Update on Enrollment in Part B of Medicare

Individuals who need to enroll in Part who are over 65 and working, are required to have the Employment Request form (OMB 0938-0787 / CMSL564 completed by the employer. The second form that is needed for Part B enrollment OMB 0938-1230 / CMS408. The two forms are attached. Both these forms can be mailed or faxed to a person's local Social Security Office. If a person does not know the local office fax, he/she can call the local office for it. Recently Social Security announced a new national fax number that can also be used when the local office fax number is not available.

This national fax number for enrollment in Part B forms only is: 838-914-2016.

Form Approved
OMB No. 0938-1230
Expires: 02/20

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number

2. Do you wish to sign up for Medicare Part B (Medical Insurance)? ☒ YES

3. Your Name (Last Name, First Name, Middle Name)

4. Mailing Address (Number and Street, P.O. Box, or Route)

5. City | State | Zip Code

6. Phone Number (including area code)

( ) –

7. Written Signature (DO NOT PRINT)

SIGN HERE

8. Date Signed

/ /

IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW.

9. Signature of Witness

N/A

10. Date Signed

/ /

11. Address of Witness

N/A

12. Remarks

I would like Part B to start on _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1230. The time required to complete this information is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name

2. Date ☐☐ / ☐☐ / ☐☐☐☐

3. Employer's Address

City

State ☐☐

Zip Code ☐☐☐☐☐

4. Applicant's Name

5. Applicant's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

6. Employee's Name

7. Employee's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? ☒ Yes ☐ No

2. If yes, give the date the applicant's coverage began. (mm/yyyy)
☐☐ / ☐☐☐☐

3. Has the coverage ended? ☐ Yes ☐ No

4. If yes, give the date the coverage ended. (mm/yyyy)
☐☐ / ☐☐☐☐

5. When did the employee work for your company?
From: (mm/yyyy) ☐☐ / ☐☐☐☐
To: (mm/yyyy) ☐☐ / ☐☐☐☐
Still Employed: (mm/yyyy) ☐☐ / ☐☐☐☐

N/A 6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.
From: (mm/yyyy) ☐☐ / ☐☐☐☐
To: (mm/yyyy) ☐☐ / ☐☐☐☐

For Hours Bank Arrangements ONLY:

N/A 1. Is (or was) the applicant covered under an Hours Bank Arrangement? ☐ Yes ☐ No

N/A 2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ No

N/A 3. Date reserve hours ended or will be used? (mm/yyyy)
☐☐ / ☐☐☐☐

All Employers:

✓ Signature of Company Official

Date Signed ☐☐ / ☐☐ / ☐☐☐☐

✓ Title of Company Official

Phone Number (☐☐☐) ☐☐☐ – ☐☐☐☐

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