Primary Payment Notice

[Print Date]

[Employer Name]
[ATTN: Director of Benefits or COORDINATION OF BENEFITS DEPARTMENT]
[Employer Address 1]
[Employer Address 2]
[City], [State] [Zip]

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

Re: PPN Letter ID: [PPN Letter ID#]
PPN Response Due Date: **November 10, 2013**

Please respond using the attached Primary Payment Notice Worksheet

Dear [Employer 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 we issue a demand for payment. Medicare is requesting that you review the following information on the enclosed worksheet and provide corrected or missing information.

[Bar Code Place Here]

Note: Items in red are provided as sample text responses.

- 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.

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

If you do not respond to us with verification of the attached information by **November 10, 2013**, a Demand Letter 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 us, 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 following address:

Commercial Repayment Center
PO Box 93945
Cleveland, Ohio 44101-5945

If you have any questions concerning this matter, please direct your inquiry to Medicare's Commercial Repayment Call Center at 1-855-798-2627 (TTY/TDD line at 1-855-797-2627) between the hours of 8:00 am and 8:00 pm EST.

Sincerely,

Commercial Repayment Center

Enclosure: a/s

cc: [Insurer/TPA]

PPN Letter ID: [PPN Letter ID#]
[Employer Name]

Primary Payment Notice Worksheet
Response Due Date: **November 10, 2013**

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

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

Please mail completed form to:
Commercial Repayment Center
PO Box 93945
Cleveland, Ohio 44101-5945
Or Fax to: 1-216-781-5516

For Questions:
Telephone Number: 1-855-798-2627 / TTY/TDD: 1-855-797-2627

Please note: We 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.

PPN Letter ID: [PPN Letter ID#]
Date of PPN Letter: [PPN Letter Date]
Employer/Other Plan Sponsor Name: [Plan Sponsor on Record]
Insurer/TPA Name: [Insurer/TPA on Record]

Beneficiary Listing						**Please complete shaded area for each Beneficiary listed**				
Subscriber Name	Beneficiary Name	Policy #/ Group ID #	Health Insurance Claim Number (HICN)	Relation to Subscriber	Coverage Start Date	Coverage End Date	Start Date	End Date	Retirement Date	No Record
Suzanne Smith	Suzanne Smith	XYZ111 /ABCDE	122346789A	Self	01/02/09	06/30/11	*March 1, 2004*	*June 30, 2011*	*June 15, 2011*	

PPN Letter ID: [PPN Letter ID#]
[Employer Name]

Note: Items in red are provided as sample text responses.

Please provide a primary point of contact for any questions about your submission.

Name:	Jonathon Doe	Title:	Benefits Coordinator
Company Name:	ABDC Enterprise	Phone Number:	555-555-5555
Address:	123 Fourth Street	Fax Number:	222-222-2222
City, State Zip:	Anytown, USA 11111		
Email Address:	jdoe@abcd.com		

Please check the applicable certification, sign and date the statement, and return to Medicare's Commercial Repayment Center by the date provided above. Note: Without a signed certification statement, we will not be able to update Medicare records.

☒ *Employer certifies, to the best of their knowledge, that the changes they have provided in this PPN Worksheet are complete and accurate.*
☐ *Employer certifies, to the best of their knowledge, that the eligibility data provided by Medicare's Commercial Repayment Center concerning coverage/eligibility is correct.*

☐ *Insurer or TPA certifies, to the best of their knowledge, that the changes they have provided in this PPN Worksheet are complete and accurate.*
☐ *Insurer or TPA certifies, to the best of their knowledge, that the eligibility data provided by Medicare's Commercial Repayment Center concerning coverage/eligibility is correct.*

Jonathon Doe	1/1/2014
Representative's Signature	Date
Jonathon Doe	ABCD Enterprise
Printed Name	Company Name

Note: Without a signed certification statement, the CRC 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.