Form Approved
OMB No. 3220-0185

UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
<OFFICE NAME>
<OFFICE ADDRESS>
<OFFICE CITY, STATE, ZIP CODE>
WWW.RRB.GOV

OFFICE HOURS: 9:00 AM TO 3:30 PM
MONDAY THROUGH FRIDAY

TOLL-FREE NUMBER: 1-877-772-5772

Send reply to: U.S. RAILROAD RETIREMENT BOARD **<Field Office Return Address>**	RRB Claim Number Medicare Claim Number Part A Effective Date / Part B Effective Date Beneficiary's Own Social Security Number Beneficiary's DOB / Sex: Male ☐ Female ☐
Report of Problem: ☐ Buy-in Accretion Alleged ☐ Buy-in Deletion Alleged ☐ Other:	Social Security Claim Number Medicaid Number Beneficiary's Name Beneficiary's Address:
Signature of RRB Employee	Title
Telephone Number	Date

Information from State Records or Action Being Taken by State

Read the important notice on the next page.

To be completed by State Representative

1. ☐ State has been paying Medicare premium since _____. (Month/Year)
2. ☐ State paid Medicare premium from _____ (Month/Year) through _____. (Month/Year)
3. ☐ Beneficiary died _____. (Month/Year)

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4. ☐ Claim number under which state paid premium (if different from RRB Medicare claim number) _____.

5. ☐ State will submit a buy-in accretion effective _____ (Month/Year) in the _____ (Month/Year) data exchange with CMS.

6. ☐ State will submit a buy-in deletion effective _____ (Month/Year) in the _____ (Month/Year) data exchange with CMS.

7. ☐ Buy-in problem case on this beneficiary was submitted to CMS on _____ (Month/Year). Allow _____ days for resolution.

8. ☐ Beneficiary never eligible for buy-in.

9. ☐ State has no record of this beneficiary. Beneficiary should contact the following office and file a Medicaid application.

_____

_____

10. ☐ RRB inquiry has been referred to the office listed in item 9 above.

11. ☐ Other:

_____

_____

_____

Signature of State Representative	Title	
Printed Name	Telephone Number	Date

Return this form to the Railroad Retirement Board at the address shown on the first page.

Paperwork Reduction Act Notice

This notice is given under the Paperwork Reduction Act of 1995. Under Section 7(d) of the Railroad Retirement Act (RRA), the Railroad Retirement Board (RRB) is authorized to collect the information requested on this form. The information is needed by the RRB to determine the eligibility of an individual receiving benefits under the RRA for the payment of his or her Medicare medical insurance (Part B) premiums by the State. The information is also used by the RRB to determine if we should stop premium deductions for Medicare medical insurance from the benefits paid to the individual. Your obligation to provide us with this information is required under the law.

We estimate this form takes an average of 10 minutes to complete, including the time for 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 the Chief of Information Resources Management, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-2092.