AUDIENCE: *CA, CDA, CR, CRTA, DRT, FR, OA, RECONR, RR, SR, TSCSR*

REPORT OF CONTACT

(Use ink or typewriter)

ACCOUNT NUMBER AND SYMBOL

NAME OF WAGE EARNER OR SE PERSON

TO: **NE** **MAT** **SE** **GL** **WN** **MAM** **ODO** **OIO** **DDS** **CMS/CBC**

PERSON(S) CONTACTED AND ADDRESSES ☐ WE OR SE PERSON ☐ OTHER *(Specify)*

Other SSN

CONTACT MADE: ☐ Field Office ☐ PHONE: ☐ OTHER DATE OF CONTACT

SUBJECT: **Premium Problem** ☐ **Individual** ☐ **Group Payer** ☐ CSR

NOTE: Include current DB (individual involved) or MBR (group payer or CS involved) query response with proofs when forwarding case.

☐ No DB **Record (Per Attached Query Response)**

☐ Incorrect Billing for Date of Bill Amount

☐ No Billing for

☐ Premium Payment Alleged: Amount Date of Payment

☐ Proof of Payment: Check Mo. Other(Describe in Remarks)

☐ Incorrect Check Deduction (Describe in Remarks) Date of CK. Amount

☐ HI-SMI Terminated for Nonpayment of Premiums (Describe in Remarks)

☐ Premium Refund Due (Describe in Remarks)

☐ Private Third Party Group Payer Code Name

☐ Civil Service Number: CSA or CSF

☐ Annuitant's Name (If other than above)

REMARKS:

Requester's Phone: Local: (Area Code) ☐ Reply Requested

SIGNATURE

Field Office

☐ CR ☐ FR ☐ SR ☐ CLAIMS CLERICAL ☐ OTHER *(Specify)*

DATE OF REPORT

PAGE OF

DO NOT WRITE IN MARGIN

Form **SSA-5002 HB** (03/01)

Prior editions may be used until exhausted