



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.

Medicare will only pay for medically necessary shipboard services if the services were provided while the ship was within U.S. waters (i.e., in a U.S. port, or within 6 hours of departure or arrival at a U.S. port).

If you had medical services aboard a ship and the doctor's office is in the United States, the doctor will submit the claim to Medicare. Please contact the doctor to submit the claim.

If the doctor's office is not in the United States, you will need to mail a CMS-1490S form to Medicare. Where you return the form will depend on your ship's port of departure and the port of arrival.

- If the doctor's office is not in the United States and the trip began in the United States, the Medicare contractor at the port of departure will process your claim. For example, if the trip began in New York and ended in Spain, the Medicare contractor for New York will process the claim.
- If the doctor's office is not in the United States and the trip began in another country and ended in the United States, the Medicare contractor at the arrival port will process the claim. For example, if the trip began in Spain and ended in New York, the Medicare contractor for New York will process the claim.
- If the doctor's office is not in the United States and the trip began in another country and ended in another country, the Medicare contractor in the state that you live will process the claim.

Please send the Patient's Request for Medical Payment form, your itemized bill, and any supporting documents to the Medicare contractor at the appropriate port and explain in detail your reason for submitting the claim. You should mail the original claim form to Medicare 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 the port of departure/arrival is in, or the state that you live in is:	Return your form to:
Alabama	Alabama Medicare Part B Claims P.O. Box 830140 Birmingham, AL 35283-0140
Alaska	Medicare Part B P.O. Box 6703 Fargo, ND 58108-6703
American Samoa	J1 MAC - Palmetto GBA P.O. Box 1051 Augusta, GA 30903-1051
Arkansas	Pinnacle Medicare Services P.O. Box 1418 Little Rock, AR 72203-1418
Arizona	Noridian Administrative Services P.O. Box 6704 Fargo, ND 58108-6704
California	J1 MAC - Palmetto GBA P.O. Box 1051 Augusta, GA 30903-1051
Colorado	TrailBlazer Health Enterprises, LLC P.O. Box 650705 Dallas, TX 75265-0705
Connecticut	National Government Services, Inc. P.O. Box 4797 Syracuse, NY 13221-4797
Delaware	Highmark Medicare Services P.O. Box 890397 Camp Hill, PA 17089-0397
District of Columbia (Washington DC)	Highmark Medicare Services P.O. Box 890396 Camp Hill, PA 17089-0396
Florida	First Coast Service Options P.O. Box 2525 Jacksonville, FL 32231-2525
Georgia	Georgia Medicare Part B Claims P.O. Box 12847 Birmingham, AL 35202
Guam	J1 MAC - Palmetto GBA P.O. Box 1051 Augusta, GA 30903-1051
Hawaii	J1 MAC - Palmetto GBA P.O. Box 1051 Augusta, GA 30903-1051
Idaho	CIGNA P.O. Box 22599 Nashville, TN 37202-2599

Illinois	Wisconsin Physicians Service P.O. Box 1030 Marion, IL 62959-1030
Indiana	National Government Services P.O. Box 6160 Indianapolis, IN 46206-6160
Iowa	Wisconsin Physicians Service P.O. Box 8550 Madison, WI 53708-8550
Kansas	Wisconsin Physicians Service P.O. Box 7238 Madison, WI 53707-7238
Kentucky	National Government Services P.O. Box 6160 Indianapolis, IN 46206-6160
Louisiana	Pinnacle Medicare Services P.O. Box 8082 Little Rock, AR 72203-8082
Maine	National Heritage Insurance Company P.O. Box 2323 Hingham, MA 02044-2323
Maryland	Highmark Medicare Services P.O. Box 890398 Camp Hill, PA 17089-0398
Massachusetts	National Heritage Insurance Company P.O. Box 1212 Hingham, MA 02044-1212
Michigan	Wisconsin Physicians Service P.O. Box 5555 Marion, IL 62959-5555
Minnesota	Wisconsin Physicians Service 8120 Penn Avenue South, Suite 200 Bloomington, MN 55431
Mississippi	Mississippi Medicare Part B Claims P.O. Box 547 Birmingham, AL 35201
Missouri (East)	Wisconsin Physicians Service P.O. Box 14260 Madison, WI 53708-0260
Missouri (West)	Wisconsin Physicians Service P.O. Box 7128 Madison, WI 53707-7128
Montana	Noridian Administrative Services P.O. Box 6735 Fargo, ND 58108-6735
Nebraska	Wisconsin Physicians Service P.O. Box 8667 Madison, WI 53708-8667
Nevada	J1 MAC - Palmetto GBA P.O. Box 1051 Augusta, GA 30903-1051

New Hampshire	National Heritage Insurance Company P.O. Box 1717 Hingham, MA 02044-1717
New Jersey	Highmark Medicare Services P.O. Box 890030 Camp Hill, PA 17089-0030
New Mexico	TrailBlazer Health Enterprises, LLC P.O. Box 650705 Dallas, TX 75265-0705
New York (Lower State)	National Government Services, Inc. P.O. Box 4751 Syracuse, NY 13221-4751
New York (Upper State)	National Government Services, Inc. P.O. Box 4803 Syracuse, NY 13221-4803
New York (Queens County)	National Government Services, Inc. P.O. Box 4794 Syracuse, NY 13221-4794
North Carolina	CIGNA P.O. Box 671 Nashville, TN 37202-0671
North Dakota	Noridian Administrative Services P.O. Box 6706 Fargo, ND 58108-6706
Northern Mariana Islands	J1 MAC - Palmetto GBA P.O. Box 1051 Augusta, GA 30903-1051
Ohio	Palmetto GBA P.O. Box 182932 Columbus, OH 43218-2932
Oklahoma	TrailBlazer Health Enterprises, LLC P.O. Box 650706 Dallas, TX 75265-0706
Oregon	Noridian Administrative Services P.O. Box 6702 Fargo, ND 58108-6702
Pennsylvania	Highmark Medicare Services P.O. Box 890418 Camp Hill, PA 17089-0418
Puerto Rico	Triple S, Inc. P.O. Box 71391 San Juan, PR 00936 -1391
Rhode Island	Pinnacle Medicare Services P.O. Box 8102 Little Rock, AR 72203-8102
South Carolina	Palmetto GBA P.O. Box 100190 Columbia, SC 29202

South Dakota	Noridian Administrative Services P.O. Box 6707 Fargo, ND 58108-6707
Tennessee	CIGNA P.O. Box 1465 Nashville, TN 37202-1465
Texas	TrailBlazer Health Enterprises, LLC P.O. Box 650705 Dallas, TX 75265-0705
Utah	Noridian Administrative Services P.O. Box 6725 Fargo, ND 58108-6725
Vermont	National Heritage Insurance Company P.O. Box 7777 Hingham, MA 02044-7777
Virginia (Arlington and Fairfax Counties including city of Alexandria)	Highmark Medicare Services P.O. Box 890396 Camp Hill, PA 17089-0396
Virginia (The rest of the state.)	TrailBlazer Health Enterprises, LLC P.O. Box 650208 Dallas, TX 75265-0208
Virgin Islands	Triple S, Inc. P.O. Box 71391 San Juan, PR 00936 -1391
Washington	Noridian Administrative Services P.O. Box 6700 Fargo, ND 58108-6700
West Virginia	Palmetto GBA P.O. Box 182932 Columbus, OH 43218-2932
Wisconsin	Wisconsin Physicians Service P.O. Box 1787 Madison, WI 53701-1787
Wyoming	Noridian Administrative Services P.O. 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.



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).

1	Name of Beneficiary from Health Insurance Card (Last) (First) (Middle)		SEND COMPLETED FORM TO: Your Medicare Carrier If you need help, call 1-800-MEDICARE (1-800-633-4227)	
	2	Claim Number from Health Insurance Card		
3	Patient's Mailing Address (City, State, Zip Code) Check here if this is a new address <input type="checkbox"/>		Telephone Number (Include Area Code) (_ _ _) _ _ - _ _ - _ _	
	_____ (Street or P.O. Box – Include Apartment Number) _____ (City) (State) (Zip)			
4	Describe the illness or injury for which patient received treatment		Condition was related to: A. Patient's employment <input type="checkbox"/> Yes <input type="checkbox"/> No B. Accident <input type="checkbox"/> Auto <input type="checkbox"/> Other	
			Was patient being treated with chronic dialysis or kidney transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5	a. Are you employed and covered under an employee health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Is your spouse employed and are you covered under your spouse's employee health plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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		Policy or Medical Assistance No.	
	Policyholder's Name: _____ Note: If you DO NOT want payment information on this claim released, put an (X) here <input type="checkbox"/>			
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)		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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.