

SSO REPORT OF STATE BUY-IN PROBLEM	IDENTIFICATION										
To: CMS P.O. Box 11977 Baltimore, Maryland 21207-0977	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2">Medicare Beneficiary Identifier</td> </tr> <tr> <td>Railroad Retirement Board (RRB) Number</td> <td>Sex <input type="checkbox"/> M <input type="checkbox"/> F</td> </tr> <tr> <td>Welfare ID Number</td> <td>Social Security Number (BOAN)</td> </tr> <tr> <td colspan="2">State and County of Residence</td> </tr> <tr> <td colspan="2">Claimant's Mailing Address</td> </tr> </table>	Medicare Beneficiary Identifier		Railroad Retirement Board (RRB) Number	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	
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From:											

PART 1 Report of Problem by SSO			
<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)			

PART 2 SSI Status at SSO		
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.

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.