OSAG

Mandatory Medicare Reporting Requirement

******* Please complete this form with each report of injury*******

The Centers for Medicare & Medicaid Services require mandatory reporting of workers' compensation claims. Please complete the following to see if this is an eligible claim to report.

To be completed by the employee (Please print)

Date: _____

Injured Worker Name: _____
(Name as it appears on your social security card)

Social Security Number: **XXX-XX-_ _ _ _** Date of Birth:_____

Dear Injured Worker, please provide an answer to the following questions:

YES	NO	
☐	☐	**Are you currently on SSDI? (Social Security Disability)**
☐	☐	**Have you ever applied for SSDI?**
☐	☐	**Do you anticipate filing for SSDI within the next 30 months?**
☐	☐	**Are you a Medicare beneficiary?**
☐	☐	**Have you or are you currently participating in a Medicare Advantage Plan?** (This is a Medicare supplement product purchased from a private carrier such as Humana, Blue Cross Blue Shield etc.) **If so, name of Carrier: _____**
☐	☐	**Do you anticipate filing for Medicare benefits in the next 30 month?**

_____

Signature of Injured Worker Date

PLEASE FORWARD THE COMPLETED FORM TO:

CONSOLIDATED BENEFITS RESOURCES
Post Office Box 581630
Tulsa, Oklahoma 74158-1630
918.594.5170 *telephone*
800.826.0419 *toll free telephone*
918.594.5171 *facsimile*
888.594.5171 *toll free facsimile*