Claim Filing Instructions

Do NOT mail the instructions with your request to Medicare

HOW TO FILL OUT THIS MEDICARE FORM

Medicare may pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Mail your completed claim form to the Medicare contractor responsible for processing your claim. If you need additional assistance, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit **https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE (1-800-633-4227) for more information.

FOLLOW THESE INSTRUCTIONS CAREFULLY BY COMPLETING THE FOLLOWING SECTIONS:

Section 1 – PATIENT INFORMATION

- Print your name as shown on your Medicare card (Last Name, First Name, Middle Name).
- Print your Medicare Number exactly as it is shown on the Medicare card.
- Print your date of birth (mm/dd/yyyy)
- Check the appropriate box for the patient's sex.
- Furnish your mailing address and include your telephone number

Section 2 – INFORMATION ABOUT SERVICES FURNISHED

- Answer the following questions

Was the condition related to:

○Yes ○No Employment
○Yes ○No Auto Accident
○Yes ○No Treatment for chronic dialysis or kidney transplant
○Yes ○No Other Accident

Section 3 – INFORMATION ABOUT HEALTH INSURANCE OTHER THAN MEDICARE

- Complete this section if you have a secondary insurance plan to Medicare

Section 4 – SIGNATURE

- Sign your name and date the form

Claim Filing Instructions

**Fill in the date of service and quantity of batteries purchased on the Supporting Details page attached.

Mail the supporting details page, the invoice and receipt from Cochlearbatteries and a physician's order (if you have one) along with your Medicare Request for Medical Payment Form to one of the following addresses depending on the state you live in.

Make a copy of your claim submission for your records and allow at least 60 days for Medicare to receive and process your request.

Please note: this process applies to traditional Medicare plans only. If you have a Managed Medicare plan you will need to contact your health plan for claims filing instructions.

If you live in:	Mail your form and supporting documentation to:
Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	Noridian JA P.O. Box 6780 Fargo, ND 58108-6780
Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin	CGS Administrators, LLC P.O. Box 20013 Nashville, TN 37202-0013
Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, West Virginia	CGS Administrators, LLC P.O. Box 20010 Nashville, TN 37202-0010
Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, Wyoming	Noridian JD P.O. Box 6727 Fargo, ND 58108-6727

Supporting Details - Medicare Request for Medical Payment

- Date of service (the date batteries were purchased) =_____
- Quantity (the total # of batteries purchased ex. 180 – 3 boxes of 60) = _____
- Place of service = 12 – Home
- HCPCS = L8621 Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each
- Description of illness - ICD-10 = H90.3 – Sensorineural hearing loss, bilateral
- Unenrolled Medicare supplier name and address

Global Exports USA, INC Tax-ID = 65-0410392
d.b.a. Cochlearbatteries
7350 NW 35th Terrace
Miami, FL 33122

Description of service: I am a hearing impaired beneficiary with cochlear implant technology. Medicare does not have an enrolled supplier that can provide the disposable batteries (HCPCS L8621) that are medically necessary to treat my sensorineural hearing loss (ICD10 H90.3). These batteries are a covered item and without them I am unable to power my external sound processor and therefore unable to hear. I had to purchase these batteries from a retail supplier due to Medicare not having an enrolled provider within 200 miles of me.

Please refer to the *NCD for Cochlear Implantation (50.3)* and the *DMEPOS Fee Schedule HCPCS Codes Payable as a Replacement Part, Accessory or Supply for Prosthetic Implants and Surgically Implanted DME* for coverage details regarding HCPCS L8621.

Form Approved OMB
No. 0938-1197

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT: PLEASE READ THE ATTACHED INSTRUCTIONS PRIOR TO SUBMITTING A CLAIM TO MEDICARE

SEND ONLY THE COMPLETED FORM TO YOUR MEDICARE ADMINISTRATIVE CONTRACTOR – Include a copy of the itemized bill and any supporting documents. Make a copy of your claim submission for your records and allow at least 60 days for Medicare to receive and process your request.

Reference the Medicare Administrative Contractor Address Table for the correct address to mail your claim form.

Medicare will not process a beneficiary request for payment for diabetic test strips, Part B drugs, or for items paid for under the DMEPOS Competitive Bidding program.

Your reason for submitting this claim: (see the Instructions for additional information, check one box only)

- ○ The provider or supplier refused to file a claim for Medicare Covered Services
- ○ The provider or supplier is unable to file a claim for the Medicare Covered Services
- ◉ The provider or supplier is not enrolled with Medicare

IF YOU NEED HELP, CALL 1-800-MEDICARE (1-800-633-4227). TTY USERS SHOULD CALL 1-877-486-2048.

Type of Patient's Request (see instructions for additional information, check one box only):

- ○ Influenza/Pneumococcal Vaccination, Part B (includes physician, laboratory, imaging services), Foreign Travel (including Canada and Mexico) and/or Shipboard Services
- ◉ Durable Medical Equipment, Prosthetics, Orthotics and Supplies

PLEASE TYPE OR PRINT INFORMATION

SECTION 1 - PATIENT INFORMATION

Patient's Name as shown on Medicare Card *(Last, First, Middle)*

Patient's Medicare Number exactly as it is shown on the Medicare card:	Date of Birth *(mm/dd/yyyy)*	○Male ○Female

Street address (or P.O. Box - include apartment number)

City	State	Zip code

Telephone number

SECTION 2 - INFORMATION ABOUT SERVICES FURNISHED

FOR ALL CLAIMS including Influenza and Pneumococcal Vaccinations, describe the illness or injury for which you received treatment.

I am a hearing impaired beneficiary with cochlear implant technology. Medicare does not have an enrolled supplier that can provide the disposable batteries (HCPCS L8621) that are medically necessary to treat my sensorineural hearing loss (ICD10 H90.3). These batteries are a covered item and without them I am unable to power my external sound processor and therefore unable to hear. I had to purchase these batteries from a retail supplier due to Medicare not having an enrolled provider within 200 miles of me.

Attach all supporting documentation to the form including an itemized bill with the following information:

- Date of service
- Place of service
- Description of illness or injury
- Description of each surgical or medical service or supply furnished
- Charge for each service
- The doctor's or supplier's name and address
- The provider or supplier's National Provider Identifier (NPI) If known Tax-ID = 65-0410392

IMPORTANT: If the itemized bill is from:

- A Clinical laboratory for ordered tests
- An independent diagnostic imaging center for ordered imaging procedures
- A supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS

The ordering & referring providers legal name **MUST** be included on the itemized bill.

Please also include the ordering & referring providers National Provider Identifier (NPI) if known.

Was the condition related to:

◯Yes◯No Employment

◯Yes◯No Auto Accident

◯Yes◯No Treatment for chronic dialysis or kidney transplant

◯Yes◯No Other Accident

SECTION 3 - INFORMATION ABOUT HEALTH INSURANCE OTHER THAN MEDICARE

Complete this section if you are age 65 or older and enrolled in a health insurance plan where you or your spouse are currently working and covered by any medical coverage other than Medicare.

◯Yes◯No Are you employed and covered under an employee health plan?

◯Yes◯No Is your spouse employed and are you covered under your spouse's employee health plan?

◯Yes◯No Do you have any medical coverage other than Medicare, such as private insurance, MEDIGAP, employment related insurance, Medicaid,or the Veterans Administration (VA)?

Name of other Medical Insurance

Policy Number including Medicaid ID Number

Policyholder's Name *(Last, First, Middle)*

Street Address (or P.O. Box) of other Medical Insurance

City	State	Zip code

Please attach a copy of your primary insurer's Explanation of Benefits if Medicare is secondary.

SECTION 4 - SIGNATURE

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

I authorize any holder of medical or other information about me to release it to the Centers for Medicare & Medicaid Services or its designated contractor or the Social Security Administration for this Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to me.

Signature of Patient	Date Signed *(mm/dd/yyyy)*

If you cannot sign your name, mark an (X) on the signature line. Have a witness sign his/her name next to the "X" and complete the section below.

If signing this form on behalf of a Medicare patient, on the 'Signature of Patient' line above, indicate the patient's name followed by "By" and sign your name. Provide your name, address, and relationship to the patient with a brief explanation why the patient cannot sign.

Name of Witness *(Last, First, Middle)*

Street Address

City	State	Zip code

Relationship to the Patient

Signature of Witness	Date Signed *(mm/dd/yyyy)*

Briefly explain why the Patient cannot sign:

Send the completed form and supporting documentation to your Medicare contractor. Reference the Medicare Administrative Contractor Address table for the correct address to mail your claim form. If you still do not know the address of your Medicare contractor, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.