Medicare Coverage Form

Submit completed form to:
Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

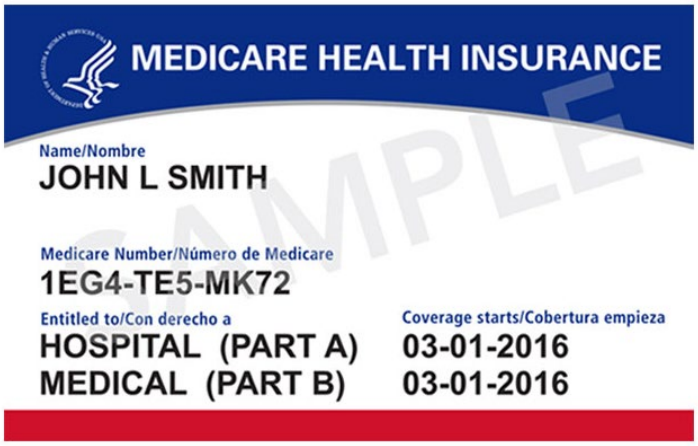
SANFORD HEALTH PLAN

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to their Medicare benefits. There are federal rules that determine whether Medicare or the other GHP insurance pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that group health insurers, claims processing third-party administrators, and certain employer self-funded/self-administered plans report specific information about Medicare beneficiaries who have other group coverage. This reporting is to assist CMS and other health 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, a spouse, or other family members covered by your group health plan have, or has ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No

If yes, please complete the following. If no, proceed to Section II.

Full Name *(Please print the name exactly as it appears on your SSN or Medicare card if available).*

Medicare Number:	**Date of Birth** (Mo/Day/Year
****Social Security Number:** *(If Medicare Number is Unavailable)*	**Sex:** ☐ Female ☐ Male

**Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

Section II

Do you have a spouse that is presently, or has ever been enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section III.		
Full Name *(Please print the name exactly as it appears on your SSN or Medicare card if available).*		
Medicare Number:	**Date of Birth** (Mo/Day/Year	
****Social Security Number:** (If Medicare Number is Unavailable)	**Sex:** ☐ Female ☐ Male	

Section III

Do you have another covered family member that is presently, or has ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section IV. If additional space is needed for completion of this section, please attach another sheet.		
Full Name *(Please print the name exactly as it appears on your SSN or Medicare card if available).*		
Relationship *(Dependent child, domestic partner, etc.)*		
Medicare Number:	**Date of Birth** (Mo/Day/Year	
****Social Security Number:** (If Medicare Number is Unavailable)	**Sex:** ☐ Female ☐ Male	

Full Name *(Please print the name exactly as it appears on your SSN or Medicare card if available).*	
Relationship *(Dependent child, domestic partner, etc.)*	
Medicare Number:	**Date of Birth** (Mo/Day/Year
****Social Security Number:** (If Medicare Number is Unavailable)	**Sex:** ☐ Female ☐ Male

Full Name *(Please print the name exactly as it appears on your SSN or Medicare card if available).*	
Relationship *(Dependent child, domestic partner, etc.)*	
Medicare Number:	**Date of Birth** (Mo/Day/Year
****Social Security Number:** (If Medicare Number is Unavailable)	**Sex:** ☐ Female ☐ Male

Section IV

I understand that the information requested is to assist my insurer, third-party administrator or group health plan to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Subscriber Name | **Subscriber's Plan ID**

Name of Person Completing This form (Please Print)

Signature of Person Completing This Form | **Date**

If you have completed Sections I-IV above, stop here. If you are refusing to provide the information requested in Sections I-IV, proceed to Section V.

Section V

Subscriber Name (Please Print) | **Subscriber's Plan ID**

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**