United States of America
Railroad Retirement Board

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. 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 Section 1** ☐ No - **Go to Section 2**

Section 1 Services provided before period of this claim

6a. Enter an "X" in the appropriate box and the period of service.		Month	Day	Year
☐ Hospital…….. ►	Admitted	|	|	| | | |
	Discharged	|	|	| | | |
☐ Nursing Home/Convalescent Hospital……. ►	Admitted	|	|	| | | |
	Discharged	|	|	| | | |

b. Enter the name and address of the hospital or nursing home in which you were an inpatient in the 60-day period ***before*** the first day you were furnished the services covered by this claim. ……. ►

Name of Hospital or Nursing Home

Full Address (Include City, Province, ZIP Code)

Section 2 Services covered by this claim

7a. Enter an "X" in the appropriate box and the period of service covered by this claim.		Month	Day	Year
☐ In-Patient Hospital …….. ►	Admitted	|	|	| | | |
	Discharged	|	|	| | | |
☐ In-Patient Nursing Home/Convalescent Hospital ……. ►	Admitted	|	|	| | | |
	Discharged	|	|	| | | |
☐ Home Health ……..► Enter total number of visits _____ ….. ►	First Visit	|	|	| | | |
	Last Visit	|	|	| | | |

7b. **Only complete** Item 7b if the address is different from Item 5c above. ….. ►

Otherwise, enter an "X" in the box to indicate the address is the same. …..► ☐

Name of Hospital or Nursing Home

Full Address (Include City, Province, ZIP Code)

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 ACT AND PRIVACY ACT NOTICES

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 aspect of this form, including suggestions for reducing completion time, to Chief of Information Resources Management, Railroad Retirement Board, 844 Rush St, Chicago, Illinois 60611-2092.