[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION

MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

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).

SEND COMPLETED FORM TO:

Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

1 Name of Beneficiary from Health Insurance Card (Last) (First) (Middle)
DOE, JOHN P.

2 Claim Number from Health Insurance Card
99765432 1

Patient's Sex
☑ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
6789 WELLNESS LANE
(Street or P.O. Box – Include Apartment Number)
VIDALIA CA 99999
(City) (State) (Zip)

3b Telephone Number (Include Area Code)
(999) 5551234

4 Describe the illness or injury for which patient received treatment
SHOULDER PAIN

4b Condition was related to:
A. Patient's employment
☐ Yes ☑ No
B. Accident
☐ Auto ☐ Other N/A

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☑ No

5 a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No

b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:

Name and Address of other insurance, State Agency (Medicaid), or VA office
INSURANCE CO X (NFA)

Policyholder's Name:

Policy or Medical Assistance No.
XXX 12345

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

6 I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED 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 (If patient is unable to sign, see Block 6 on reverse)
John P Doe

6b Date signed
1/19/XX

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

Form CMS-1490S (SC) (01/05) EF 02/2005