Medicare

Beneficiary Services: 1-800-MEDICARE (1-800-633-4227)
TTY/ TDD: 1-877-486-2048

Thank you for your recent request for the Patient's Request for Medical Payment form (CMS 1490S). Enclosed is the form, instructions for completing it, and where to return the form for processing.

In most situations, Medicare will not pay for health care outside the United States and its territories. The term "outside the U.S." means anywhere other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Medicare will only pay for care in a foreign hospital (a hospital outside the U.S.) if:

- You are in the United States when a health emergency occurs, and the foreign hospital is closer than the nearest United States hospital that can treat the illness or injury.
- You are traveling, without delay, by the most direct route between Alaska and another state, when a health emergency occurs and the nearest hospital that can treat the emergency is in Canada.
- You live in the United States and the foreign hospital is closer to your home than the nearest United States hospital that can treat your medical condition, regardless of whether it is an emergency.

Please send the completed claim form, your itemized bill, and any supporting documents to the Medicare contractor and explain in detail your reason for submitting the claim. You should mail the original claim form and make copies for your records. Please allow at least 60 days for Medicare to receive and process your request.

If you have any other questions, please feel free to call us at 1-800-MEDICARE (1-800-633-4227).

Sincerely,

Centers for Medicare and Medicaid Services

Medicare

Beneficiary Services: 1-800-MEDICARE (1-800-633-4227)

HOW TO FILL OUT YOUR MEDICARE CLAIM FORM

Medicare will consider payment to you directly when you complete this form and attach an itemized bill from your Medicare enrolled provider.

Your bill does not have to be paid before you submit the claim form, but you MUST attach an itemized bill in order for Medicare to process your claim for consideration.

FOLLOW THESE INSTRUCTIONS CAREFULLY:

- BLOCK 1: Print your name shown on your Medicare Card (Last Name, First Name, Middle Name).
- BLOCK 2: Print your Medicare number including the letter(s) located either at the beginning or the end of your Medicare Number exactly as it is shown on your Medicare Card. In the same block, please check the appropriate box for **Patient's Sex**.
- BLOCK 3: Please provide your full mailing address.
- BLOCK 3B: Please provide your telephone number including area code.
- BLOCK 4: Describe the medical condition for which you are being treated.
- BLOCKS 4B and 4C: Please check the appropriate boxes
- BLOCK 5A: If you are 65 or older, employed, and enrolled in a health insurance plan under your employer, complete this block.
- BLOCK 5B: If you are 65 or older and covered under a health insurance plan under your spouse's employer, complete this block.

- BLOCK 5C: If you have any other medical coverage other than Medicare, provide the Policy or Medical Assistance Number.

- Please check the box provided if you do not want payment information from this claim release to another insurer.

- BLOCK 6: Be sure to sign your name. If you cannot sign your name, make an "X" mark and have a witness sign his or her name in Block 6 also.
  If you are completing this form for another Medicare beneficiary, you should write "By" and sign your name and provide your address in Block 6. You should also show your relationship to the beneficiary and briefly explain why the beneficiary can not sign.

    - BLOCK 6B: Please print the date you completed this claim form.

Use the following address table to ensure the correct address will be provided on the claim.

If you live in:	**Return your form to:**
Alabama	Alabama Medicare Part B Claims PO Box 830140 Birmingham, AL 35283-0140
Alaska	Medicare Part B PO Box 6703 Fargo, ND 58108-6703
American Samoa	Medicare Part B PO Box 6701 Fargo, ND 58108-6701
Arkansas	Pinnacle Medicare Services Attn: Claims P.O. Box 1418 Little Rock, AR 72203-8102
Arizona	Medicare Part B PO Box 6704 Fargo, ND 58108-6704
Northern California	NHIC Medicare Claims P.O. Box 2804 Chico, CA 95927-2804
Southern California	NHIC Medicare Claims P.O. Box 272852 Chico, CA 95927-2852
Colorado	TrailBlazer Health Enterprises, LLC Part B Claims P.O. Box 650705 Dallas, TX 75265-0705
Connecticut	Medicare Part B CT Claims P.O. Box 44234 Jacksonville, FL 32231-4234
Delaware	TrailBlazer Health Enterprises, LLC PO Box 650094 Dallas, TX 75265-0094
District of Columbia (Washington DC)	TrailBlazer Health Enterprises, LLC PO Box 650092 Dallas, TX 75265-0092
Florida	First Coast Service Options P.O. Box 2525 Jacksonville, FL 32231-0019
Georgia	Georgia Medicare Part B Claims PO Box 12847 Birmingham, AL 35202
Guam	Medicare Part B PO Box 6701 Fargo, ND 58108-6701
Hawaii	Medicare Part B PO Box 6701

	Fargo, ND 58108-6701
Idaho	CIGNA Government Services PO Box 22599 Nashville, TN 37202-2599
Illinois	Medicare Part B PO Box 1030 Marion, IL 62959
Indiana	National Government Services P.O. Box 6160 Indianapolis, IN 46206-6160
Iowa	WPS Medicare Part B Claims Department P.O. Box 8550 Madison, WI 53708-8550
Kansas	WPS Medicare Part B Claims Department P.O. Box 7238 Madison, WI 53707
Kentucky	National Government Services P.O. Box 7154 Indianapolis, IN 46207-7154
Louisiana	LA Claims PO Box 8082 Little Rock, AR 72203
Maine	NHIC Medicare Claims P.O. Box 2323 Hingham, MA 02044
Maryland	TrailBlazer Health Enterprises, LLC PO Box 660595 Dallas, TX 75266-0595
Massachusetts	NHIC Medicare Claims P.O. Box 1212 Hingham, MA 02044
Michigan	Medicare Part B PO Box 5555 Marion, IL 62959
Minnesota	Wisconsin Physician Services 8120 Penn Avenue S., Suite 200 Bloomington, MN 55431
Mississippi	Mississippi Medicare Part B Claims PO Box 547 Birmingham, AL 35201
Western Missouri	WPS Medicare Part B Claims Department P.O. Box 7128 Madison, WI 53707
Eastern Missouri	Pinnacle Medicare Services P.O. Box 8170 Little Rock, AR 72203
Montana	Medicare Part B PO Box 6735

	Fargo, ND 58108-6735
Nebraska	WPS Medicare Part B Claims Department P.O. Box 8667 Madison, WI 53708
Nevada	Noridian Administrative Services PO Box 6705 Fargo, ND 58108-6705
New Hampshire	NHIC Medicare Claims P.O. Box 1717 Hingham, MA 02044
New Jersey	National Government Services, Inc. PO Box 69201 Harrisburg, PA 17106-9201
New Mexico	Part B Claims/ADS - New Mexico TrailBlazer Health Enterprises, LLC Part B Claims P. O. Box 650699 Dallas, TX 75265-0699
New York - Counties include: Bronx, Manhattan, Staten Island, Brooklyn, Nassau, Suffolk, Columbia, Orange, Sullivan, Delaware, Putnam, Ulster, Dutchess, Rockland, Westchester, Greene Counties	National Government Services, Inc. P.O. Box 4751 Syracuse, NY 13221-4751
New York - Queens County Only	GHI P.O. Box 2870 New York, NY 10116
New York - Upstate	HealthNow NY P.O. Box 5200 Binghamton, NY 13902-5200
North Carolina	CIGNA Government Services PO Box 671 Nashville, TN 37202-0671
North Dakota	Medicare Part B PO Box 6706 Fargo, ND 58108-6706
Northern Mariana Islands	Medicare Part B PO Box 6701 Fargo, ND 58108-6701
Ohio	Palmetto GBA PO Box 182932 Columbus, OH 43218-2932
Oklahoma	Part B Claims/ADS – Oklahoma TrailBlazer Health Enterprises, LLC Part B Claims P. O. Box 650706 Dallas, TX 75265-0706
Oregon	Medicare Part B PO Box 6702 Fargo, ND 58108-6702

Pennsylvania	Highmark Medicare Services PO Box 890418 Camp Hill, PA 17089-0418
Puerto Rico	Triple S, Inc./Medicare PO Box 71391 San Juan, PR 00936 -1391
Rhode Island	Claims Department Pinnacle Medicare Services P.O. Box 8102 Little Rock, AR 72203-8102
South Carolina	Palmetto GBA PO Box 100190 Columbia, SC 29202
South Dakota	Medicare Part B PO Box 6707 Fargo, ND 58108-6707
Tennessee	CIGNA Government Services PO Box 1465 Nashville, TN 37202-1465
Texas	TrailBlazer Health Enterprises, LLC Medicare Part B Claims PO Box 660031 Dallas, TX 75266-0031
Utah	Medicare Part B PO Box 6725 Fargo, ND 58108-6725
Vermont	NHIC Medicare Claims P.O. Box 7777 Hingham, MA 02044
Virginia	TrailBlazer Health Enterprises, LLC PO Box 650208 Dallas, TX 75265-0208
Virgin Islands	Triple S, Inc./Medicare PO Box 71391 San Juan, PR 00936 -1391
Washington	Medicare Part B PO Box 6700 Fargo, ND 58108-6700
West Virginia	Palmetto GBA PO Box 182932 Columbus, OH 43218-2932
Wisconsin	Medicare Part B Claims Processing PO Box 1787 Madison, WI 53701-1787
Wyoming	Medicare Part B PO Box 6708 Fargo, ND 58108-6708

INFORMATION THAT SHOULD BE INCLUDED ON ITEMIZED BILL:

- Date of each service or supply received
- Description of each medical service or supply furnished
- Amount Charged for each service received
- The name and address of the company who provided the services. The company's Medicare supplier number ***must*** be included (the company can give you this information).
- Mark out any services or supplies on the itemized bill which do not apply.
- If you send in a prescription for a medical supply or service, make sure the diagnosis code is listed on the prescription. Your physician will have this information.
- If you are filing this claim on behalf of a deceased beneficiary, please contact your local Social Security office for any additional information necessary to send to Medicare for processing of the claim.
- If you are covered under an insurance that pays before Medicare, attach an Explanation of Benefits from that insurance company if you are also requesting Medicare payment.

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

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

SEND COMPLETED FORM TO:

Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

1 Name of Beneficiary from Health Insurance Card
(Last) (First) (Middle)

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
(Street or P.O. Box – Include Apartment Number)
(City) (State) (Zip)

3b Telephone Number
(Include Area Code)
(___ ___ ___)
___ ___ ___ – ___ ___ ___ ___

4 Describe the illness or injury for which patient received treatment

4b Condition was related to:
A. Patient's employment
☐ Yes ☐ No
B. Accident
☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5
a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No
b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No
c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policyholder's Name:

Policy or Medical Assistance No.

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

6 I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you MUST attach an itemized bill in order for Medicare to process this claim. Mail your completed claim form to the Medicare Carrier responsible for processing your claim. If you do not know the address of your carrier, call 1-800-MEDICARE (1-800-633-4227).

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

Block 1. Print your name shown on your Medicare Card (Last Name, First Name, Middle Name).

Block 2. Print your Health Insurance Claim Number including the letter at the end **exactly** as it is shown on your Medicare card. Check the appropriate box for the patient's sex.

Block 3. Furnish your mailing address and include your telephone number in Block 3b.

Block 4. Describe the illness or injury for which you received treatment. Check the appropriate box in Blocks 4b and 4c.

Block 5a. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where you are currently working.

Block 5b. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where your spouse is currently working.

Block 5c. Complete this Block if you have any medical coverage other than Medicare. Be sure to provide the Policy or Medical Assistance Number. You may check the box provided if you do not wish payment information from this claim released to your other insurer.

Block 6. Be sure to sign your name. If you cannot write your name, make an (X) mark. Then have a witness sign his or her name and address in **Block 6** too.

If you are completing this form for another Medicare patient you should write (By) and sign your name and address in **Block 6.** You also should show your relationship to the patient and briefly explain why the patient cannot sign.

Block 6b. Print the date you completed this form.

B. Each itemized bill MUST show all of the following information:

- Date of each service
- Place of each service

Doctor's Office	Independent Laboratory	Outpatient Hospital
Nursing Home	Patient's Home	Inpatient Hospital

- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor's or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THE ONE WHO TREATED YOU BE IDENTIFIED. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is also shown on the physician's bill. If not, be sure you have completed **Block 4** of this form.
- Mark out any services on the bill(s) you are attaching for which you have already filed a Medicare claim.
- If the patient is deceased, please contact your Social Security office for instructions on how to file a claim.
- Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Centers for Medicare & Medicaid Services to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information to a hospital or doctor about the Medicare benefits you have used.

With one exception, which is discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.