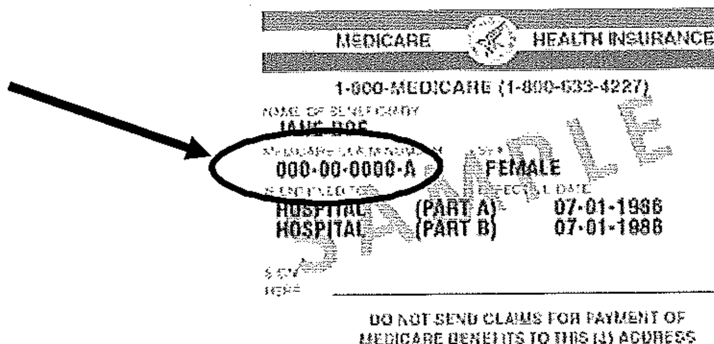
Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), requires health insurance plans to report specific information about their members to the Centers for Medicare and Medicaid Services (CMS). The intent of this reporting is to help Medicare properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

Depending on your status with Medicare, there are two options for you to respond in writing with the information we need to comply with this requirement:

- Option 1 – Provide your Social Security number (SSN) or Medicare Claim Number (HICN). If you provide your SSN or Medicare Claim Number, no future action will be required.
- Option 2 – Sign an annual waiver. This option is for members who have not received Medicare benefits. If you sign waiver, we will need to contact you every year to re-confirm your Medicare status.

**Option 1 – Provide SSN or Medicare Claim Number**

If you or your dependents are listed in the table below, you may write your SSN in the table below and return it to us in the pre-paid envelope. If you have received Medicare benefits, please write your Medicare Claim Number in the table and mail this form to us in the pre-paid envelope. Your Medicare Claim Number can be found on your Medicare card as shown in the sample below. If you are not able to provide the Medicare Claim Number, please write your SSN. **If you provide us with your SSN or Medicare Claim Number, we will not need to contact you in the future to collect this information.**




| Name | Member ID | Social Security Number (If Medicare Claim Number is unavailable) | Medicare Claim Number (As shown on sample Medicare card above) |
| --- | --- | --- | --- |
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**Option 2 – Annual Waiver**

If you or your dependents listed in the table on the previous page have not received Medicare benefits and you do not wish to provide your SSN, you may sign the waiver below and mail this form to us in the pre-paid envelope. Signing the waiver indicates that you are not a Medicare beneficiary. **Please note that according to the federal requirement, this waiver must be signed annually for you and your dependents. If you choose to sign this waiver, we will contact you again in twelve months to re-confirm your status with Medicare.**

**I certify that neither I nor my dependents have received Medicare benefits. I choose not to provide Social Security numbers for me or my dependents at this time.**

______________________________________________________________________

Subscriber Signature                                                                                    Date

______________________________________________________________________

Subscriber Name (Please Print)

Subscriber ID#:
(From Providence ID card)