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

CARRIER OR INTERMEDIARY REQUEST FOR SSO ASSISTANCE

1. DATE	CARRIER OR INTERMEDIARY USE

2a. BENEFICIARY NAME	b. SEX ☐ M ☐ F	c. HEALTH INSURANCE CLAIM NUMBER	d. PHONE NUMBER
3. ADDRESS OF BENEFICIARY		4a. NAME AND ADDRESS OF PERSON TO BE CONTACTED IF OTHER THAN BENEFICIARY	b. PHONE NUMBER c. RELATIONSHIP TO BENEFICIARY

5. TO *(Assisting SSO Office) (Send through parallel SSO unless direct contact permitted.)*	6. FROM

PART I – CARRIER OR INTERMEDIARY REQUEST

7. CLAIMS MATERIAL ATTACHED ☐ YES ☐ NO

8. DEVELOPMENT REQUEST *(Please obtain)*

a. ☐ COMPLETION OF (Form CMS-1490) (CMS-ITEM(S):

b. ☐ UNDERPAYMENT DEVELOPMENT *(Contact is shown in 6 above above if known.)*
MEDICAL EXPENSES PAID ☐ YES ☐ NO
OBTAIN:

c. ☐ EOMB UNDELIVERABLE. NO BETTER ADDRESS AVAILABLE.

d. ☐ CODE REJECT. SEE SPECIFIC INSTRUCTIONS FOR DO HANDLING OF THIS TYPE OF REJECT. IF NECESSARY, TAKE STEPS TO ENTER OR CORRECT INFORMATION ON HI TAPE.

e. ☐ BENEFICIARY NEEDS SPECIAL ASSISTANCE. CONTACT IS SHOWN IN 6 ABOVE

f. ☐ OTHER

9. INFORMATION REQUEST *(Please verify)*

a. ☐ HI CLAIM NUMBER

b. ☐ BENEFICIARY NAME

c. ☐ ADDRESS OF BENEFICIARY

d. ☐ OTHER

10. ☐ FOLLOW-UP TO ORIGINAL REQUEST

11. REMARKS

PART II – SSO REPLY *(Return through parallel SSO unless direct return permitted.)*

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

Form CMS-1980 (3-78)

1. Servicing SSO

CARRIER OR INTERMEDIARY REQUEST FOR SSO ASSISTANCE

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