
PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT: PLEASE READ THE ATTACHED INSTRUCTIONS PRIOR TO SUBMITTING A CLAIM TO MEDICARE SEND ONLY THE COMPLETED FORM TO YOUR MEDICARE ADMINISTRATIVE CONTRACTOR – Include a copy of the itemized bill and any supporting documents. Make a copy of your claim submission for your records and allow at least 60 days for Medicare to receive and process your request.

Reference the Medicare Administrative Contractor Address Table for the correct address to mail your claim form.

Medicare will not process a beneficiary request for payment for diabetic test strips, Part B drugs, or for items paid for under the DMEPOS Competitive Bidding program.

Your reason for submitting this claim: (see the Instructions for additional information, check one box only)

- The provider or supplier refused to file a claim for Medicare Covered Services
- The provider or supplier is unable to file a claim for the Medicare Covered Services
- The provider or supplier is not enrolled with Medicare

IF YOU NEED HELP, CALL 1-800-MEDICARE (1-800-633-4227). TTY USERS SHOULD CALL 1-877-486-2048.

Type of Patient's Request (see instructions for additional information, check one box only):

- Influenza/Pneumococcal Vaccination, Part B (includes physician, laboratory, imaging services), Foreign Travel (including Canada and Mexico) and/or Shipboard Services
 - Durable Medical Equipment, Prosthetics, Orthotics and Supplies
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PLEASE TYPE OR PRINT INFORMATION

SECTION 1 - PATIENT INFORMATION

Patient's Name as shown on Medicare Card (*Last, First, Middle*)

Patient's Medicare Number exactly as it is shown on the Medicare card:	Date of Birth (<i>mm/dd/yyyy</i>)	<input type="radio"/> Male <input type="radio"/> Female
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Street address (or P.O. Box - include apartment number)

City	State	Zip code
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Telephone number

SECTION 2 - INFORMATION ABOUT SERVICES FURNISHED

FOR ALL CLAIMS including Influenza and Pneumococcal Vaccinations, describe the illness or injury for which you received treatment.

Attach all supporting documentation to the form including an itemized bill with the following information:

- Date of service
- Place of service
- Description of illness or injury
- Description of each surgical or medical service or supply furnished
- Charge for each service
- The doctor's or supplier's name and address
- The provider or supplier's National Provider Identifier (NPI) if known_____

IMPORTANT: If the itemized bill is from:

- A Clinical laboratory for ordered tests
- An independent diagnostic imaging center for ordered imaging procedures
- A supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS

The ordering & referring providers legal name **MUST** be included on the itemized bill.

Please also include the ordering & referring providers National Provider Identifier (NPI) if known.

Was the condition related to:

- Yes No Employment
- Yes No Auto Accident
- Yes No Treatment for chronic dialysis or kidney transplant
- Yes No Other Accident
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SECTION 3 - INFORMATION ABOUT HEALTH INSURANCE OTHER THAN MEDICARE

Complete this section if you are age 65 or older and enrolled in a health insurance plan where you or your spouse are currently working and covered by any medical coverage other than Medicare.

- Yes No Are you employed and covered under an employee health plan?
- Yes No Is your spouse employed and are you covered under your spouse's employee health plan?
- Yes No Do you have any medical coverage other than Medicare, such as private insurance, MEDIGAP, employment related insurance, Medicaid, or the Veterans Administration (VA)?
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Name of other Medical Insurance

Policy Number including Medicaid ID Number

Policyholder's Name (*Last, First, Middle*)

Street Address (or P.O. Box) of other Medical Insurance

City	State	Zip code
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Please attach a copy of your primary insurer's Explanation of Benefits if Medicare is secondary.

SECTION 4 - SIGNATURE

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

I authorize any holder of medical or other information about me to release it to the Centers for Medicare & Medicaid Services or its designated contractor or the Social Security Administration for this 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.

Signature of Patient

Date Signed (mm/dd/yyyy)

If you cannot sign your name, mark an (X) on the signature line. Have a witness sign his/her name next to the "X" and complete the section below.

If signing this form on behalf of a Medicare patient, on the 'Signature of Patient' line above, indicate the patient's name followed by "By" and sign your name. Provide your name, address, and relationship to the patient with a brief explanation why the patient cannot sign.

Name of Witness (Last, First, Middle)

Street Address

City

State

Zip code

Relationship to the Patient

Signature of Witness

Date Signed (mm/dd/yyyy)

Briefly explain why the Patient cannot sign:

Send the completed form and supporting documentation to your Medicare contractor. Reference the Medicare Administrative Contractor Address table for the correct address to mail your claim form. If you still do not know the address of your Medicare contractor, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 0938-1197. The time required to complete this information collection is estimated to average 15 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, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. **DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.**

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 also be given to other providers of services, Medicare Administrative Contractor (MAC), 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. Failure to furnish any other information, such as name or Medicare number, would delay 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. If you are being treated for a work related injury be sure to check the appropriate box in Section 2 titled 'Condition Related to'.

Physicians and other suppliers, such as clinical laboratories, imaging service suppliers, and durable medical equipment suppliers are required by law to submit a claim for Medicare covered services furnished to you, the Medicare beneficiary, within one year of the date of service.

To reduce your out-of-pocket expenses, Medicare beneficiaries should always obtain medical care from physicians and other suppliers who are enrolled in the Medicare program. If you submit a claim for covered services furnished by a physician or other supplier who is not enrolled with the Medicare program, your claim may be denied.

For a list of participating Medicare enrolled physicians in your area, please go to www.medicare.gov/physiciancompare or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If a physician or supplier furnishes Medicare covered services to you and refuses to submit a claim on your behalf for those services, please call 1-800-MEDICARE (1-800-633-4227) in order to file a complaint with the Medicare contractor. TTY users should call 1-877-486-2048.

When you submit your own claim to Medicare, complete the entire form. If the claim form has incomplete or invalid information, the Medicare contractor will return the claim along with a letter to you clearly stating what information is missing or invalid.

If the Patient is deceased, please contact your Social Security office for instructions on how to file a claim.

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 (20 CFR 422.510).

MEDICARE ADMINISTRATIVE CONTRACTOR ADDRESS TABLE

FOREIGN TRAVEL (INCLUDING CANADA AND MEXICO) AND SHIPBOARD SERVICES

If you live in:	Mail your claim form, itemized bill and supporting documents to:
Maryland	<p>Novitas Solutions, Inc. P.O. Box 3398 Mechanicsburg, PA 17055-1843</p> <p>(Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050</p>
Massachusetts	<p>National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178</p>
Michigan	<p>Wisconsin Physicians Service P.O. Box 8987 Madison, WI 53708-8987</p>
Minnesota	<p>National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46206-6475</p>
Mississippi	<p>Novitas Solutions P.O. Box 3129 Mechanicsburg, PA 17055-1834</p> <p>(Address to send Medicare 1490 claims via Priority mail or through a commercial courier (UPS, FedEx) for which a PO Box cannot be used, please use the following street address: Novitas Solutions, Inc. Attention: Claims Department 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050</p>
Missouri	<p>Wisconsin Physicians Service P.O. Box 14260 Madison, WI 53708-0260</p>
Montana	<p>Noridian Healthcare Solutions, LLC P.O. Box 6735 Fargo, ND 58108-6735</p>
Nebraska	<p>Wisconsin Physicians Service P.O. Box 8667 Madison, WI 53708-8667</p>
Nevada	<p>Noridian Healthcare Solutions, LLC P.O. Box 6776 Fargo, ND 58108-6776</p>
New Hampshire	<p>National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178</p>