BlueCross BlueShield of Western New York

Community Blue • Traditional Blue

PO Box 80 • Buffalo, New York 14240-0080

Medicare Certification Form

Member Name: _____
Identification #: _____
Group #: _____

Our records indicate that the member named above may be eligible for Medicare. We are sending this letter to both the subscriber and the employer, as the information below is needed to determine Medicare eligibility. Federal Law affects how we must handle any future claims for the Medicare-eligible member.

- **To the Subscriber**: Please complete Section C of this form and return it to us at: Medicare Certification; PO Box 80; Buffalo, NY 14240-0080. Please contact Customer Service at the number on the back of your identification card if you need assistance. We encourage you to provide the same Medicare information to your employer to ensure your records are up-to-date.

- **To the Employer**: Please complete Sections A and B of the form and return it to us at: Medicare Certification; PO Box 80; Buffalo, NY 14240-0080. After reviewing the Medicare information provided, we will make any applicable changes to the policy. If you (the employer) have at least 20 employees, you are required to provide the same health benefits under the same conditions to Medicare eligible employees and the Medicare eligible spouses of employees as you provide to employees and spouses who are not Medicare eligible.

MEDICARE CERTIFICATION FORM

Please complete the following information for the Medicare-eligible member:

Member Name: _____
ID #: _____
Group #: _____

Section A: *(To be completed by the employer)*

Please check the box that indicates the total number of full and part-time employees during the past two calendar years to appropriately determine if your group is TEFRA or OBRA eligible. (TEFRA and OBRA are federal regulations which require group health coverage to be primary to Medicare if certain requirements are met.)

☐ Less than 20

☐ 20 - 99 (during 20 or more weeks of this year or last year)

☐ 100 or more (on 50% or more of the business days of this year or last year)

Please check and complete the response below that best suits the situation of **the above-mentioned member**:

☐ This member either retired from our employ on _____ or is the spouse of a retiree, and is therefore qualified to have Medicare as the primary payer and to remain covered by the group health plan.

☐ We **do not** have at least 20 employees, therefore, this member is qualified to remain covered by the group health plan and Medicare will be the primary payer.

☐ We **do** have at least 20 employees, and this member is considered an active employee, or the spouse of an active employee. Coverage will continue under the group health plan with the group health plan as primary payer over Medicare.

☐ We **do** have at least 20 employees and this member is considered an active employee or the spouse of an active employee, **but** this member has elected to have Medicare as the primary payer. Please cancel group health plan coverage for this member effective the date Medicare coverage begins.

☐ **The member named above** is **not** eligible for Medicare benefits for the following reason:

_____

_____

Section B: *(To be completed by the employer)*

If and when the employment status of this employee changes, it is the employer's responsibility to notify our office so that membership information is kept up-to-date.

IMPORTANT:

The information provided in this letter authorizes us to put the member in the applicable product. Failure to respond to this request will cause automatic rejection of claims for dates of service on or after the employee or spouse's Medicare eligibility.

Please see your contract for more information.

_____ _____

Employer's Signature Date

Section C: *(To be completed by the member)*

If applicable, please provide the following information as it appears on the member's Medicare Identification Card:

Member's Medicare Information - Health Insurance

Social Security Act

Name of Beneficiary: _____

Claim Number: _____

Sex: _____

Is Entitled to:

Hospital (Part A) Effective Date: _____

Medical (Part B) Effective Date: _____

Drug (Part D) Effective Date: _____

Member's Date of Birth: _____

If Medicare coverage is due to disability, please give reason: _____

_____

If Medicare coverage is due to End Stage Renal Disease, please specify first date of dialysis: _____

_____ _____

Member's Signature Date