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

FORM APPROVED
OMB NO. 0938-0041

THIRD PARTY PREMIUM BILLING REQUEST

PRIVACY ACT STATEMENT

This statement is to be completed by an individual who desires that his/her Supplemental Medical Insurance premiums be paid by a third party as permitted under the Code of Federal Regulations. Section 1840 of the Social Security Act requires that the information on this form only be used to identify the premium payer named by the insured individual. There are no routine uses for this form. Although the completion of this form is voluntary, the enrollee, rather than a third party, will be billed for the premiums unless all information requested below is furnished. You should be aware that the information you provide may be verified through a computer match (P.L. 100-503).

Date

I. INDIVIDUAL'S AUTHORIZATION

NAME OF ENROLLEE	HEALTH INSURANCE NUMBER

I request that my Medicare premium bill be sent to _____

rather than to me, because _____

I also authorize release to him/her of any information in regard to my rights under Title XVIII of the Social Security Act.

SIGNATURE OF ENROLLEE	ADDRESS *(Street, City, State, Zip Code)*

II. REQUEST OF THIRD PARTY PAYER

I request that the Medicare premium bill for the enrollee named above be sent to me rather than to him/her. I understand that I must pay the premiums promptly to protect the enrollee's benefit rights. I agree to notify SSA or CMS promptly if my address changes; and if for any reason it becomes impossible for me to pay the premiums, I will try to give SSA or CMS as much advance notice as possible (preferably 3 months) so that other arrangements can be made for payment of the enrollee's premiums.

I believe that I am the proper person to receive premium notices on behalf of the above enrollee because (check each of the following blocks that are applicable):

1. ☐ I am a relative *(Give relationship)*	2. ☐ The enrollee is living with me
3. ☐ I am financially responsible for the enrollee	4. ☐ Other reasons not included above *(explain below)*

EXPLAIN REASONS

SIGNATURE OF THIRD PARTY PAYER	ADDRESS *(Street, City, State, Zip Code)*

III. SSA ACTION *(This space for District Office use only)*

COMMENTS

SIGNATURE OF DISTRICT OFFICE OFFICIAL	REQUEST APPROVED ☐ Yes ☐ No	DATE sent to Program Service Center