Recurring Medicare Part B Reimbursement Form

OneExchange™ from Towers Watson

Mail: P.O. Box 2396 Omaha, NE 68103-2396 Fax: 1-855-321-2605

① Employer Name

Total Pages

Account Holder Name – Last

First

Middle

Social Security Number

Zip Code

②

Action	Relationship	Premium Type	Start Date	End Date	Monthly Amount
New	*Self*	*Medicare Part B*	*01/01/2015*	*12/31/2015*	*$104.90*
		Medicare Part B			
		Medicare Part B			

③ By signing below, I certify that the information provided on this reimbursement request form is correct and that the expenses for which I am requesting or for which I am providing validation: were incurred for expenses for the covered participant while eligible under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement. Upon receiving notice of a change in premium or a cancellation of coverage, I will notify OneExchange within a suitable time period.

Account Holder Signature

Date

④ To qualify for your reimbursement you must provide a third party document that includes the information to the right.

Please CHECK ☑ Each Reimbursement Request Qualification as you complete them.

☑ **Does your documentation cover these items?**

- ☐ Covered Participant's Name (John Doe)
- ☐ Premium Type (Medicare Part B)
- ☐ Date of Service (e.g. 01/01/2015 thru 12/31/2015)
- ☐ Monthly Amount (e.g. $104.90)
- ☐ Proof of Payment (Social Security Administration Award Letter)

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Guide to Requesting Recurring Medicare Part B Reimbursement

Recurring Medicare Part B Reimbursement is for those who want to be automatically reimbursed monthly for their premiums deducted from their social security benefit check. Submit one specialized reimbursement form at the beginning of the year to setup automatic reimbursement for the following twelve months. There will be no need to file a reimbursement request again for Medicare Part B until the following year.

① **Account Holder Information:** Fill in the boxes with information for the account holder. Usually the account holder is the retiree.

② **Reimbursement Request Information:** This section must be completed with a line for each person that requests Medicare Part B reimbursement.

Action: A request may be submitted at the first of each new year, or when a Medicare Part B premium change occurs. Enter: "New", "Change" or "End".

Relationship: Include the relationship between the account holder and the person requesting the premium reimbursement (e.g. self, spouse).

Premium Type: Medicare Part B is the only premium allowed on this form.

Start Date: This is usually 01/01/2015 of each new year or the effective date of the coverage period, such as when a participant becomes Medicare-eligible.

End Date: This is usually 12/31/2015, or could be earlier if there is a death of a covered participant.

Monthly Amount: This amount must match the amount on the supporting document.

③ **Certification Requirement:** Carefully read the certification requirements before signing.

④ **Documenting Your Medicare Part B Reimbursement Request:** All Medicare Part B premium requests require third party documentation showing each item below:

- ☐ Covered Participant's Name (John Doe)
- ☐ Premium Type (Medicare Part B)
- ☐ Date of Service (e.g. 01/01/2015 thru 12/31/2015)
- ☐ Monthly Amount (e.g. $104.90)
- ☐ Proof of Payment (Social Security Administration Award Letter)

Use the Social Security Benefit Award Letter issued by the Social Security Administration (SSA) each year, usually during the month of October or November, as your third party documentation. **Watch for this document to arrive in the mail.**

For lost documents you can request a "Proof of Income" letter by contacting the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) or www.ssa.gov.