NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Medicare Part B
Income Related Monthly Adjustment Amount (IRMAA) Reimbursement Application

IRMAA 1/2018 APPL

Please complete this form ONLY if you and/or your dependent were subject to the Medicare Part B Income Related Monthly Adjustment Amount (IRMAA).

ENROLLEE INFORMATION

Name

_____
(Last) (First) (MI)

Last four of SSN

X X X – X X – __ __ __ __

Mailing Address ☐ **Check here if this is a change of address**

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Home: (____) _____ Cell: (____) _____

DEPENDENT INFORMATION

Name

_____
(Last) (First) (MI)

Last four of SSN

X X X – X X – __ __ __ __

Application is for (check all that apply) ☐ Self ☐ Dependent

Application is for which year? (check all that apply) ☐ 2017 ☐ 2016 ☐ 2015 ☐ 2014*

*Applications requesting reimbursement of 2014 amounts must be received by 4/15/2018

2017 Medicare Part B premium including IRMAA ☐ $187.50 ☐ $267.90 ☐ $348.30 ☐ $428.60

REQUIRED DOCUMENTATION

Please enclose all required documentation for each person for which you are applying.

☐ Notice from Social Security Administration outlining your premium for Medicare Part B including IRMAA, **and**

☐ Proof of Payment for ALL months of Medicare Part B premiums for each eligible person. (See the reverse side of this form for acceptable proofs)

SIGNATURE (Required)

By completing and signing this application, I certify that I and/or my dependent(s) were required to pay an Income Related Monthly Adjustment Amount (IRMAA) for Medicare Part B, and are not reimbursed by another source.

Enrollee Signature: _____ **Date:** _____

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Form Submission

Send this form and all required documentation to our secure fax number at (518) 485-5590

or mail to:
NYS Department of Civil Service, Employee Benefits Division
Empire State Plaza, Core Bldg 1
Albany, NY 12239

Please Note: IRMAA reimbursement for both the enrollee and dependent will be issued to the enrollee only. In order for the Employee Benefits Division to speak with the dependent regarding the IRMAA application, we must have a HIPAA Release Form (EBD-543) completed and signed by the enrollee. You may obtain the authorization for release of protected health information online at www.cs.ny.gov.

Acceptable Proof of Payment Chart

Documentation is required for each person for which you are applying. Proof of payment must indicate payments made for all months of each year.

Did you collect Social Security or Railroad Retirement benefits?	Enclose Proof of Payment of Medicare Part B premium:	Where can you obtain this proof?
Yes	**Form SSA-1099** or **RRB-1099** (Retirement Benefit Statement)	Social Security Administration, or Railroad Retirement Board
No	**CMS-500** (Notice of Medicare Premium Payment Due)	CMS Billing Notices (12 months)
Partial Year	**SSA-1099 and CMS-500** or **RRB-1099 and CMS-500**	(See above)

Contact Information

Social Security Administration (SSA)	Centers for Medicare and Medicaid Services (CMS)	Railroad Retirement Board (RRB)
www.ssa.gov/onlineservices	www.cms.gov	www.rrb.gov/Benefits/Medicare
1-800-772-1213	1-800-633-4227	1-877-772-5772

Personal Privacy Protection Law Notification: The information you provide on this form is requested for the principal purpose of authorizing the use and/or disclosure of protected health information pursuant to 45 CFR 164.508. Failure to provide the information may interfere with our ability to use or disclose protected health information necessary to administer NYSHIP. The information will be maintained by the Director of the Employee Benefits Division (in the capacity as the HIPAA Privacy Official), Department of Civil Service, Albany, NY 12239. The information will be used in accordance with Public Officers Law section 96(1), also known as the Personal Privacy Protection Law. If you have any questions regarding this form or your insurance coverage, please call (518) 457-5754 or 1-800-833-4344.