



PROPOSED

UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
 RECONSIDERATION SECTION
 844 NORTH RUSH STREET
 CHICAGO, IL 60611-1275
 WWW.RRB.GOV

Form Approved
 OMB No. 3220-0185

OFFICE HOURS: M-T-TH-F 9:00 AM TO 3:30 PM
 WEDS. 9:00 AM TO 12:00 PM - CLOSED FEDERAL HOLIDAYS

TOLL-FREE NUMBER: 1-877-772-5772

XX-XX-XXXX

Send reply to: U.S. RAILROAD RETIREMENT BOARD	RRB Claim Number	
	Medicare Beneficiary Identifier	
	Part A Effective Date	Part B Effective Date
	Beneficiary's Own Social Security Number	
	Beneficiary's DOB	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Report of Problem: <input type="checkbox"/> Buy-in Accretion Alleged <input type="checkbox"/> Buy-in Deletion Alleged <input type="checkbox"/> Other:	Medicaid Number	
	Beneficiary's Name	
	Beneficiary's Address	
Signature of RRB Employee	Title _____	
Telephone Number	Date	

Commented [SSA1]: This is a fillable form that the field office send to the state agency. This should not be changed from the original form. Remove the reconsideration section and the address.

Commented [SSA2]: Remove this. This is filled out by the field office representative.

Information from State Records or Action Being Taken by State
Read the important notice on the next page.

To be completed by State Representative

1. State has been paying Medicare premium since _____.
 (Month/Year)
2. State paid Medicare premium from _____ through _____.
 (Month/Year) (Month/Year)
3. Beneficiary died _____.
 (Month/Year)

- 4. Medicare Beneficiary Identifier under which state paid premium _____.
- 5. State will submit a buy-in accretion effective _____ in the _____ data exchange with CMS. (Month/Year) (Month/Year)
- 6. State will submit a buy-in deletion effective _____ in the _____ data exchange with CMS. (Month/Year) (Month/Year)
- 7. Buy-in problem case on this beneficiary was submitted to CMS on _____. Allow _____ days for resolution. (Month/Year)
- 8. Beneficiary never eligible for buy-in.
- 9. State has no record of this beneficiary. Beneficiary should contact the following office and file a Medicaid application.

- 10. RRB inquiry has been referred to the office listed in item 9 above.
- 11. Other:

Signature of State Representative	Title	
Printed Name	Telephone Number	Date

Return this form to the Railroad Retirement Board at the address shown on the first page.

Paperwork Reduction Act Notice

This notice is given under the Paperwork Reduction Act of 1995. Under Section 7(d) of the Railroad Retirement Act (RRA), the Railroad Retirement Board (RRB) is authorized to collect the information requested on this form. The information is needed by the RRB to determine the eligibility of an individual receiving benefits under the RRA for the payment of his or her Medicare medical insurance (Part B) premiums by the State. The information is also used by the RRB to determine if we should stop premium deductions for Medicare medical insurance from the benefits paid to the individual. Your obligation to provide us with this information is required under the law.

We estimate this form takes an average of 10 minutes to complete, including the time for 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 this form, including suggestions for reducing completion time, to the Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611-1275.