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[BENEFNAME M BENELNAME]
[MADD1 MADD2]
[MCITY MSTATE MZIP]

[DATE]

SUBJECT: Medicare Secondary Payer Rights and Responsibilities
Beneficiary's Name [BENEFNAME M BENELNAME]
HIC#: [CLAIMNUM]
Date of Incident: [TCI DATE]
Case #: [Remas Case#]

Dear [BENEFNAME M BENELNAME]:

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not at the end of this letter indicating that he/she is receiving a copy, please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other individual in this matter, you may wish to talk to your representative before contacting us.

We understand that you have made a claim against other insurance or workers' compensation. This letter is to let you know:

- What your responsibilities are as a Medicare beneficiary in connection with your claim;
- What information we need if you have a representative;
- What information we are requesting regarding your claim;
- What information we need if there is a settlement, judgment, award or other payment for your claim (or if your claim is dismissed or otherwise abandoned).

NOTE: This letter also tells you about other information we will send to you regarding claims Medicare paid on your behalf on or after the date of your incident/injury, and provides information for mailing or faxing information to us.

Your Responsibilities as a Medicare Beneficiary

- When no-fault insurance, liability insurance or workers' compensation is available to you, it must pay before Medicare pays. Some examples of no-fault and liability insurance include automobile or homeowners' medical payments coverage or personal injury protection, automobile liability or no-fault insurance, liability insurance which pays you because another individual or entity is negligent, malpractice insurance, etc.

- Medicare makes “conditional” payments while your insurance or workers’ compensation claim is pending to ensure that you receive the medical services you need in a timely manner.
- Once you receive a settlement, judgment, award, or other payment from the liability insurance, no-fault insurance or workers’ compensation, the conditional payments Medicare made on your behalf must be repaid to the Medicare program. Medicare should be repaid before funds are disbursed for other purposes. (The applicable law can be found at 42 U.S.C. 1395y(b)(2)(A) & (B).)

Information We Need If You Have a Representative

If someone is acting as your representative (that is, an attorney or other individual who is acting on your behalf), you should have the following information sent to us so we can communicate directly with your representative as well as with you.

- If your representative is an attorney, he/she should send us a copy of the agreement you signed when you retained the attorney. The agreement should also be signed or countersigned and dated by the attorney; be on the attorney’s letterhead (or have a cover letter from the attorney); and have your name and Medicare Health Insurance Claim Number (the number on your Medicare card) at the top of the document. This will act as proof that this attorney is representing you, may act on your behalf, and receive your Medicare claims information directly from us.
- If someone other than an attorney is your representative, you must send a letter that is signed and dated, telling us that he/she is your representative and the date of the incident or injury for which he/she is acting as your representative. Please include your name and Medicare Health Insurance Claim Number at the top of the letter so that we can easily associate your agreement with your file. Your representative must also sign and date the letter to show that he/she has agreed to represent you. (Model language for proof of representation is available on our website at www.msprc.info.)

As we stated at the beginning of this letter, if we have information that you have a representative, we are copying him/her on this letter. Your representative can take care of submitting this information to us. (However, if your representative’s name is not shown at the end of this letter, please contact us immediately and give a copy of this letter to your representative.)

Information Requested Regarding Your Insurance or Workers’ Compensation Claim

We are requesting that your representative send us the name, address, and telephone number of the insurer or workers’ compensation carrier involved and, if available, the policy number, claim number, and claim adjuster’s name. (If you do not have a representative, we ask that you send us this information.)

If we have a name and address for the insurer or workers’ compensation, we are copying them on this letter. However, we may not have more specific information, such as the claims adjuster you are working with, so we are requesting that you send us the complete information.

Information We Need If There Is a Settlement, Judgment, Award, or Other Payment (or If Your Claim Is Dismissed or Otherwise Abandoned)

Once you have a settlement, judgment, award, or other payment for your claim, if you have a representative, he/she should send us the following information. (If you do not have a representative, you will need to send us this information.)

- A copy of the settlement, judgment, award or other document regarding payment indicating the appropriate date and the total amount of the settlement, judgment, award or other payment.
- An itemized statement of attorney fees and other procurement costs that you are paying.

If your claim has been dismissed or otherwise abandoned without a settlement, judgment, award, or other payment, please send us any documentation of these actions so that we may close our record of this incident.

Information Regarding Claims Medicare Paid On Your Behalf on or After Your Date of Incident

Beneficiary representatives often ask us what “conditional” payments Medicare made on or after your date of incident. “Conditional” payments are those Medicare payments that are related to your pending insurance or workers’ compensation claim.

Within sixty-five days from the date of this letter, you will receive a Conditional Payment Letter (CPL) which will show you the conditional payments Medicare has made on your behalf at that time (an interim conditional payment amount). If you have an attorney or other representative, and we have appropriate proof of representation, we will also send a copy of this information to your representative. If we do not have the appropriate proof of representation, only you will receive the CPL; and you should supply a copy to your representative. (Please see the section above for information on appropriate proof of representation documentation.)

If your claim is for no-fault insurance or workers’ compensation benefits, a copy of the CPL will be sent to the insurer or workers’ compensation carrier if we have that information.

Please do not submit a request for a CPL because we will send one to you automatically as soon as the information is available. A separate request will not make the information available faster.

Once we send the CPL, we will also post this conditional payment information under the “MyMSP” tab of the www.mymedicare.gov website. The information at www.mymedicare.gov will be updated weekly with any newly processed claims. If you wish, you can also keep track of the medical expenses that were paid by Medicare, and if you have an attorney or other representative, provide him/her with this information. This may assist him/her with finalizing your settlement.

Mailing or Faxing Information to the MSPRC

Please use a copy of the enclosed “Correspondence Cover Sheet” whenever you or your representative submit any correspondence pertaining to the incident identified in the subject field of this letter. This cover sheet includes our address information and is pre-filled with information that will facilitate processing your correspondence. If you do not include a copy of this cover sheet, please include your name and your Medicare Health Insurance Claim Number (the number on your Medicare card) on all correspondence. This will allow us to associate the correspondence with the appropriate records.

Attached is a Privacy Act Statement that explains your privacy rights. You may be interested in the enclosed brochure about the MSPRC.

Sincerely,
MSP Recovery Contractor

Enclosures:
Privacy Statement
Medicare Secondary Payer Recovery Contractor Brochure
Correspondence Cover Sheet

[Copies to: Attorney/Other Representative, No-Fault Insurance (if information is available),
Workers’ Compensation Entity (if information is available)]

**NOTICE TO BENEFICIARY ABOUT THE COLLECTION AND
USE OF MEDICARE INFORMATION
(PRIVACY ACT STATEMENT)**

The Social Security Act mandates the collection of this information. The purpose of collecting this information is to properly pay medical insurance benefits to you or on your behalf.

Information collected may be given to health insurance providers and suppliers of services (and their authorized billing agents) directly or through fiscal intermediaries or carriers, for administration of Title XVIII; and to an individual or organization for a research evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration or maintenance of health.

The identification number we are using is your Medicare Health Insurance Number. While furnishing the information on this form is voluntary, the Medicare program may not be able to make accurate claims payment when the requested information is not available in its records.

Public Law 100-503, the computer Matching and privacy Protection Act of 1988, permits the government to verify information by way of computer matches. Anyone who knowingly and willfully makes, or causes to be made, a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both.

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 is 0938-0214. The time required to complete this information collection is estimated to average 5 minutes per responder, 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 suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



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Correspondence Cover Sheet

Beneficiary's Name [BENEFNAME M BENELNAME]

HIC#: [CLAIMNUM]

Date of Incident: [TCI DATE]

Case #: [Remas Case#]

This cover sheet is for your use when mailing or faxing in correspondence to the MSPRC. Please retain a COPY of this cover sheet for any future correspondence. The information above will ensure accuracy when handling your case documentation.

Please indicate the type of correspondence you are submitting to the MSPRC to facilitate routing. Check all that apply:

- Check
- Settlement information
- Retainer agreement or other authorization documentation
- Other _____

Note: A Conditional Payment Letter is sent automatically, as soon as the information is available. Separate requests for initial Conditional Payment Amounts will not make Conditional Payment information available sooner.

In order to accurately associate claims to your case, please include a description of the injury. (ie: Knee, Physical Therapy, Slip and Fall, Lumbar Injury...)

Submit correspondence to the appropriate MSPRC address listed below:

Liability Insurance or No Fault Insurance:

MSPRC Auto/Liability
PO Box 33828,
Detroit, MI 48232-5828

Workers' Compensation:

Workers' Compensation MSP Recovery
MSPRC WC
PO Box 33831
Detroit, MI 48232-5831