Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0035

SSO REPORT OF STATE BUY-IN PROBLEM

To:

CMS
P.O. Box 11977
Baltimore, Maryland 21207-0977

From:

IDENTIFICATION

Name

Medicare Beneficiary Identifier

Railroad Retirement Board (RRB) Number

Sex ☐ M ☐ F

Welfare ID Number

Social Security Number (BOAN)

State and County of Residence

Claimant's Mailing Address

PART 1 Report of Problem by SSO

☐ A. Part B Claim Denied
Carrier Name

☐ B. Premium being deducted from beneficiary check

☐ C. Being billed for premiums

☐ D. Individual received Part B Termination Notice

☐ E. Other *(Explain—Give Form numbers if applicable)*

PART 2 SSI Status at SSO

Receiving:

		Start Date	Stop Date
Federal SSI Check	☐		
Federal Admin. State Supp.	☐		

(Attach SSR & HMQ Printouts)

Signature of SSO Representative	Title	Date

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.) ___________________

☐ 3. Has been eligible for State buy-in only for months of _______________ through _______________ (Inclusive)

If eligibility ended because of death, give date of death.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0035. The time required to complete this information collection is estimated to average 17.5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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.

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.