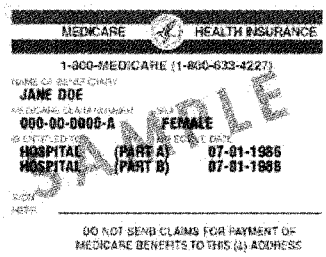
MEDICARE INSURANCE VERIFICATION FORM

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires insurers to report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist Centers for Medicare & Medicaid Services (CMS) and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been enrolled in Medicare Part A or Part B ?

☐ **NO -** Proceed to Section II

☐ **YES -** Complete Section I + II

Full Name: (Please print the name exactly as it appears on your SSN or Medicare Card if available)

_____

Medicare Claim Number: _____ **Date of Birth:** (Mo/Day/Year) _____

Social Security Number: _____ **Gender:** ☐ **Female** ☐ **Male**

Section II

I understand that the information requested is to assist the SC Insurance Reserve Fund to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligation under the Medicare law.

_____ _____

Claimant Name (Please Print) IRF Claim Number (IRF use only)

_____

Name of Person Completing This Form If Claimant is Unable (Please Print)

_____ _____

Signature of Person Completing This Form Date

If you have completed Sections I and II above, **stop here**.
If you are refusing to provide the requested information in Sections I and II, **complete Section III**.

Section III

_____ _____

Claimant Name (Please Print) IRF Claim Number (IRF use only)

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____ _____

Signature of Person Completing This Form Date