



August 30, 2010

insert name
insert address 1
insert address 2
insert city, state, zip code

Your response to the PPN must be received by the response due date on the PPN coversheet.

Primary Payment Notice (PPN)

Response Due Date: November 1, 2010

ReMAS Case ID Number: [Insert ReMAS Case ID]

Please respond using the attached Primary Payment Notice Worksheet.

Dear Company Name:

We are writing to advise you that the Centers for Medicare & Medicaid Services (CMS) has identified instances where Medicare may have mistakenly made a primary payment when other primary insurance exists. Medicare believes a Group Health Plan (GHP) that you sponsor or to which you contribute should have been the primary payer for the beneficiaries and corresponding coverage dates listed in the enclosed worksheet. We request that you verify this listing to ensure that the beneficiary and coverage information is accurate, as this information is to be used to issue a demand for payment where Medicare mistakenly made primary payment. (Individual claim information will be provided with any subsequent demand letter.)

It is important to understand that when certain conditions set forth in the Medicare laws (42 U.S.C. § 1395y(b)) and regulations (42 C.F.R. § 411.20 ff) are satisfied, GHPs are required to pay primary to Medicare. The Medicare Secondary Payer (MSP) statute and regulations also require Medicare to recover primary payments Medicare made when a GHP is the proper primary payer. Medicare may recover this mistaken payment from any entity responsible for making primary payment, including employers that sponsor or contribute to GHPs, other plan sponsors, the plan, insurers and third party administrators (TPAs). You are receiving this letter because you will be responsible for payment by virtue of the Medicare law, and we want to afford you the opportunity to verify the information used in making this determination before the MSPRC issues a demand for payment. Medicare is requesting that you review the following information on the enclosed worksheet and provide corrected or missing information.

- Review coverage dates for each beneficiary and enter corrected coverage dates, where applicable.
- Enter the date the Employee/Subscriber retired, if applicable.
- Ensure the beneficiary is covered by the Insurer/TPA listed.



Learn about your letter at www.msprc.info

For assistance in verifying this information, we encourage you to contact the other entities responsible for payment.

If you do not respond to the Medicare Secondary Payer Recovery Contractor (MSPRC) with verification of the attached information by **November 1, 2010**, a demand will be sent for repayment for all of the claims associated with the beneficiaries and corresponding coverage dates identified in this notice. Once you receive this demand, you will be responsible for payment or for submitting a valid documented defense. Any unpaid debts will be referred to Treasury for further collection activities, including the Treasury Offset Program.

We encourage both you, and any entity copied on this letter, to respond timely to the MSPRC, so that any coverage information can be corrected and an accurate demand for payment can be sent. The updated worksheet and signed certification statement should be sent to the MSPRC at the address provided. If you have any questions concerning this matter, please write or call us at the address and phone number provided on the enclosed Primary Payment Notice (PPN) Worksheet.

Sincerely,

Medicare Secondary Payer Recovery Contractor

Enclosures:
PPN Worksheet

cc: **[Insurer/TPA]**



Learn about your letter at www.msprc.info

Primary Payment Notice Worksheet

Response Due Date: November 1, 2010

Respond only on the PPN response worksheet. Do not send additional documentation outside of worksheet.

THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME.

When responding to the MSPRC about changes to the information below, please identify your changes on this worksheet and return to the MSPRC. Please do not submit changes in a separate document or an alternate format.

Please mail completed form to:

MSPRC/GHP
PO BOX 33829
DETROIT, MI 48232-58
Or fax to: 1-734-957-0998

For questions:

Telephone Number: 1-866-677-7220
TTY/TDD: 1-866-677-7294

ReMAS Case ID Number: []
Date of PPN: []

Employer /Other Plan Sponsor Name: []
Insurer/TPA Name: []

Please note: The MSPRC will update the identified records on the MSP system of record and generate a demand. Please fill in, where applicable, corrected coverage dates, the Employee/Subscriber's retirement date, or indicate if you have no record of the Medicare beneficiary listed.

BENEFICIARY NAME & MEDICARE ELIGIBILITY	HIC NUMBER	POLICY NUMBER	GROUP ID	EMPLOYEE (SUBSCRIBER) NAME	RELATIONSHIP TO EMPLOYEE (SUBSCRIBER)	COVERAGE DATES	ENTER CORRECTED COVERAGE DATES (FILL IN ONLY IF APPLICABLE)	EMPLOYEE (SUBSCRIBER) RETIREMENT DATE (FILL IN ONLY IF APPLICABLE)	INDICATE WITH (X) IF YOU HAVE NO RECORD OF THIS BENEFICIARY	COMMENTS
Jones, Sam ESRD	123456785A	123456789	G12345	Sam Jones	Self	1/1/1992 – 12/31/2010	<i>1/1/1993 – 12/31/2010</i>			
Smith, Lulu Working Aged	999881234B	123456987	G12345	John Smith	Wife	1/1/1992 – 12/31/2010		<i>06/30/2008</i>		
Joseph, Jim <i>Disability</i>	112233445A	123344556	G12345	Jane Joseph	Husband	7/1/2009 -			X	

Note: Items in red are sample responses.

Please provide a primary point of contact in case we have questions about your submission.

Name: Jonathan Doe
Company Name: ABCD Enterprise
Email Address: jdoe@abcde.com
Address: 123 Fourth Street
Anytown, TX 98765

Title: Health Benefits Coordinator
Phone Number: 555-555-5555
Fax Number: _____

Please check the applicable certification, sign and date the statement, and return to the MSPRC by the date provided above.

- I certify, to the best of my knowledge, that the changes I have provided in this PPN Worksheet are complete and accurate.
- I certify, to the best of my knowledge, that the eligibility data provided by the MSPRC concerning this customer coverage/eligibility is correct.

Jonathan Doe
Signature

09/08/10
Date

Jonathan Doe
Printed Name of Signatory

ABCD Enterprise
Company Name

- Employer
 Insurer
 TPA
 Other Plan Sponsor
 Plan

All recipients should respond. Please indicate who you represent.

Note: Without a signed certification statement, the MSPRC will not be able to update Medicare records.

A complete response to the PPN includes both the completed PPN worksheet and the signed certification statement.