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. The address where you need to return the form for processing depends on where the service was received. For example: If you received the service in Ontario, you need to send your claim to the address for Ontario provided on the chart included in this packet.

In most situations, Medicare will not pay for health care outside the United States (U.S.) 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 may pay for inpatient hospital, doctor, or ambulance services you get in Canada or Mexico:

- If an emergency happened within the U.S. and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.
- If you are traveling through Canada without delay, by the most direct route between Alaska and another state, when a health emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- If you live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your condition, regardless of whether an emergency exists.

Please send the completed claim form, your itemized bill, and any supporting documents to the appropriate Medicare contractor and explain in detail your reason for submitting the claim. For example, include a statement that notifies the Medicare contractor that you are sending the claim for a denial for your secondary insurance, or you are sending a claim because you have received a service outside of the United States and/or your provider is unable to file a claim for a Medicare-covered service and/or is not enrolled with Medicare.

When you submit your own claim to Medicare, complete the entire form. If the claim form has incomplete or invalid information, the Medicare contractor will return the claim along with a letter to you clearly stating what information is missing or invalid.

You should mail the original claim form, a copy of the itemized bill, and supporting documents to Medicare. You should make copies of your claim submission 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 & Medicaid Services

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

If you received a service in:	**Return your form to:**
Canada	
New Brunswick Newfoundland Nova Scotia Quebec Prince Edward Island	NHIC, Corp. 75 Sgt. William Terry Drive Hingham, MA 02044-9194
Ontario	**For Part A services use the address below.** National Government Services, Inc. Part A Foreign Claims P.O. Box 7150 Indianapolis, IN 46207-7150 **For Part B services use the address below.** Wisconsin Physicians Service P.O. Box 5555 Marion, IL 62959
Alberta Manitoba Saskatchewan	**For Part A services use the address below.** Noridian Administrative Services P.O. Box 6732 Fargo, ND 58108-6732 **For Part B services use the address below.** Noridian Administrative Services P.O. Box 6735 Fargo, ND 58108-6735
British Columbia Northwest Territories Vancouver Yukon Territories	**For Part A services use the address below.** Noridian Administrative Services P.O. Box 6720 Fargo, ND 58108-6720

	For Part B services use the address below. Noridian Administrative Services P.O. Box 6735 Fargo, ND 58108-6735

Mexico	
Western Mexico (Sonora and the Bajas)	J1 MAC Palmetto GBA P. O. Box 1051 Augusta, GA 30903-1051
Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	Trailblazer Health Enterprises, LLC P.O. Box 660155 Dallas, Texas 75266-0155

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.