to Item 6**

b. Name and Address of Hospital or Home

		Month	Day	Year
Hospital	Admitted			
	Discharged			
Nursing Home or Convalescent Hospital	Admitted			
	Discharged			

6. Name and address of hospital or agency furnishing the service covered by this claim. If same as above, enter "Same."

7. Type of service and period in which furnished.

		Month	Day	Year
☐ In-Patient Hospital	Admitted			
	Discharged			
☐ In-Patient Nursing Home or Convalescent Hospital.....	Admitted			
	Discharged			
☐ Home Health . . . . Number of visits ____	First Visit			
	Last Visit			

8. Describe the illness or injury for which you received treatment.

9. Was your illness or injury connected with your employment? ☐ Yes ☐ No

10a. Were you billed for any of the services furnished?

☐ Yes - **Go to Item 10b**
☐ No - **Go to Item 11**

b. How much did you pay? $

11. Please verify that you have furnished all information requested by signing and dating this form. You **must** also enclose:

- your doctor's certification that the service was medically necessary (certification is not required if any part of the charges for such services is payable under a provincial program), and
- your receipted bills.

Return this form to: U.S. Railroad Retirement Board
844 North Rush Street
Chicago, IL 60611-2092

12.	Signature of Patient		Date	
13.	Street Address			
	City and Province			
	Daytime Telephone Number	Area Code	Telephone Number	

14. If this form is signed by mark ("X") in Item 12, two witnesses who know the person signing must sign below giving their full addresses and daytime telephone numbers.

a	**Signature of Witness**			
	Address			
	Daytime Telephone Number	Area Code	Telephone Number	
b	**Signature of Witness**			
	Address			
	Daytime Telephone Number	Area Code	Telephone Number	

PAPERWORK REDUCTION AND PRIVACY ACT NOTICE

We are authorized to ask you for information needed in the administration of the Medicare program. Authority to collect information is in Sections 7(b) and 7(d) of the Railroad Retirement Act (RRA).

The information we obtain on your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to make proper payment.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under railroad retirement law for refusing to supply information. However, failure to furnish the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work-related injury so we can determine whether worker's compensation will pay for the treatment. Section 13(a) of the RRA provides criminal penalties for withholding this information.

We estimate this form takes an average of 10 minutes per response to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspects of this form, including suggestions for reducing completion time, to Chief of Information Management, Railroad Retirement Board, 844 Rush St, Chicago, Illinois 60611-2092.