United States of America
Railroad Retirement Board

CURRENT

Form Approved
OMB No. 3220-0131

PATIENT'S REQUEST FOR MEDICARE PAYMENT

Medical Insurance Benefits – Railroad Retirement Beneficiaries – Social Security Act

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424, Subpart C).

IMPORTANT: See next page for detailed Instructions. Type or print legibly in ink.

1		Print your name exactly as shown on your Medicare Card.	
2	a	Enter your Claim Number exactly as shown on your Medicare card.	PREFIX / CLAIM NUMBER
	b	Indicate your gender? →	☐ Male ☐ Female
3	a	Enter your Full Mailing Address → Check here if new address. ☐	
		STREET OR P.O. BOX – INCLUDE APARTMENT NUMBER	
		CITY, STATE, ZIP CODE	
	b	Enter your Daytime Telephone Number.	AREA CODE / TELEPHONE NUMBER
4	a	Describe the illness or injury for which you received treatment.	
	b	Indicate whether the illness or injury was related to your employment or an accident.	1 ☐ Employment 2 ☐ Accident → ☐ Auto ☐ Other 3 ☐ Neither
	c	Were you treated with chronic dialysis or given a kidney transplant?	☐ Yes ☐ No
5	a	Are you covered under an Employer Health Plan where you currently work?	☐ Yes ☐ No
	b	Are you covered under an employed spouse's or other family member's Employer Health Plan?	☐ Yes ☐ No
	c	If you have medical coverage other than Medicare (such as private insurance, employment-related insurance, or Medicaid), enter the name and address of the other insurance, State Agency (Medicaid), or VA office. Policyholder's Name: Address: **NOTE:** *Check here if you do not want the payment information on this claim released.* ☐	Policy or Medical Assistance Number
6		I authorize any holder of medical or other information about me to release to the Railroad Retirement Board, Centers for Medicare & Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to me.	
	a	SIGNATURE (If you are unable to sign, follow the instructions in Item 6a on reverse side.)	b DATE SIGNED

SEND COMPLETED FORM TO:	IMPORTANT
PALMETTO GBA Railroad Medicare Part B Office P.O. Box 10066 Augusta, GA 30999-0001	Attach itemized bills from your doctor(s) or supplier(s) to the back of form.

HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you **MUST** attach an itemized bill in order for Medicare to process the claim.

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. COMPLETION OF THIS FORM

Item 1 Self-Explanatory.

Item 2 Self-Explanatory.

Item 3 Self-Explanatory.

Item 4 Describe the illness or injury for which you received treatment.
Check the appropriate boxes in Items 4b and 4c.

Item 5a-b Self-Explanatory.

Item 5c Complete this item if you have any medical coverage other than Medicare. Be sure to provide the Policy or Medical Assistance Number. You may check the box provided if you do not wish the payment information from this claim released to your other insurer.

Item 6a Be sure to sign your name.

- If you cannot sign your name, make an "X" mark and have a witness sign his or her name and address in Item 6a.
- If you are completing this form on behalf of the patient, put the word “By” in front of your signature, enter your address, show your relationship to the patient and attach a brief statement explaining why the patient cannot sign.

Item 6b Enter the date you completed this form.

B. Each itemized bill MUST show all of the following information:

- Date of each service.
- Place of each service *Doctor's Office *Independent Laboratory *Outpatient Hospital *Nursing Home *Patient's Home *Inpatient Hospital
- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor's or supplier's name and address. Many times a bill will show the name of several doctor's or suppliers. **IT IS VERY IMPORTANT THAT THE ONE WHO TREATED YOU BE IDENTIFIED**. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is also shown. If not, be sure you have completed Item 4 of this form.
- Draw a line through any services for which you have already filed a Medicare claim.
- If the patient is deceased, please contact the Railroad Retirement Board for instructions on how to file a claim.
- Attach an *Explanation of Benefits* notice from the other insurer if you have one for this service.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Centers for Medicare & Medicaid Services to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete 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 insure that proper payment is made.

The information may 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 to a hospital or doctor about the Medicare benefits you have used.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent 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 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

We estimate this form takes an average of 15 minutes per response to complete, including 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 the form, including suggestions for reducing completion time, to the Chief of Information Resources Management, Railroad Retirement Board, 844 N. Rush Street, Chicago, IL 60611-2092.