



## **815.5 Situations That Initiate Enrollment Process**

### **815.5.1 Medicare Only Application**

The application initiates manual or computer action to determine the applicant's entitlement to Part A and, when appropriate, to Part B.

### **815.5.2 Annuity Application**

The application initiates manual or computer action to determine the applicant's entitlement to an annuity and, when appropriate, to Parts A and B.

### **815.5.3 SS Certifications**

RRB assumes Medicare jurisdiction for individuals whose SS benefits are certified to the RRB. The certification includes a determination of the beneficiary's entitlement to Part A and Part B and the effective dates of coverage. Based on this information, the RRB initiates manual or computer action to enroll the beneficiary.

## **815.10 Enrollments During The Initial Enrollment Period (IEP)**

### **815.10.1 Automatic Enrollment - Attainments**

Individuals who are entitled to a RR annuity, a SS benefit certified to the RRB, or for inclusion in the O/M for at least 6 months before becoming eligible for Medicare are enrolled for coverage automatically. Such enrollments are referred to as "attainments." The chart below indicates the month by which an individual must be on the rolls in order to be enrolled automatically.

<b>If HI Is Effective In</b>	<b>Beneficiary Must Be On The Rolls In The Previous</b>
January	June
February	July
March	August
April	September



## RRB Medicare Systems and Records March 13, 2007

U.S. Railroad Retirement Board  
844 North Rush Street  
Chicago Illinois, 60611-2092

Phone: (312) 751-7139  
TTY: (312) 751-4701  
Web: <http://www.rrb.gov>

May	October
June	November
July	December
August	January
September	February
October	March
November	April
December	May

These individuals will be enrolled for Part A and, if a resident of the U.S., will be automatically enrolled for Part B. Premium deductions are generally done timely and begin with the check paid on the first day of the month Medicare coverage begins. Little or no delay in receipt of the annuity or SS benefit should occur.

### **815.10.2 Accretions**

Individuals who are not on the rolls as annuitants, IPIs, or SS beneficiaries at least 6 months before their Medicare coverage can begin must file a benefit annuity or health insurance application at RRB or SSA. Such enrollments are referred to as accretions. Manual action is generally required in the processing of accretion enrollments; premium deductions will not be initiated until after an annuity is put in payment status. Examiners may deduct SMI premiums from initial SS benefit certifications. Individuals enrolled as accretions will be enrolled for Part A coverage, and if residents of the U.S., Part B coverage, unless SMI was refused on the application.

### **815.15 Enrollments After The Initial Enrollment Period**

#### **815.15.1 General Enrollment Period (GEP) Enrollment**

Individuals who have Part A coverage only may enroll for Part B by submitting a statement requesting Part B coverage, a completed Form G-44 or a completed Form G-44b during any GEP.



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At the beginning of each year, enrollment kits consisting of a Form G-44, Form RB-20, Form G-860 and a return envelope addressed to P.O. Box 10794 are released to the following U.S. residents:

- A. Beneficiaries who refused Part B coverage in the previous year,
- B. Beneficiaries who withdrew from Part B coverage in the previous year, and
- C. Beneficiaries whose Part B coverage terminated in the previous year for failure to pay premiums.

### **815.15.2 Deemed GEP Enrollment**

Part A entitlement will be established for a beneficiary who files a Medicare only, annuity, or O/M application after his/her IEP. If the application establishes Medicare entitlement for the first time, the beneficiary does not have to file an application electing Part B in the next GEP. An application is deemed filed in the next GEP and the beneficiary will be automatically enrolled for Part B unless the person refused Part B on the application.

### **815.20 Medicare Claim Numbers**

#### **815.20.1 General**

A Medicare claim number is the prefix and number established on the Health Insurance Master (HIM) to identify a beneficiary. Once a prefix and claim number is used for a beneficiary, it cannot be used to identify another beneficiary. If a beneficiary's RRB claim number (prefix + number) was previously used as another individual's Medicare claim number, another number, called a pseudo number, must be assigned to the beneficiary for his/her Medicare claim number. Refer to FOM-1-815.20.4 for further information about pseudo numbers.

#### **815.20.2 Beneficiary Entitled to Annuity**

An annuitant's RRB claim number (RR annuity or SS annuity certified to the RRB) will be used as his/her Medicare claim number as long as a Medicare record was not previously established on the claim number.

If a beneficiary is entitled under two RRB claim numbers, the primary number, employee or joint and survivor, will be used as his/her Medicare claim number.



### **815.20.3 Beneficiary Not Entitled to Annuity**

- A. Medicare Alone - A beneficiary who has filed for Medicare alone will be assigned a Medicare claim number as if he/she is entitled to an annuity.
- B. Included in O/M - Beneficiaries included in the O/M will be assigned a Medicare claim number using the employee's number and a prefix as follows:

Spouse - MA

Child - CA

However, if this number was previously used as another individual's Medicare claim number, a pseudo number must be assigned for Medicare purposes.

### **815.20.4 Pseudo Number - Entitled or Not Entitled to Annuity**

The HIM only accepts a prefix and number to identify each individual. In addition, the HIM considers the MA prefix plus a number and the WA prefix plus the same number to be identical Medicare claim numbers. However, RRB records use a prefix, number and payee code to identify each individual; the same prefix and claim number with a separate payee code is used to identify each individual when there are more than one beneficiary in the same category.

Whenever a beneficiary is enrolled for Medicare and his/her RRB claim number (prefix + number) was previously used as a Medicare claim number for another individual, a pseudo claim number must be assigned for Medicare purposes. The situations in which a pseudo number is required include:

- A. A second or later disabled child is enrolled for Medicare,
- B. A second or later wife is enrolled for Medicare,
- C. A widow, if a previous wife was enrolled for Medicare, and
- D. A second dependent parent is enrolled for Medicare.

The Medicare Section (MS) will assign and process all pseudo numbers. The pseudo number will be the beneficiary's prefix plus his/her own SS number. Prior to December 1, 1974, the beneficiary's prefix plus a six-digit number from 995001 through 999995 was assigned as the pseudo number. MS will advise the beneficiary in a letter that a pseudo number is required, and provide the number that has been assigned.



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## 815.25 Basis For Determining Effective Dates Of Coverage

### 815.25.1 Application Filing Date

When an individual files an application for Medicare only, for an annuity, or for inclusion in the O/M and is eligible for Part A coverage in or before the month of filing, the filing date will be used to establish the Part A effective date. If it is during the individual's Part B IEP or GEP, the same filing date will also be used to establish the Part B effective date.

### 815.25.2 Application Deemed Filed

- A. Annuity or O/M application filed prior to Part A enrollment period and prior to Part B IEP - An application for Part A and for an automatic election of Part B is deemed filed during the first 3 months of the Part A and B enrollment periods and is used to establish the earliest possible effective dates for Parts A and B.
- B. Application filed during Part A enrollment period, but after Part B IEP - The application filing date will be used to establish the Part A effective date. If this is the first time Medicare coverage is established for the individual, an application for Part B coverage will be deemed filed during the next GEP and will be used to establish the Part B effective date. Otherwise, the individual must actually file an election for Part B coverage during a GEP.

### 815.25.3 Date of Birth on First Day of the Month

An individual whose birthday is on the first day of the month attains age 65 on the last day of the previous month and the earliest effective date for Medicare coverage would be the first day of the month prior to the month of his or her birthday. If such an individual files an application in the month of his or her birthday, Part B coverage would not be effective until the first of the second month following the beneficiary's month of birth.

When developing the application, determine if the applicant thought he or she attained age 65 on the actual date of birth instead of the day before. If so, and if the applicant wants the earliest Part B effective date, submit a statement from the applicant. MS will review the statement and determine the earliest effective date.



### **815.25.4 Discrepant Date of Birth - Applicant Older Than Originally Thought**

An individual who has relied on particular evidence for his or her DOB and subsequently locates better evidence that establishes an earlier DOB, may fail to file an application during the correct IEP, which may have already passed.

- A. Applicant files during IEP based on erroneous younger DOB - A statement should be submitted from the applicant explaining why he or she did not file in the IEP.

MS will review the statement and may establish a deemed IEP based on the erroneous younger DOB. The applicant's Part B effective date and premium rate will be based on the deemed IEP.

The Part A effective date will be established based on the actual application filing date and correct DOB.

- B. Applicant files after IEP based on correct DOB - A statement should be submitted from the applicant explaining why he or she did not file in the IEP. MS will review the statement and establish the Part A effective date based on the actual application filing date and correct DOB. Part B will be determined as follows:

1. If the application was filed during a GEP, the applicant is enrolled for Part B in the GEP without a premium increase; or
2. If the application is not filed during a GEP, the applicant is advised to file during the next GEP or in the deemed IEP (based on the erroneous younger DOB), whichever will result in the earlier effective date.

### **815.25.5 Discrepant Date of Birth - Applicant Younger than Originally Thought**

An individual who has relied on particular evidence for his or her DOB and subsequently locates better evidence, which establishes a later DOB, may be enrolled for Medicare erroneously. Refer to FOM-1-810.35.21 for an explanation of how such a situation is handled by OPRNS. Submit proof of the new alleged DOB along with a statement explaining how and when the applicant discovered the new DOB evidence. On the transmittal advise OPRNS that the new DOB will affect Medicare coverage.

### **815.30 Establishing A Medicare Record**

Action to establish a Medicare record for an individual involves the Railroad Retirement Board, the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS).



### **815.30.1 Eligibility Determination**

A determination of Medicare eligibility can be made mechanically or manually. At the RRB, the eligibility determination for most retirement applications, Medicare only applications, and attainments are made mechanically using retirement and research computer programs. These determinations are subsequently passed to the Medicare computer programs. Eligibility determinations for survivor applications, accretions, some retirement applications, some Medicare only applications, and some attainments are made by examiners. The examiner completes an input form and enters the information into the Medicare computer programs.

### **815.30.2 RRB Initial Computer Processing**

Information about eligible aged and disabled Medicare beneficiaries is entered into the Medicare computer system MIRTEL - Medicare Information Recorded, Transmitted, Edited and Logged. MIRTEL edits the information, sets up a pending record for the beneficiary, and transmits the information to the Master Benefit Record (MBR) at SSA. The purpose of this action is to see if SSA has already established a Medicare record or has conflicting information. We are, in other words, getting clearance from SSA that there is no conflict.

### **815.30.3 SSA Computer Processing**

The MBR is the computer system at SSA that contains information about all beneficiaries entitled to SS benefits. The MBR is also earmarked when we transmit information from MIRTEL as indicated in FOM-1-815.30.2 to show that RRB has jurisdiction of Medicare. If SMI premiums are being collected by SSA, SSA will stop deducting premiums and transfer jurisdiction to RRB. The information from MIRTEL is updated with any Medicare information from the MBR. The MBR then transmits a record to the Health Insurance Master record (HIM) and, at the same time, a reply to the RRB's MIRTEL system.

### **815.30.4 Health Insurance Master (HIM) Record Processing**

Although the RRB establishes entitlement, enrolls, collects premiums and maintains a record for all QRRBs and deemed QRRBs, SSA in Baltimore maintains the HIM that permits and records payment of HI-SMI benefits. The information transmitted from the MBR is edited and a record is established on the RR portion of the HIM. If a record was previously established on the SS portion of the HIM, it is cross-referenced to the RR number.



If a problem is encountered during the editing or cross-referencing process, or in establishing the HIM record, a reject will be transmitted to the RRB and a HIM record will not be established.

### **815.30.5 RRB Final Processing**

When MIRTEL receives the reply from SSA, it assumes a record will be established on the HIM. The pending record on MIRTEL is cleared and updated with any information from the MBR, a Medicare identification card is released and collection of SMI premiums is initiated.

### **815.35 Medicare Identification Card**

#### **815.35.1 Initial ID Card**

A Medicare identification card is automatically released to the beneficiary after MIRTEL's pending record is cleared. The card serves as a notice to the beneficiary of his or her coverage and the identifying information established on the HIM for him. A Medicare handbook is also mailed to the beneficiary separately by CMS.

ID card Form G-41 is released to beneficiaries enrolled for Part B under the automatic enrollment provisions and ID card Form G-43 is released to all other beneficiaries.

#### **815.35.2 Temporary Notice of HI Eligibility**

A. General - An applicant for Medicare will normally receive an HI card within 30 to 60 days after filing. If the applicant will need medical care before receipt of the HI card, the D/O may issue a temporary notice of HI eligibility (Form Letter RL-345) if all of the following criteria are met:

1. An application has been filed. (It may be filed at the time the notice is issued.)
2. The applicant's eligibility as a QRRB is apparent or has been determined.
3. Health insurance services are needed immediately or will be needed before an HI card can be issued in normal operations.
4. MS has been notified of the D/O's intention to issue the notice or the D/O has been authorized by MS to do so.

Since the applicant will make early use of the temporary notice, MS must immediately establish the HI record so that it is available when an intermediary



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queries SSA for eligibility information. To do this, MS will initiate clearance with SSA based on data provided by the D/O or, if clearance has already been initiated but is pending, take any action needed to expedite or force clearance.

- B. Action by D/O to determine eligibility - Before issuing a temporary notice, the following information should be considered.
1. Need for temporary notice - The applicant must be able to give reasonable assurance that he or she will be using covered services in the immediate future and before he or she could normally receive the HI card.
  2. Proofs - The applicant must submit acceptable proof of age and other proofs required to substantiate the claim.
  3. 120 months of RR service, or 60 months of service after 1995 (employee/spouse applicant) - The employee must have 120 railroad service months, or at least 60 months of service after 1995. Verify that the employee has sufficient service months from his or her Form BA-6, or by checking EDMA.
  4. Insured status (survivor applicant) - The D/O will make an insured status determination of whether RRB has jurisdiction of the survivor claim.
  5. Jurisdiction - SSA has a similar procedure to provide temporary notices of HI eligibility. Therefore, refer the applicant to SSA if:
    - a. SSA has jurisdiction of survivor benefits, or
    - b. The employee has less than 120 months of RR service, or fewer than 60 months of RR service after 1995.
- C. Telephone notice to MS - When it is determined that an apparently eligible applicant needs a temporary notice of HI eligibility, call MS and furnish the data required as follows:
1. RRB claim number, symbol, and prefix - Check EDMA to determine that no 6-digit claim number was previously established; furnish the employee's SS number with the appropriate symbol and prefix. If there is a known prior claim number, furnish it.
  2. Date of birth
  3. Beneficiary SS number - If the applicant is other than an employee, his or her own SS number is required.



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4. Employee's SS number - This is required for any type of beneficiary.
  5. Status of annuity - Furnish the type of application filed, i.e., Form AA-1, AA-6, AA-17, etc. If the applicant is a survivor, indicate if annuity payments cannot be made because of work deductions.
  6. SMI effective date - Furnish this date only if a timely election is made. Do not provide a date if the applicant is not in an enrollment period.
  7. HI effective date - The earliest date the applicant became a QRRB, or 6 months prior to the filing date of an HI or annuity application, whichever is later. The effective date for the divorced spouse of a disabled employee may be 12 months before the HI or annuity application filing date.
- D. Temporary notice of HI eligibility - Issue Form Letter RL-345 to an employee, spouse or widow applicant as evidence of entitlement to health insurance benefits. Forward a copy of the notice to MS.

**815.35.3 Duplicate ID Card**

Field offices may generate a duplicate Medicare card for release to a beneficiary who reports his or her card lost, stolen, misplaced or destroyed. Field offices should prepare a MEDCOR Activity 62L to generate the replacement Medicare card. Access this screen by entering 62 in the Activity Input field on the main MEDCOR MENU Screen. Here are step-by-step instructions.

Step	Action				
1	Select MEDCOR (27) from the RRAPID Main Menu.				
2	Complete the following fields on the MEDCOR Menu screen: <table border="1" style="margin-left: 20px;"> <tr> <td style="text-align: center;">Unit</td> <td>Enter "BFS"</td> </tr> <tr> <td style="text-align: center;">Claim Number</td> <td>Enter the beneficiary's RRB claim number, including symbol and prefix.</td> </tr> </table>	Unit	Enter "BFS"	Claim Number	Enter the beneficiary's RRB claim number, including symbol and prefix.
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	Ben SSA Number	<b>If the beneficiary is other than an employee and does <u>not</u> have a pseudo number</b> , enter the beneficiary's SS number. Otherwise, leave blank.
	Pseudo Number	<b>If the beneficiary is other than an employee and has a pseudo number</b> , enter the beneficiary's pseudo number. Otherwise, leave blank.
	Activity Input	Enter "62"
Press Enter.		
3	<p>Review the information on the Activity 62, Duplicate Medicare Card Request screen to ensure it is correct. If okay, press PF2. The message "To Add, Press PF2 Again" will appear. Press PF2 again to complete the request.</p> <p>If the address on record is incorrect or the annuitant requests that the duplicate Medicare card be mailed to a temporary address, you can replace the prefilled address with the new or temporary address before pressing PF2 twice to complete the transaction. Keep in mind that this only changes the address for purposes of mailing the card. If a permanent address change is needed, you must complete a FAST-COA and/or MEDCOR Activity 22L.</p>	

Note: Do **not** enter 62L in the Activity Input field; enter 62. The L refers to the type of 62 activity. All activity screens that are accessed directly from the main MEDCOR Menu are "long" form versions. If you enter an "11" in the Activity Input field on the main MEDCOR MENU screen, you access the MEDCOR Miscellaneous Input Screen. This screen is referred to as the "short" form version. Various activities can be created using the MEDCOR Miscellaneous Input Screen. If you request a 62 activity from the MEDCOR Miscellaneous Input Screen, the system generates a 62S, or the "short" form version. The Pending Activities List screen and the Completed Activities List screen on MEDCOR will show either a 62L or 62S depending on which screen was added to generate the duplicate Medicare card. Requests for Medicare cards using the activity 62L are generated daily.

Field offices should use the new Activity 62L MEDCOR screen to process all requests for replacement Medicare cards, except in cases involving emergency situations. In dire need situations, the field office may type a duplicate ID card. Before issuing a duplicate ID card, use MOLI to verify the claim number, coverage entitlements, and effective dates. Prepare an original and a xerox copy of Form G-43. Give the original



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card to the QRRB, and retain the copy in the field office's file. Refer to FOM-I-1720, Form G-43.