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

Form Approved
OMB No. 0938-0008

REQUEST FOR MEDICARE PAYMENT BY ORGANIZATIONS WHICH QUALIFY TO RECEIVE PAYMENT FOR PAID BILLS

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 405.1678).

NOTICE — Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

	1. Name of Patient	2. ☐ Male ☐ Female
	3. Claim Number *(Copy from Patient's Medicare Card)*	4. Telephone Number
	5. Street Address, City, State, ZIP Code	

PART I – CLAIMS INFORMATION

6. Describe the illness or injury for which the patient received treatment. *(Always fill in this item if the doctor does not complete Part II below.)*	7. Was patient's illness or injury connected with his employment? ☐ Yes ☐ No

8. I request payment of SMI benefits on behalf of _____
(Name and address of organization)

hereinafter referred to as "the organization," in accordance with approval # _____. I certify in connection with this request that the patient named above has been furnished the services described in this claim, and that the organization:

a. has paid in full the amount of the charges for the services shown in this claim;

b. has the patient's written authorization to receive SMI benefits due on the basis of bills paid in full by the organization;

c. relieves the patient of liability for payment of the services specified in this claim, and will not seek any reimbursement from him with respect to such services, if an SMI benefit is paid to the organization on this claim.

9. Signature of Organization Representative	Title	Date

PART II – PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

10. A. Date of each service	B. Place of service *(*See codes below)*	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given (If Lab Service, indicate if automated)	Procedure Code	D. Nature of illness or injury requiring services or supplies	E. Charges *(If related to unusual circumstances explain in 10C)*	Leave Blank
					$	

11. Name and address *(Number and Street, City, State, ZIP Code)* of physician or supplier	Telephone Number	12. Total charges	$
		13. Amount paid	$
	Physician or supplier code	14. Any unpaid balance due	$

15. Show name and address of facility where services were performed *(Complete if outside your own office or patient's residence)*

16. Signature of physician or supplier (I certify that the statements under Physicians' Notes on the reverse apply to this bill and are made a part hereof.)	Date signed

* O Doctor's Office
IL Independent Laboratory
H Patient's Home *(If portable X-ray services, identify the supplier)*
IH Inpatient Hospital
SNF Skilled Nursing Facility
OH Outpatient Hospital
OL Other Locations
NH Nursing Home

INSTRUCTIONS—PLEASE READ BEFORE COMPLETING THE OTHER SIDE OF THIS FORM

INSTRUCTIONS TO THE ORGANIZATION

An authorized representative of the organization should enter the patient's name, health insurance claim number, address, and sex in the appropriate blocks. The representative should complete item 6 in all cases if Part II is not completed and check the appropriate box. The representative should enter the organization's name and assigned number in the spaces provided in item 8 and sign the form in item 9 including his/her title and the date.

The form serves as a paid bill when the physician completes Part II.

If itemized bills are attached, THEY MUST SHOW:

- Name of person or organization furnishing the medical services or supplies. If they were not furnished by a physician, the name of the physician who prescribed the services or supplies should be shown.
- Name of patient receiving services or supplies.
- Each date services or supplies were provided.
- Place services were provided (home, office, hospital, etc.) and name of facility where service was rendered if other than home or office visits.
- A description of the services or supplies provided on each occasion. If the bill is for ambulance service, it should show the origin and destination.
- The charges for each medical service or item.
- To help speed handling of claims, the claim number should be written on each bill.

(It is helpful if the diagnosis is also shown.)

NOTE: No payment may be made to the patient or any other party for any charges which are imposed by an immediate relative of the patient (i.e., his spouse, parent, child, brother, sister or by a member of his household).

MAILING INSTRUCTIONS

Mail this form to the carrier handling medical insurance benefits in the area where the medical services or items were furnished. The nearest Social Security office will be glad to help anyone who calls, writes, or telephones for assistance in filing his claim. If it is more convenient, you may get help from the carrier designated to handle medical insurance benefits for your area.

FOR MORE INFORMATION

If you have a question about the way a particular claim was handled, you should get in touch with the carrier which made the payment or with the nearest Social Security office.

INSTRUCTIONS TO PHYSICIAN OR SUPPLIER FOR COMPLETING PART II

PHYSICIAN OR SUPPLIER—For each date in item 10, the physician or supplier should indicate the place of service (see footnote on front), and show in item 15 the name of the place where the services were rendered if they were rendered at a place other than a physician's office or the patient's home. The physician or supplier should describe any medical or surgical procedure, attaching a supplementary statement if necessary, and should describe the illness or injury being treated. If more than one procedure or treatment was provided on a single date, describe each procedure separately. Include any charges for preoperative and postoperative care in surgical charges. The physician's or supplier's name and address should be entered in item 11. Complete items 12–14 to show amounts paid and balance due.

SUPPLIER—If the services or supplies were not furnished by a physician, the supplier should show in item 10D the name of the physician prescribing them. A report for ambulance service should show the origin and destination in item 10C.

PHYSICIAN'S or SUPPLIER'S CODE in item 11 should be completed by entering the number agreed upon with the insurance carrier which handles medical insurance benefits.

The physician or supplier, or an authorized representative of either, should sign in item 16.

SIGNATURE OF PHYSICIAN OR SUPPLIER: I certify that the services shown on this form were medically indicated and necessary for the health of the patient. I further certify that these services were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision; i.e., none of the services listed on this form were performed by another person not in my employ or by an organization except as noted in item 16.

For services to be considered as 'incident to' a physician's professional service, the following conditions must be met: 1) the services must be rendered under the physician's immediate personal supervision by his employee; 2) the services must be an integral, although incidental, part of a covered physician's service; 3) the services must be of kinds commonly furnished in physicians' offices; and 4) the services of the nonphysicians must be included on the physician's bills.

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction, be subject to fine and imprisonment under applicable Federal law.