

Social Security Number Submission/Waiver Form

Effective January 1, 2011, CMS updated provisions of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), which 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.

We request your response. Based on your status with Medicare, you have two options to respond:

- **Option 1** – Fill out the form below and provide your Social Security number (SSN) or Medicare Claim Number (HICN). Please be assured that SSNs will be protected and will not appear on identification cards or material. Return your completed form by using the postage-paid envelope. No future action will be required.
- **Option 2** – Sign an annual waiver if you have not received Medicare benefits. Return your completed waiver form by using the postage-paid envelope. If you sign the 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 provide us with your SSN or Medicare Claim Number, we will not need to contact you in the future to collect this information. Fill in your name, your Providence Health Plan ID Number from your member identification card and your SSN. If you have received Medicare benefits, please include your Medicare Claim Number as shown in the sample below, instead of your SSN.



Name	ID Number	Social Security Number (If Medicare Claim Number is unavailable)	Medicare Claim Number (See Medicare card sample above)

ATTN: Membership Accounting

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 to: Providence Health Plan, P.O. Box 4327, Portland, OR 97208. 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

Member ID Number
(from Providence Health Plan ID Card)

Subscriber Name (Please Print)

Date

ATTN: Membership Accounting