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

SSO Request For Carrier or Intermediary Assistance

1. DATE	CARRIER OR INTERMEDIARY USE

2. BENEFICIARY NAME	a. SEX ☐ M ☐ F	2.b. HEALTH INSURANCE CLAIM NUMBER	2.c. PHONE NO.

3. ADDRESS OF BENEFICIARY	4. NAME AND ADDRESS OF INQUIRER IF OTHER THAN BENEFICIARY	4.a. PHONE NO.
		4.b. RELATIONSHIP TO BENEFICIARY
5. NAME OF WE *(If different from beneficiary)*		

6. TO (Assisting carrier or intermediary) *(Send thru parallel SSO unless direct contact permitted)*	7.a. REQUESTING OFFICE ADDRESS
	7.b. PARALLEL OFFICE ADDRESS

PART 1 — SSO REQUEST

8. DESCRIPTION OF SERVICES *(Do not complete if EOMB is attached.)*

8.a. PHYSICIAN/SUPPLIER *(Show full name and address)*	8.b. DATE(S) OF SERVICE	8.c. TYPE/PLACE OF SERVICE	8.d. AMOUNT

9. ☐ FURNISH STATUS OF CLAIM	DATE CLAIM SUBMITTED	10. ☐ FOLLOW UP TO ORIGINAL REQUEST

11. REMARKS OR ☐ FURNISH THE FOLLOWING INFORMATION *(Attach copy of EOMB or show intermediary control number if pertinent.)*

12. PLEASE REPLY TO: ☐ BENEFICIARY ☐ INQUIRER ☐ REQUESTING OFFICE ☐ PARALLEL OFFICE

PART 2 — CARRIER OR INTERMEDIARY REPLY *(Return through parallel SSO unless direct return is permitted.)*

13. REPLY (Continue on reverse side if necessary) OR ☐ *IS ATTACHED.*

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2 PARALLEL SSO