CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

Beneficiary Services: 1-800-MEDICARE (1-800-633-4227)
TTY/TDD: 1-877-486-2048

Thank you for your recent request for the Patient's Request for Medical Payment form (CMS-1490S). Enclosed is the form, instructions for completing it, and where to return the form for processing. Medicare will only pay for medically necessary shipboard services if the services were provided while the ship was within United States (U.S.) waters (for example, in a U.S. port, or within 6 hours of departure or arrival at a U.S. port).

If you had medical services aboard a ship and the doctor's office is in the U.S., the doctor will submit the claim to Medicare. Please contact the doctor to submit the claim.

If the doctor's office is not in the U.S., you will need to mail the CMS-1490S form to Medicare. Where you return the form will depend on your ship's port of departure and the port of arrival.

- If the doctor's office is not in the U.S. and the trip began in the U.S., the Medicare contractor at the port of departure will process your claim. For example, if the trip began in New York and ended in Spain, the Medicare contractor for New York will process the claim.

- If the doctor's office is not in the U.S. and the trip began in another country and ended in the U.S., the Medicare contractor at the arrival port will process the claim. For example, if the trip began in Spain and ended in New York, the Medicare contractor for New York will process the claim.

- If the doctor's office is not in the U.S. and the trip began in another country and ended in another country, the Medicare contractor in the state that you live will process the claim.

Please send the completed claim form, your itemized bill, and any supporting documents to the appropriate Medicare contractor at the appropriate port and explain in detail your reason for submitting the claim. For example, include a statement that notifies the Medicare contractor that you are sending the claim for a denial for your secondary insurance, or you are sending a claim because you have received a service while on the cruise ship and/or your provider is unable to file a claim for a Medicare-covered service and/or is not enrolled with Medicare.

When you submit your own claim to Medicare, complete the entire form. If the claim form has incomplete or invalid information, the Medicare contractor will return the claim along with a letter to you clearly stating what information is missing or invalid.

You should mail the original claim form, a copy of the itemized bill, and supporting documents to Medicare. You should make copies of your claim submission for your records. Please allow at least 60 days for Medicare to receive and process your request.

If you have any other questions, please feel free to call us at 1-800-MEDICARE (1-800-633-4227).

Sincerely,

Centers for Medicare & Medicaid Services

Use the following address table to ensure the correct address will be provided on the claim.

If the port of departure/arrival is in, or the state that you live in is:	**Return your form to:**
Alabama	Alabama Medicare Part B Claims P.O. Box 830140 Birmingham, AL 35283-0140
Alaska	Noridian Administrative Services P.O. Box 6700 Fargo, ND 58108-6700
American Samoa	Palmetto GBA - J1 MAC P.O. Box 1051 Augusta, GA 30903-1051
Arkansas	Pinnacle Medicare Services P.O. Box 1418 Little Rock, AR 72203-1418
Arizona	Noridian Administrative Services P.O. Box 6704 Fargo, ND 58108-6704
California	Palmetto GBA - J1 MAC P.O. Box 1051 Augusta, GA 30903-1051
Colorado	TrailBlazer Health Enterprises, LLC P.O. Box 660031 Dallas, TX 75266-0031
Connecticut	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
Delaware	Novitas Solutions P.O. Box 890397 Camp Hill, PA 17089-0397
District of Columbia (Washington DC)	Novitas Solutions P.O. Box 890396 Camp Hill, PA 17089-0396
Florida	First Coast Service Options P.O. Box 2525 Jacksonville, FL 32231-0019
Georgia	Georgia Medicare Part B Claims P.O. Box 12847 Birmingham, AL 35202
Guam	Palmetto GBA - J1 MAC P.O. Box 1051 Augusta, GA 30903-1051
Hawaii	Palmetto GBA - J1 MAC P.O. Box 1051 Augusta, GA 30903-1051
Idaho	Noridian Administrative Services P.O. Box 6701 Fargo, ND 58108-6701

Illinois	Wisconsin Physicians Service P.O. Box 1030 Marion, IL 62959-1030
Indiana	National Government Services, Inc. P.O. Box 6160 Indianapolis, IN 46206-6160
Iowa	Wisconsin Physicians Service P.O. Box 8550 Madison, WI 53708-8550
Kansas	Wisconsin Physicians Service P.O. Box 7238 Madison, WI 53707-7238
Kentucky	CIGNA Government Services P.O. Box 20019 Nashville, TN 37202
Louisiana	Pinnacle Medicare Services P.O. Box 8082 Little Rock, AR 72203-8082
Maine	NHIC, Corp. P.O. Box 2323 Hingham, MA 02044-2323
Maryland	Novitas Solutions P.O. Box 890398 Camp Hill, PA 17089-0398
Massachusetts	NHIC, Corp. P.O. Box 1212 Hingham, MA 02044-1212
Michigan	Wisconsin Physicians Service P.O. Box 5555 Marion, IL 62959-5555
Minnesota	Wisconsin Physicians Service 8120 Penn Avenue South, Suite 200 Bloomington, MN 55431
Mississippi	Mississippi Medicare Part B Claims P.O. Box 547 Birmingham, AL 35201
Missouri	Wisconsin Physicians Service P.O. Box 14260 Madison, WI 53708-0260
Montana	Noridian Administrative Services P.O. Box 6735 Fargo, ND 58108-6735
Nebraska	Wisconsin Physicians Service P.O. Box 8667 Madison, WI 53708-8667
Nevada	Palmetto GBA - J1 MAC P.O. Box 1051 Augusta, GA 30903-1051
New Hampshire	NHIC, Corp. P.O. Box 1717 Hingham, MA 02044-1717

New Jersey	Novitas Solutions P.O. Box 890030 Camp Hill, PA 17089-0030
New Mexico	TrailBlazer Health Enterprises, LLC P.O. Box 660031 Dallas, TX 75266-0031
New York	National Government Services, Inc. P.O. Box 6178 Indianapolis, IN 46206-6178
North Carolina	Palmetto GBA - J11 MAC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190
North Dakota	Noridian Administrative Services P.O. Box 6706 Fargo, ND 58108-6706
Northern Mariana Islands	Palmetto GBA - J1 MAC P.O. Box 1051 Augusta, GA 30903-1051
Ohio	CIGNA Government Services P.O. Box 20019 Nashville, TN 37202
Oklahoma	TrailBlazer Health Enterprises, LLC P.O. Box 660031 Dallas, TX 75266-0031
Oregon	Noridian Administrative Services P.O. Box 6702 Fargo, ND 58108-6702
Pennsylvania	Novitas Solutions P.O. Box 890418 Camp Hill, PA 17089-0418
Puerto Rico	First Coast Service Options P.O. Box 45036 Jacksonville, FL 32232 -5036
Rhode Island	NHIC, Corp. P.O. Box 9203 Hingham, MA 02044-9203
South Carolina	Palmetto GBA - J11 MAC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190
South Dakota	Noridian Administrative Services P.O. Box 6707 Fargo, ND 58108-6707
Tennessee	Cahaba GBA P.O. Box 12086 Birmingham, AL 35202-2086
Texas	TrailBlazer Health Enterprises, LLC P.O. Box 660031 Dallas, TX 75266-0031

Utah	Noridian Administrative Services P.O. Box 6725 Fargo, ND 58108-6725
Vermont	NHIC, Corp. P.O. Box 7777 Hingham, MA 02044-7777
Virginia (Arlington and Fairfax Counties including city of Alexandria)	Novitas Solutions P.O. Box 890396 Camp Hill, PA 17089-0396
Virginia (The rest of the state.)	Palmetto GBA - J11 MAC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190
Virgin Islands	First Coast Service Options P.O. Box 45098 Jacksonville, FL 32232 -5098
Washington	Noridian Administrative Services P.O. Box 6700 Fargo, ND 58108-6700
West Virginia	Palmetto GBA - J11 MAC Mail Code: AG-600 P.O. Box 100190 Columbia, SC 29202-3190
Wisconsin	Wisconsin Physicians Service 1717 W. Broadway P.O. Box 1787 Madison, WI 53701-1787
Wyoming	Noridian Administrative Services P.O. Box 6708 Fargo, ND 58108-6708

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

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

SEND COMPLETED FORM TO:

Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

1 Name of Beneficiary from Health Insurance Card
(Last) (First) (Middle)

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
(Street or P.O. Box – Include Apartment Number)
(City) (State) (Zip)

3b Telephone Number
(Include Area Code)
(___ ___ ___)
___ ___ ___ – ___ ___ ___ ___

4 Describe the illness or injury for which patient received treatment

4b Condition was related to:
A. Patient's employment
☐ Yes ☐ No
B. Accident
☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5
a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No
b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No
c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policyholder's Name:

Policy or Medical Assistance No.

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

6 I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you MUST attach an itemized bill in order for Medicare to process this claim. Mail your completed claim form to the Medicare Carrier responsible for processing your claim. If you do not know the address of your carrier, call 1-800-MEDICARE (1-800-633-4227).

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

Block 1. Print your name shown on your Medicare Card (Last Name, First Name, Middle Name).

Block 2. Print your Health Insurance Claim Number including the letter at the end **exactly** as it is shown on your Medicare card. Check the appropriate box for the patient's sex.

Block 3. Furnish your mailing address and include your telephone number in Block 3b.

Block 4. Describe the illness or injury for which you received treatment. Check the appropriate box in Blocks 4b and 4c.

Block 5a. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where you are currently working.

Block 5b. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where your spouse is currently working.

Block 5c. Complete this Block if you have any medical coverage other than Medicare. Be sure to provide the Policy or Medical Assistance Number. You may check the box provided if you do not wish payment information from this claim released to your other insurer.

Block 6. Be sure to sign your name. If you cannot write your name, make an (X) mark. Then have a witness sign his or her name and address in **Block 6** too.

If you are completing this form for another Medicare patient you should write (By) and sign your name and address in **Block 6.** You also should show your relationship to the patient and briefly explain why the patient cannot sign.

Block 6b. Print the date you completed this form.

B. Each itemized bill MUST show all of the following information:

- Date of each service
- Place of each service

Doctor's Office	Independent Laboratory	Outpatient Hospital
Nursing Home	Patient's Home	Inpatient Hospital

- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor's or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THE ONE WHO TREATED YOU BE IDENTIFIED. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is also shown on the physician's bill. If not, be sure you have completed **Block 4** of this form.
- Mark out any services on the bill(s) you are attaching for which you have already filed a Medicare claim.
- If the patient is deceased, please contact your Social Security office for instructions on how to file a claim.
- Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Centers for Medicare & Medicaid Services to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information to a hospital or doctor about the Medicare benefits you have used.

With one exception, which is discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.