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 you live. For example: If you live in Alabama, you need to send your claim to the address for Alabama 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 a foreign hospital (a hospital outside the U.S.) in the following situations:

- If an emergency arose 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 medical 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 medical 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 live in:	**Return your form to:**
Alabama	Cahaba GBA Medicare Part B Claims P.O. Box 6169 Indianapolis, IN 46206
Alaska	Noridian Healthcare Solutions P.O. Box 6703 Fargo, ND 58108-6703
American Samoa	Noridian Healthcare Solutions P.O. Box 6777 Fargo, ND 58108-6777
Arkansas	Novitas Solutions P.O. Box 3098 Mechanicsburg, PA 17055-1816
Arizona	Noridian Healthcare Solutions P.O. Box 6704 Fargo, ND 58108-6704
California (Northern)	Noridian Healthcare Solutions P.O. Box 6774 Fargo, ND 58108-6774
California (Southern)	Noridian Healthcare Solutions P.O. Box 6775 Fargo, ND 58108-6775
Colorado	Novitas Solutions P.O. Box 3107 Mechanicsburg, PA 17055-1823
Connecticut	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
Delaware	Novitas Solutions P.O. Box 3397 Mechanicsburg, PA 17055-1842
District of Columbia (Washington DC)	Novitas Solutions P.O. Box 3396 Mechanicsburg, PA 17055-1841
Florida	First Coast Service Options, Inc. P.O. Box 2525 Jacksonville, FL 32231-0019
Georgia	Cahaba GBA Medicare Part B Claims P.O. Box 6169 Indianapolis, IN 46206
Guam	Noridian Healthcare Solutions P.O. Box 6777 Fargo, ND 58108-6777

If you live in:	Return your form to:
Hawaii	Noridian Healthcare Solutions P.O. Box 6777 Fargo, ND 58108-6777
Idaho	Noridian Healthcare Solutions P.O. Box 6701 Fargo, ND 58108-6701
Illinois	National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46206-6475
Indiana	Wisconsin Physicians Service P.O. Box 8940 Madison, WI 53708-8940
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	CGS Administrators, LLC P.O. Box 20019 Nashville, TN 37202
Louisiana	Novitas Solutions P.O. Box 3097 Mechanicsburg, PA 17055-1815
Maine	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
Maryland	Novitas Solutions P.O. Box 3398 Mechanicsburg, PA 17055-1843
Massachusetts	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
Michigan	Wisconsin Physicians Service P.O. Box 8987 Madison, WI 53708-8987
Minnesota	National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46206-6475
Mississippi	Novitas Solutions P.O. Box 3129 Mechanicsburg, PA 17055-1834
Missouri	Wisconsin Physicians Service P.O. Box 14260 Madison, WI 53708-0260
Montana	Noridian Healthcare Solutions P.O. Box 6735 Fargo, ND 58108-6735

If you live in:	Return your form to:
Nebraska	Wisconsin Physicians Service P.O. Box 8667 Madison, WI 53708-8667
Nevada	Noridian Healthcare Solutions P.O. Box 6776 Fargo, ND 58108-6776
New Hampshire	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
New Jersey	Novitas Solutions P.O. Box 3030 Mechanicsburg, PA 17055-1802
New Mexico	Novitas Solutions P.O. Box 3107 Mechanicsburg, PA 17055-1823
New York	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
North Carolina	Palmetto GBA - J11 MAC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190
North Dakota	Noridian Healthcare Solutions P.O. Box 6706 Fargo, ND 58108-6706
Northern Mariana Islands	Noridian Healthcare Solutions P.O. Box 6777 Fargo, ND 58108-6777
Ohio	CGS Administrators, LLC P.O. Box 20019 Nashville, TN 37202
Oklahoma	Novitas Solutions P.O. Box 3107 Mechanicsburg, PA 17055-1823
Oregon	Noridian Healthcare Solutions P.O. Box 6702 Fargo, ND 58108-6702
Pennsylvania	Novitas Solutions P.O. Box 3418 Mechanicsburg, PA 17055-1854
Puerto Rico	First Coast Service Options, Inc. P.O. Box 45036 Jacksonville, FL 32231-5036
Rhode Island	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178

If you live in:	Return your form to:
South Carolina	Palmetto GBA - J11 MAC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190
South Dakota	Noridian Healthcare Solutions P.O. Box 6707 Fargo, ND 58108-6707
Tennessee	Cahaba GBA Medicare Part B Claims P.O. Box 6169 Indianapolis, IN 46206
Texas	Novitas Solutions P.O. Box 3108 Mechanicsburg, PA 17055-1824
Utah	Noridian Healthcare Solutions P.O. Box 6725 Fargo, ND 58108-6725
Vermont	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
Virginia (Arlington and Fairfax Counties including city of Alexandria)	Novitas Solutions P.O. Box 3396 Mechanicsburg, PA 17055-1841
Virginia (The rest of the state.)	Palmetto GBA - J11 MAC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190
Virgin Islands	First Coast Service Options, Inc. P.O. Box 45098 Jacksonville, FL 32231-5098
Washington	Noridian Healthcare Solutions P.O. Box 6700 Fargo, ND 58108-6700
West Virginia	Palmetto GBA - J11 MAC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190
Wisconsin	National Government Services, Inc. P.O. Box 6475 Indianapolis, IN 46206-6475
Wyoming	Noridian Healthcare Solutions P.O. Box 6708 Fargo, ND 58108-6708

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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 of fice 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 or ganizations 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 char ged 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.