825.5 Who May Claim Payment for Part A (HI) Benefits - Beneficiary Alive

The provider of Part A services will have the beneficiary sign a claim form or will use the beneficiary's signature on its records and will submit all required admission information and billing copies to its intermediary. The intermediary will process the information and make payment to the provider.

EXCEPTION: If emergency inpatient services were provided by a nonparticipating hospital that does not bill for Medicare patients, the beneficiary will have to file a claim for payment. Such beneficiaries should be referred to the Social Security Administration (SSA) district office for development and filing of a claim.

825.10 Who May Claim Payment for Part B (SMI) Benefits - Beneficiary Alive

825.10.1 Services Performed by Part A Provider in the U.S.

In many instances the beneficiary does not have to file a claim for payment of Part B benefits. The provider will file a claim for payment with its intermediary as it would for Part A services.

825.10.2 Part B Services Performed by Physician or Supplier

When a beneficiary receives Part B services, a claim must be submitted before payment can be made. There are two methods to claim benefits.

A. Beneficiary request payment - The beneficiary submits a claim to the Medicare Part B carrier. The Medicare Part B carrier will process the claim and, after the deductible has been met, will pay 80% of the reasonable charge to the beneficiary.

B. Physician or supplier requests payment - This method is often called the Assignment Method. The physician or supplier files the claim for payment with the Medicare Part B carrier and agrees to accept the approved charge as full payment for services. In addition, the beneficiary must agree on this method of payment. The physician or supplier can only bill the beneficiary for the amount of the deductible and/or 20% of the approved charge, i.e., the amount not paid by Medicare. The Medicare Part B carrier will process the claim and after the deductible has been met will pay 80% of the approved charge to the physician or supplier.

825.10.3 Beneficiary Incapable of Signing Claim Form

The beneficiary ordinarily signs the admissions and/or claims form requesting Medicare payment. If the beneficiary is in such bad physical or mental condition that (s)he cannot or should not transact business, the claim may be submitted and signed by one of the following:

A. Representative payee,

B. Legal representative,

C. Relative,

D. Friend,

E. Governmental agency which provides assistance, or

F. Institution which provides care or support.

825.15 Who May Claim Payment For Benefits - Beneficiary Deceased

825.15.1 Part A Services Not Paid For

If the provider would file for and receive payment for Part A services before the beneficiary's death, the provider will do so after the beneficiary's death and payment will be made to the provider.

If the beneficiary would file for payment of Part A services (emergency inpatient services at a nonparticipating hospital), the services must be paid before payment can be made.

825.15.2 Part B Services Not Paid For

If the physician or supplier had agreed to accept assignment before the beneficiary's death, payment will be made to the physician or supplier.

If the physician or supplier had not agreed to accept assignment before the beneficiary's death, he may file a claim form accepting assignment after the beneficiary's death.

If the physician or supplier refuses to accept assignment, an individual who has paid the bill(s) or who accepts responsibility for payment may file a Form G-740s with the Medicare Part B carrier for payment. If the bill(s) have not been paid, the following will be required in addition to the Form G-740s.

A. A signed statement which should have similar language to the following paragraph:

"I have assumed the legal obligation to pay (name of physician or supplier) for services furnished (name of deceased beneficiary) on (date{s}). I hereby claim any Medicare benefits due for these services."

B. A signed statement by provider or physician indicating he will not accept assignment.

C. An itemized bill identifying "the individual claiming benefits" as the person to whom the physician or supplier looks for payment.

825.15.3 Part A or B, Services Paid by Deceased Beneficiary

If the beneficiary paid for the services before death but had not filed for reimbursement, person(s) as outlined below should contact the Medicare Part B carrier to secure Form HCFA-1660 to file for benefits.

A. If a legal representative has been appointed, he/she should file a claim for benefits.

B. If a legal representative has not been appointed, the beneficiary's survivors in following order of priority are eligible to file a claim for benefits.

1. The surviving spouse who was either living in the same household with the beneficiary at death or entitled to monthly SS or RR benefits on the same earnings record as the beneficiary for the month of death;

2. The child(ren) of the beneficiary who was entitled to monthly SS or RR benefits on the same earnings record as the beneficiary for the month of death;

3. The parent(s) of the beneficiary who was entitled to monthly SS or RR benefits on the same earnings record as the beneficiary for the month of death;

4. The surviving spouse of the beneficiary who was not living in the same household nor entitled to monthly SS or RR benefits on the same earnings record as the beneficiary for the month of death;

5. The child(ren) of the beneficiary who was not entitled to monthly SS or RR benefits on the same earnings record as the beneficiary for the month of death;

6. The parent(s) of the beneficiary who was not entitled to monthly SS or RR benefits on the same earnings record as the beneficiary for the month of death.

825.15.4 Part A or B, Services Paid by Person Other than Deceased Beneficiary

When services have been paid for by a person other than the deceased beneficiary, a claim for benefits should be submitted by the person who paid for the services. If the person who paid for the services dies before payment is made, his/her estate does not become entitled; the surviving relatives of the beneficiary become entitled and should submit a claim.

825.20 When A Claim for Benefits Must Be Filed - Part A Or Part B

The beneficiary's request and the provider's claim must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year may be considered timely filed if submitted by the end of the calendar year after the year the services were furnished.

825.25 Filing A Claim For Benefits

825.25.1 Part A, Services Furnished in the U.S.

In most instances, the provider of the Part A services will file a claim and submit the required evidence to its intermediary. If emergency inpatient services were provided by a nonparticipating hospital that does not bill for Medicare patients, refer the beneficiary to the SSA district office to file a claim.

825.25.2 Part B, Services Furnished in the U.S.

A. Forms for claiming benefits - There are two forms that should be used to file for Part B benefits for services furnished in the U.S.

1. G-740s should be used by the beneficiary, the person(s) who paid the bill or assumed responsibility for payment, when such person(s) are filing for benefits. The form cannot be used if the physician or supplier will accept assignment. This is an RRB-stocked form and has the Medicare Part B Carrier's address pre-printed on it.

2. HCFA-1500 should be used by the physician, supplier or provider when filing for benefits. This is the same form used for SSA Medicare beneficiaries and may be used whether or not the physician or supplier is accepting assignment. The form is not stocked by the RRB and must be requested from the Centers for Medicare and Medicaid Services.

B. Where a claim must be filed - All beneficiaries receiving benefits from the RRB should submit claims for payment to the Medicare Part B Carrier with the following exceptions:

1. The services are furnished by a General Pre-Payment Plan which deals directly with CMS; or

2. The beneficiary is enrolled under a state buy-in agreement involving a state agency which has entered into an agreement to act as a carrier.

If a beneficiary advises he is unable to contact Palmetto GBA because the toll free number is busy, suggest the call be made early in the morning or late in the afternoon because the volume of calls are lightest at those times. If repeated inquiries are received, contact the assistant manager or supervisor of beneficiary services at Palmetto GBA.

Any inquiries you have on behalf of a beneficiary should be made to the assistant manager or supervisor of beneficiary services.

825.30 General Processing Procedure By The Medicare Part B Carrier For Payment Of Part B Benefits

The Medicare Part B carrier determines the beneficiary's entitlement status based on its own records or by querying the records at CMS.

825.30.1 Beneficiary Has Part B Coverage

If the beneficiary is entitled, the claim is reviewed to determine whether the services and/or supplies are covered and the reasonable charges are determined.

The approved charge is the lowest of the charge actually billed, the customary charge or the prevailing charge. The customary charge is the amount the physician or supplier usually billed his patients for the same service or supplies in the previous calendar year. The prevailing charge is the lowest customary charge which is high enough to include 75 percent of the services billed for the previous year in a particular locality. The yearly increase in the prevailing charge for physician’s services is further limited by the amount of the economic index for each year.

The beneficiary's deductible status is then determined. Each year, the Medicare Part B carrier queries the records at CMS for each claim submitted by or for the beneficiary until the deductible is met.

Once the deductible has been met, The Medicare Part B carrier relies on its own records for the remainder of the year. CMS is notified to update its records.

If payment is being made to the beneficiary, he receives an Explanation of Medicare Benefits (EOMB) with the benefit check. In assignment cases, both the physician or supplier and the beneficiary are sent an EOMB. The physician or supplier receives a composite check covering payment of several claims on a periodic basis, usually once a week or once a month.

825.30.2 Beneficiary Does Not Have Part B Coverage

If the beneficiary is not entitled to benefits, a denial letter will be released.

If the beneficiary advises (s)he is entitled, the Medicare Part B carrier will check its records to determine if accurate data was used in its transmission to CMS. If so, the Medicare Part B carrier will contact MS for verification of coverage. If coverage is verified, MS will be asked to correct the records at CMS. The Medicare Part B carrier will then ask MS for authorization to make a payment manually if:

A. The claim(s) submitted total $100; and

B. The claim is 90 days old.

825.35 Notification Of Payment For Services Furnished In The U.S.

825.35.1 Part A Notification

When the intermediary makes payment to the provider, it notifies CMS. CMS updates its records and sends a notice, RR-100, to the beneficiary explaining the benefits paid.

If the claim is denied, the intermediary sends a letter, HCFA-1533, to the beneficiary. A copy may be sent to the provider.

CMS would prefer that the beneficiary contact the intermediary when requesting information about, or a duplicate of, the notification letter. However, if the beneficiary wishes to request this information directly, they can write to:

Centers for Medicare & Medicaid Services

Correspondence Branch, OMB, RM B3

1717 Equitable Building

6325 Security Boulevard

Baltimore, MD 21207

Any inquiry sent to CMS should contain the beneficiary's full name, address, and Medicare claim number.

825.35.2 Part B Notification, Services Performed by Part A Provider

The Part A intermediary sends a notice, Your Record of Part B Medicare Benefits Used, when payment is made to the provider. When the Part B deductible status was not known at the time the provider collected from the beneficiary for services, the intermediary will refund any excess amount collected to the beneficiary. The refund

check will usually accompany the notice. Duplicates of the notification can be requested as indicated in FOM-I-825.35.1.

825.35.3 Part B Notification, Services Performed by Physician or Supplier

The Medicare Part B carrier sends a notice, Explanation of Medicare Benefits (EOMB), to the beneficiary when it has finished processing a claim. If payment is being made to the beneficiary, the notice will accompany the check. In assignment cases, a copy of the notice is sent to the beneficiary. Any beneficiary needing a duplicate notification should be referred to the Medicare Part B carrier. Written requests to the Medicare Part B carrier should contain the beneficiary's full name, address and Medicare claim number.