DATA CONTROL SECTION
SMIB ANALYSIS & CORRECTIONS UNIT

DATE: _____

TO: SOCIAL SECURITY ADMINISTRATION

DOC: _____

SUBJECT: MEDICARE PART B ENTITLEMENT ON

NAME: _____ PCN: _____

ADDRESS: _____

SSN: _____ SSCN: _____ DOB: _____

CATEGORY: _____AGED _____DISABLED ALIEN DATE ON SSR: _____

The Texas Health and Human Services Commission has information indicating the above-named person is potentially eligible for Medicare Part B coverage. Please complete this form and return it to the address shown below.

Fold along this line and place with address below showing in a window envelope

ATTN:

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
DATA CONTROL SECTION
SMIB ANALYSIS & CONTROL UNIT, Y-922
P.O. BOX 149030
AUSTIN, TEXAS 78714-9030

FORM 7375 / 08-2003