NATIONAL MEDICAL SUPPORT NOTICE - PART B
MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998 (CSPIA). Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such law. The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the employee. NOTE: For purposes of this form, the Custodial Parent may also be the employee when the State opts to enforce against the Custodial Parent.

Issuing Agency: _____ Issuing Agency Address: _____ _____ Notice Date: _____ CSE Agency Case Identifier: _____ Telephone Number:_____ FAX Number:_____	Court or Administrative Authority: _____ Order Date:_____ Order Identifier: _____ Document Tracking Identifier: _____ Employer web site: _____ See NMSN Instructions: www.acf.hhs.gov/programs/cse/forms/

RE:

_____
Employer/Withholder's Federal EIN Number

_____
Employer/Withholder's Name

_____
_____
_____
Employer / Withholder's Address

_____
Custodial Parent's Name (Last, First, MI)

_____
_____
_____
Custodial Parent's Mailing Address

_____
_____
_____
Child(ren)'s Mailing Address (if different from Custodial Parent's)

_____
Name and Telephone of a Representative of the Child(ren)

_____
Employee's Name (Last, First, MI)

_____
Employee's Social Security Number

_____
_____
_____
Employee's Mailing Address

_____
Substituted Official/Agency Name

_____
_____
_____
Substituted Official/Agency Address
(Required if Custodial Parent's mailing address is left blank)

_____
_____
_____
Mailing Address of a Representative of the Child(ren)

Child(ren)'s Name(s	Gender	DOB	SSN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Child(ren)'s Name(s)	Gender	DOB	SSN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The order requires the child(ren) to be enrolled in ☐ all health coverages available; or only the following coverage(s):
☐ Medical; ☐ Dental; ☐ Vision; ☐ Prescription drug; ☐ Mental health; ☐ Other (specify):_____

OMB control number: 1210-0113 Expiration Date: 10/31/2015.