

<b>SSO REPORT OF STATE BUY-IN PROBLEM</b>	<b>IDENTIFICATION</b>	
To:  <b>CMS P.O. Box 11977 Baltimore, Maryland 21207-0977</b>	Name _____	
	Medicare Claim Number _____	
From:	Social Security Number (BOAN) _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Welfare ID Number _____	Social Security Number (BOAN) _____
	State and County of Residence _____	
	Claimant's Mailing Address _____	

<b>PART 1 Report of Problem by SSO</b>			
<input type="checkbox"/> A. Part B Claim Denied Carrier Name _____	<input type="checkbox"/> B. Premium being deducted from beneficiary check	<input type="checkbox"/> C. Being billed for premiums	<input type="checkbox"/> D. Individual received Part B Termination Notice
<input type="checkbox"/> E. Other (Explain—Give Form numbers if applicable)			

<b>PART 2 SSI Status at SSO</b>		
Receiving:	Start Date	Stop Date
Federal SSI Check <input type="checkbox"/>		
Federal Admin. State Supp. <input type="checkbox"/>		
(Attach SSR & HMQ Printouts)		

Signature of SSO Representative _____	Title _____	Date _____
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**PART 3 Report of Buy-In Status by Welfare Department (Check and Complete Applicable Items)**

ACCORDING TO \_\_\_\_\_ WELFARE OFFICE, THE INDIVIDUAL IDENTIFIED ABOVE,

1. Has never been eligible for State buy-in.

2. Has been continuously eligible for State buy-in beginning (Mo., Yr.) \_\_\_\_\_

<input type="checkbox"/> 3. Has been eligible for State buy-in only for months of _____ through _____ (Inclusive)	If eligibility ended because of death, give date of death.
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**PART 4 Information from State's records and/or actions being taken by State**

1. Individual is shown on State's bill as Code 41 continuing item beginning (Mo., Yr.) \_\_\_\_\_

2. Individual is shown on State's bill as other code. (Show code) \_\_\_\_\_

3. State will submit (Show code) \_\_\_\_\_ in the monthly data exchange (Show month) \_\_\_\_\_

Accretion Effective (Mo., Yr.) \_\_\_\_\_ Deletion Effective (Mo., Yr.) \_\_\_\_\_

4. Other \_\_\_\_\_

CONTINUED ON REVERSE

Dept. of Public Welfare Signature _____	Title _____	Date _____
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## **PRIVACY ACT STATEMENT**

Section 1320.6 of title 5 to the U.S. Code authorizes collection of this information. The primary use of this information is to process changes to Hospital Insurance (HI)/Supplemental Medical Insurance (SMI) premium payments by third parties (such as State agencies, or private groups) on behalf of Medicare beneficiaries; for billing third parties; and for enrolling individuals for SMI coverage under State buy-in agreements.

Disclosure of the information may be made to State welfare departments pursuant to agreements with the Department of Health and Human Services for enrollment of welfare recipients for medical insurance under section 1843 of the Social Security Act or a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of that individual.

Where the beneficiary's identification number is their Social Security Number, collection of this information is authorized by Executive Order 9397. Furnishing the information on this form including your Social Security Number, is voluntary but failure to do so may result in disapproval of this request.