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

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 *(mm/dd/yyyy)*	○Male ○Female

Street address (or P.O. Box - include apartment number)

City	State	Zip code

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 1710908181

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

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)?

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

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:

Wisconsin Physicians Service
P.O. Box 8550
Madison, WI 53708-8550

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.**