 **Medicare Premium Reimbursement Form**

**Staff Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@­­­­­\_\_\_\_\_\_\_\_\_\_\_\_**

**First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Check all U.S. Medicare coverage that you and your adult dependents currently have:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Self** | **Spouse** | **Secondary Dependent(s)** | **Total Amount $** |
| **Part A**  |  |  |  |  |
| **Part B**  |  |  |  |  |
| **Check if you/dependents have coverage under any other country’s US health Insurance (if that is the case provide detailed information below):**  |  |  |  |  |
| **# of years that you/adult dependents have paid U.S FICA tax**  |  |  |  |  |

(Optional) Please provide any other comments you have about your coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attach** **the documents Form SSA-4926-SM (Annual statement of benefits), or Health and Human Services Form CMS-500 Medicare Premium Bill, justifying the Medicare Part A and B amounts.**

**Banking Information:**

Name on the Account (should match the Member’s name) :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Bank Name :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Account Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Routing Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Checking  Savings

**Date** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**After Completion, please return by email to** **medicare@paho.org****. Do not forget to attach** **the documents Form SSA-4926-SM (Annual statement of benefits), or Health and Human Services Form CMS-500 Medicare Premium Bill, justifying the Medicare Part A and B amounts.**

**Definitions:**

**Medicare Part A** is managed by Medicare. It provides benefits and coverage for inpatient hospital care, inpatient stays in most skilled nursing facilities, and hospice and home health services.

**Medicare Part B** is managed by Medicare. It provides benefits and coverage for doctor and clinical lab services, outpatient and preventive care, home health care, screenings, surgical fees and supplies, and physical and occupational therapy.

**FICA Tax:** The Federal Insurance Contributions Act (FICA) tax is a United States federal payroll (or employment) tax to fund Social Security and Medicare.