Medicare as secondary payer

Since 1980, a series of changes in the Medicare law has shifted costs from the Medicare program to private sources of payment. Presently, Medicare is the secondary payer for individuals:

* Aged 65 or older and currently working with coverage under an employer-sponsored or employee organization (such as a union) group health plan.
* Aged 65 or older and are covered by a working spouse's employer group health plan or employee organization (such as union) group health plan.
* Under age 65, disabled, and are covered by a large group health plan due to their own or other family member's current employment status.
* With kidney failure. Medicare is the secondary payer during the coordination of benefits (COB) period if they have coverage.
* Under their own, a spouse's, or other family member's employer-sponsored or employee organization group health plan.
* Receiving services covered under workers' compensation, Federal Black Lung, automobile, no-fault, or liability insurance plans.
* Receiving services covered under Veteran Administration.

For additional information on Medicare secondary payer (MSP) topics, please refer to the links below.

* [Working aged](#WorkingAged)
* [Vow of poverty](#Vow)
* [Disability](#Disability)
* [End Stage Renal Disease](#ESRD)
* [Worker's compensation](#WorkersComp)
* [Veterans Administration](#VA)
* [Automobile accident](#Auto)
* [Liability](#Liability)
* [Black lung](#BlackLung)
* [Primary insolvency](#Insolvency)
* [Employer Medicare Advantage plan coverage](#EmployerMA)
* [MSP questionnaire](#Questionnaire)
* [MSP billing](#Billing)
* [Determining secondary liability](#DeterSecondLiab)
* [Claim submission instructions](#ClaimSubmissionInstructions)
* [MSP file information](#MSPFileInfo)

Working aged

Medicare is secondary payer for individuals aged 65 or older who are currently working and have coverage through an employer group health plan (EGHP) Medicare is also secondary if the beneficiary has coverage through an employed spouse of any age.

In order to meet the working aged provision, the employer must have at least 20 employees working for the company. At times, two or more smaller employers combine to provide coverage, if at least one employer has 20 or more employees, the requirement is met.

Medicare is primary in the following situations:

* Individuals enrolled in Medicare Part B only.
* Individuals enrolled in Medicare Part A based on a monthly premium.
* EGHP plans with less than 20 employees and the employer does not combine with another employer with more than 20 employees.
* Individuals covered by a health plan not provided by group health plan (GHP). An example would be a plan purchased by an individual privately rather than through a group plan.
* A plan provided through retirement resulting from past employment. For Medicare to be secondary, the coverage must be the result of current employment status. The Medicare beneficiary may be retired and have retiree coverage. If the spouse is employed and provides coverage, this coverage will be primary to Medicare.

Vow of poverty

The Omnibus Budget Reconciliation Act of 1993 makes an exemption from MSP provisions for members of a religious order who have taken a vow of poverty retroactive to 1981. Employers must certify that an individual has taken a vow of poverty. Medicare is the primary payer for such individuals (i.e., nuns, priests, etc.).

Disability

Effective August 10, 1993, Medicare is secondary payer for individuals under age 65 who are entitled to Medicare due to disability and covered by a large group health plan (LGHP). Medicare secondary payer status for disabled Medicare beneficiaries is based on the "current employment status" of the beneficiaries, their spouses or any other family member. An individual has "current employment status" if the individual is actively working as an employee, the employer, or is associated with the employer in a business relationship.

Those disabled beneficiaries who have LGHP coverage because of their own or a family member's "current employment status" will continue to have Medicare as the secondary payer. Those disabled beneficiaries who do not have primary coverage with a LGHP because they do not have nor does a family member have "current employment status" will have Medicare as the primary payer.

A LGHP is defined as a plan sponsored or contributed to by an employer or employee organization (union). A LGHP provides medical benefits to employees who are currently working for an employer with 100 or more employees. If more than one employer combines to provide health coverage to their employees and at least one of the employers has 100 or more employees, the requirement is met.

Medicare is primary in the following situations:

* Individuals who work for employers of fewer than 100 employees.
* Individuals who are covered by a LGHP as the result of past employment (i.e., former retired employee or family member) and whose coverage is not based on "current employment status;"
* Individuals who are covered by a health plan that is not provided by a LGHP. An example would be a plan that is purchased privately by an individual rather than through a group plan;
* Individuals who have Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) continuation coverage, it is not based on "current employment status."

End stage renal disease (ESRD)

Medicare is secondary payer to GHP for individuals eligible for or entitled to Medicare based on ESRD during a coordination of benefits (COB) period. This provision differs from other MSP laws as it applies regardless of the number of employees employed by the employer or their employment status, active or retired. The ESRD provision applies to former as well as current employees. The provision applies where an individual is eligible for Medicare based on ESRD but who has not filed an application for entitlement to Medicare. This provision also applies when an individual is entitled based on ESRD only.

Coordination of benefits period

The COB period defines the time frame that GHP benefits pay first, or primary, and Medicare pays second. The COB period begins with the earlier of the first month of entitlement or eligibility for Medicare Part A based on ESRD. Eligibility refers to the first month the individual would have become entitled to Medicare Part A based on ESRD if the individual had filed an application for such benefits.

The COB period is 30 months.

Dual entitlement

Medicare entitlement based on ESRD and aged or disability is considered dual entitlement. For example, an individual may be entitled to ESRD and then become entitled based on aged or disability. Or an individual may be entitled to Medicare based on aged or disability and then develop ESRD.

Anytime an individual is entitled to Medicare for two different reasons, they are considered dually entitled.

GHPs must continue to pay primary benefits even if the individual becomes dually entitled during the COB period.

For more information and examples, please refer to the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM), [Publication 100-04, Medicare Secondary Payer Manual, Chapter 2](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c02.pdf).

ESRD entitlement ends

Entitlement/eligibility to Medicare based on ESRD ends 12 months after the month the individual no longer requires maintenance dialysis or 36 months after the month of a successful kidney transplant.

If after 12 months or 36 months, an individual becomes ESRD If an individual has more than one period of Part A eligibility or entitlement based on ESRD, a coordination period is determined for each period of eligibility when the individual has GHP coverage.

Effect of COBRA continuation coverage on ESRD MSP provision

COBRA requires that certain GHPs offer continuation of plan coverage for 18 to 36 months after the occurrence of certain qualifying events. An example of a qualifying event would be loss of employment or reduction of employment hours. These events could result in loss of GHP coverage unless the individual is given the opportunity to elect continued plan coverage at their own expense. Typically, Medicare is primary to COBRA plans with limited exceptions.

COBRA plans may terminate coverage upon entitlement to Medicare with one exception; a COBRA plan may not terminate continuation coverage of an individual and his/her qualified dependents if the individual retires on or before the date the employer eliminates regular plan coverage by filing for Chapter 11, bankruptcy. In this instance, if COBRA coverage overlaps the ESRD MSP coordination period, Medicare is secondary. Medicare is also secondary if the COBRA plan voluntarily chooses to remain in effect even though they are not obligated to do so under COBRA provisions.

Worker's compensation

Medicare is secondary to worker's compensation benefits if the patient is being treated for a work-related illness or injury. If the claim is contested, pending the worker's compensation board decision, the physician/supplier may bill Medicare first. A statement should be included on the claim form indicating that the worker's compensation claim is being contested.

Claims for beneficiaries who may have worker's compensation insurance will suspend for manual review to determine whether the services are related to a work illness or injury. If the services are obviously not related to a work illness or injury, the claim will be released for final processing.

Veterans Administration

Veterans entitled to Medicare may choose one of the programs to be responsible for payment of services covered by both programs. If the veteran elects Medicare coverage, it is not necessary to submit a claim to the Veterans Administration (VA) for a denial before submitting the claim to Medicare. Claims submitted to Medicare will be processed without development, assuming that Medicare coverage and eligibility requirements are met.

Claims cannot be submitted to both programs for the same dates and types of treatment. If a veteran elects Medicare coverage, a claim should not be submitted to the VA for the Medicare deductible or co-insurance.

Submission of claims to Medicare or the VA

Submit claims to the VA as follows:

* When hospital care was authorized by the VA in advance, or within 72 hours of admission.
* When outpatient medical services were authorized by the VA in advance.

Note: a VA fee basis ID card is not considered by Medicare to be an authorization, and the veteran retains his or her right to elect VA or Medicare coverage.

* When care was not authorized by the VA in advance, the veteran is eligible for payment for care as an unauthorized service, and the veteran chooses to submit a claim to the VA for unauthorized services rather than utilizing Medicare benefits.

Submit claims to Medicare as follows:

* When a veteran is eligible for Medicare benefits and hospital care was not authorized by the VA in advance, or within 72 hours of admission.
* When a veteran is eligible for Medicare benefits, has a VA fee basis ID card and elects Medicare coverage over VA.
* When a veteran is eligible for Medicare benefits and has no prior authorization from the VA for care—unless the veteran is eligible for payment for care as an unauthorized service, and the veteran chooses to submit a claim to the VA for unauthorized services rather than utilizing Medicare benefits.
* When a veteran is eligible for Medicare benefits and the VA has authorized care for only a part of the hospital treatment period. A denial from the VA is not needed prior to submitting a claim to Medicare.

VA advance authorization for care will be via sharing agreement, contract, or written communication.

Telephone authorization may be granted in emergency situations. All telephone authorizations are documented by the VA at the time the authorization is granted.

Any VA authorization for an inpatient is terminated when the veteran is determined by VA to be stable for transfer to a VA facility, or the veteran states that he or she is not willing to be transferred to a VA facility for continued treatment upon stabilization.

Medicare and VA will be performing periodic computer data matches to assure that instances of duplicate payment are identified. When duplicate payments are found, Medicare will pursue recovery of its payment, and will develop information for potential referral to the Internal Revenue Service or the Office of Inspector General.

Automobile accident

Medicare is secondary to all accident related claims. Beneficiaries may not choose which of these claims will be paid by the automobile insurance and which claims will be paid by Medicare.

Providers should submit all accident related claims to the automobile insurance before submitting them to Medicare. Claims for injuries or illnesses that are not related to the accident would be billed as Medicare primary.

To avoid late claim filing, claims may be submitted to Medicare even though payment has not been received from the automobile insurer. In addition, conditional payment can be made by Medicare if:

* The automobile insurance will not pay promptly (within 120 days); or
* Due to physical or mental incapacity, the beneficiary fails to meet the claim filing requirements of the automobile insurer. Conditional payments are made on the condition that the beneficiary will reimburse Medicare if payment is later made by the automobile insurer.

No-fault insurance

Medicare is secondary to all types of insurance that pay for medical expenses for injuries sustained on the property or premises of the insured, regardless of who caused the accident. This type of insurance includes homeowners and commercial plans. It may also be referred to as medical payments coverage, personal injury protection, or medical expense coverage.

Providers should follow the claims submission guidelines described in the automobile accident section in this chapter. The exhaustion of benefits and conditional payment rules also apply to no-fault insurance.

Medicare does not pay for services paid for or authorized by governmental entities.

Liability insurance

Liability insurance is insurance (including a self-insured plan) that provides payment based upon legally established responsibility for injury, illness or damage to property. It includes, but is not limited to automobile liability and general casualty insurance. It includes payments under State "wrongful death" statutes that provide payment for medical damages.

Providers are required to ask Medicare patients, or their representatives, if the services are for treatment of an injury or illness that resulted from an automobile accident or other incident for which the patient holds another party responsible. The provider should obtain the name, address, and policy number of any automobile or non-automobile liability insurance, no fault insurance, or any other party that may be responsible for payment of medical expenses that result from an accident or injury.

Where a provider has reason to believe that he/she provided services to a Medicare beneficiary for whom payment under liability insurance may be available, the provider may:

* Within the 120 day promptly period, the provider must bill only the liability insurer unless there is evidence that the liability insurer will not pay within the 120 day promptly period. If the provider has such evidence, he/she may bill Medicare for conditional payment, provided that documentation is supplied to support the fact that payment will not be made promptly; or
* After the 120 day promptly period has ended, the provider may, but is not required to, bill Medicare for conditional payment if the liability insurance claim is not finally resolved. If the provider chooses to bill Medicare, he/she must withdraw claims against the liability insurer or a claim against the beneficiary's settlement. If the provider chooses to continue with a claim against the liability settlement, the provider may not bill Medicare.

If a provider participates in the Medicare program

* Provider bills Medicare - The provider must accept the Medicare approved amount as payment in full and may charge beneficiaries only for deductible and coinsurance.
* Provider pursues liability insurance - The provider may charge the beneficiaries actual charges up to the amount of the proceeds of the liability settlement, but he/she may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

If a provider does not participate in the Medicare program

* Provider bills Medicare accepting assignment - The provider may accept the Medicare approved amount as payment in full and may charge the beneficiaries only for deductible and coinsurance.
* Provider bills Medicare not accepting assignment - The provider may charge beneficiaries no more than the limiting charge and may collect without regard to whether the liability insurance is available to the beneficiary.

For services for which there is no Medicare coverage available, regardless of who furnishes them, the provider may charge and collect actual charges from beneficiaries without regard to whether the proceeds of liability insurance are available to the beneficiary.

Black lung benefits

Medicare is secondary for beneficiaries who have medical benefits under the Federal Black Lung program. Medicare is secondary only for services provided for the treatment of lung conditions caused by mining. Claims for beneficiaries entitled to benefits under the Federal Black Lung program may suspend for manual review. If the diagnosis or services reported on the claim are not related to the black lung condition, Medicare is primary, and the claim will be released for final processing.

For some beneficiaries entitled to the Federal Black Lung program, the coalmine operator is responsible for medical benefits. In these cases, providers should submit the claims to the coalmine operator or its workers' compensation plan for processing.

Primary insolvency

In accordance CMS requirements, when a primary payer becomes insolvent, Medicare payments will not be made unless an explanation of benefits from the receiver (substitute primary payer decided on by the courts) and the court order of payment, accompanies the claim.

Physicians and suppliers who accept assignment may not collect or seek payment from the beneficiary or their estate for any Medicare covered service(s) during the primary insurer's insolvency process. Providers should file their claims with the primary insurer or the receiver if they have not already done so.

The receiver will determine the full primary payment to be made. Once you have been paid by the receiver, you may bill Medicare for secondary payments, if appropriate. You will have six (6) months from the date of the receiver's explanation of benefits to file a claim for secondary payments with Medicare. If the claim is received after the six-month filing limit, it will be processed as untimely.

In order for Medicare to process these claims for secondary payment, please provide the following:

* A hard copy of the claim.
* An explanation of benefits from the receiver.
* A copy of the court order that addresses this issue.

Employer plan Medicare Advantage (MA) plan coverage

The CMS has clarified that providers are responsible for submitting claims to Medicare for secondary payment consideration when the primary insurer is a MA plan. Medicare may consider secondary payment for all or part of an employer-sponsored MA Plan copayment.

A MA Plan pays providers a monthly capitation fee to care for its members. Because of this reimbursement, there are no billed charges for the rendered services. Medicare will consider the Medicare fee schedule amount as the billed charge. This amount will also be considered the primary insurer's allowed amount in calculating Medicare liability.

Since providers collect MA plan copayments at the time of service, a copayment receipt signed by the beneficiary must be submitted with the claim. The receipt will be accepted in lieu of the primary benefits statement or explanation of benefits (EOB) required in all other Medicare secondary payer situations. The receipt must clearly indicate "HMO copayment." A copy of the HMO/MA plan copayment form is available on the forms ([JH](ddocname:00088694)) ([JL](ddocname:00088692)) page of our website.

* When an acceptable co-payment receipt is not submitted with a claim, payment for these services may be delayed or could result in a denial of the claims. HMO/MA co-payment receipts submitted with Medicare secondary payer claims should meet certain requirements.
* The original co-payment receipt signed by the beneficiary on the date they were seen should be attached to the claim form.
* Should be one receipt for each date of service submitted on the claim form.
* If the patient did not pay the co-pay at the time of the service, a co-pay receipt should not have been submitted with the claim. A receipt should only be issued to the patient if the patient paid the co-pay at the time of their service.

Medicare will send any reimbursement for non-assigned claims submitted for MA plan copayment to the beneficiary. For assigned claims submitted for MA plan copayment, Medicare's payment will be sent to the provider who in turn must reimburse the beneficiary.

Services obtained outside the MA plan

Generally, Medicare will not pay for services obtained from a source outside the MA plan. If a beneficiary wants or needs to go to a provider outside the plan, an authorization must be obtained from the MA plan.

If authorization is not obtained, the MA plan will not make payment. If the beneficiary has not been notified in writing of this rule and the MA plan will not make payment, Medicare will process the claim for payment.

Once the beneficiary has been notified, Medicare payment will not be made for future services obtained outside the plan.

MSP questionnaire

* CMS IOM [Pub. 100-05, Medicare Secondary Payer, Chapter 3, Section 20.2.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf)
* [Screening for Medicare secondary payer](ddocname:00144716)

MSP billing procedures

General requirements

When Medicare is the secondary payer, the claim must first be submitted to the primary insurer. The primary insurer must process the claim in accordance with the coverage provisions of its contract. If, after processing the claim, the primary insurer does not pay in full for the services, the claim may be submitted to Medicare electronically or via a paper claim for consideration of secondary benefits.

Note: It is the provider's responsibility to obtain primary insurance information from the beneficiary and bill Medicare appropriately. Claim filing extensions will not be granted because of incorrect insurance information.

The normal Medicare claims timely filing rules apply.

If you qualify for a waiver/exception under the Administrative Simplification Compliance Act (ASCA) to submit paper claims rather than electronic claims, the paper claim must include a copy of the primary insurer's EOB. The EOB should include the following information:

* Name and address of the primary insurer.
* Name of subscriber and policy number.
* Name of the provider of services.
* Itemized charges for all procedure codes reported.
* Detailed explanation of any denials or payment codes.
* Date of service.

Note: A detailed explanation of any primary insurer denial or payment codes must be submitted with the claim and EOB. If the denial/payment code descriptions or any of the above information is not included with the claim, it may result in a delay in processing or denial of the claim.

If the beneficiary is covered by more than one insurer primary to Medicare (e.g., a working aged beneficiary who was in an automobile accident), the explanation of benefits statement from both plans must be submitted with the claim.

Electronic claim submission

To submit MSP claims electronically, please refer to the American National Standards Institute accredited standard committee X12N implementation guide. The implementation guides are available for purchase on the [Washington Publishing Company’s website](http://www.wpc-edi.com/). To learn how to report MSP claims in your software, contact your software vendor.

For information on submitting MSP claims using the PC-ACE free billing software, please refer to the [PC-ACE user guide, section 3](ddocname:00081249).

For information on submitting MSP claims using Novitasphere (Part B only) direct data entry (DDE) function, please refer to the [DDE overview](ddocname:00082244).

Records are required in order to get an MSP claim processed. For a list of those records, please refer to [chapter 14](ddocname:00004555) of the electronic data interchange billing guide. When sending an MSP claim electronically, the EOB from the primary insurance does not need to be sent separately.

More information on billing electronic MSP claims is available in chapter 14 of the [EDI billing reference guide](ddocname:00004564).

Paper claim submission

When submitting a paper claim to Medicare as the secondary payer:

* The CMS-1500 (02-12) claim form must indicate the name and policy number of the beneficiary's primary insurance in items 11-11c. For additional instructions on completing the CMS 1500 (02-12) claim form when Medicare is secondary, please refer to the [CMS-1500 (02-12) claim form instructions when Medicare is secondary](ddocname:00144707) document on our website.
* Providers must submit a claim to Medicare if a beneficiary provides a copy of the primary EOB. The claim must be submitted to Medicare for secondary payment consideration with a copy of the EOB. If the beneficiary is not cooperative in supplying the EOB, the beneficiary may be billed for the amount Medicare would pay as the secondary payer.
* Providers must bill both the primary insurer and Medicare the same charge for rendered services. If the primary insurer is billed $50.00 for an office visit and they pay $35.00, do not bill Medicare the remaining $15.00. Medicare must also be billed for the $50.00 charge, and a copy of the primary insurer's EOB must be attached to the completed claim form.

Determining secondary liability

Medicare may pay secondary when the primary insurer does not pay the entire charge. Medicare will not pay, however, if the provider accepts or is obligated to accept the primary insurer’s payment in full or if the primary insurer pays the charge in full.

If the primary insurer does not pay in full, Medicare’s secondary liability is calculated follows:

* Compare the billed amount to the primary allowed amount and limiting charge amount (non-assigned claim only). Subtract the primary paid amount from the lowest number.
* Determine what Medicare would pay if they were the primary payer.
* Take the higher of the primary allowed amount or the Medicare allowed amount. Subtract the primary paid amount.
* Compare the results of the first three steps. Medicare’s liability is the lowest of the three numbers.

If the primary insurer does not pay for certain services because the services are not covered by the plan, the benefits have been exhausted, or the primary insurer’s payment is applied to the beneficiary’s deductible, Medicare may pay primary benefits for covered services. The explanation of benefits from the primary insurer must state a valid reason for not paying certain services in order for Medicare to consider primary payment.

When the primary insurer’s reason for denial states that a service is not payable because it is considered an integral part of another service or part of a primary procedure (or similar message), Medicare has no liability. An exception may be made when the primary insurer holds the beneficiary responsible to pay for the service.

Patient liability when Medicare is secondary

Agreements with all insurance companies must be reviewed prior to balance billing a patient for a Medicare secondary claim. Consider the following before attempting to bill the patient or try using our interactive [patient responsibility calculator](ddocname:00004481).

* Non-participating with both the primary insurer and Medicare – You may bill the lower of the limiting charge amount (115% times the Medicare non-participating amount) or the billed amount.
* Non-participating with Medicare only - You may bill an amount up to the primary insurer’s allowed amount.
* Participating with both the primary insurer and Medicare or participating with Medicare only - You may bill the patient an amount up to the Medicare fee schedule allowance.

Determining who pays when coverage changes during hospital stay

When a patient’s coverage changes from one insurer to another during the course of a hospitalization, which insurance is financially responsible for the care? Part A and Part B handle this situation differently.

Example: Patient has Medicare on 10/31, the same day they were hospitalized for a two week stay. On 11/1, the patient’s insurance coverage changes to a HMO.

Part A: Whichever insurance the patient had on the day of admission is the insurer responsible for the entire hospital stay. Therefore, Medicare would be responsible for the entire Part A bill.

Part B: Responsibility shifts from one insurer to the other on the exact date of termination and enrollment. So, in this example, Medicare would be responsible only for services rendered on 10/31, and the HMO would be responsible for physician services rendered 11/1 and after.

Medicare deductible on MSP claims

Medicare applies money to a beneficiary’s deductible regardless of primary insurer benefits. This means that even if the same charge is paid in full or in part by the primary insurer, Medicare’s fee schedule amount will be applied to the beneficiary’s deductible.

Medicare has certain rules that explain how much a patient is responsible for when Medicare deductible is applied on a MSP claim. These rules differ from the standard guidelines in regard to the patient’s liability when Medicare deductible is applied.

Assigned claims

You may bill up to the Medicare fee schedule, minus payments made by the primary and secondary insurance.

Non-assigned claims

* Non-participating with both the primary insurer and Medicare – You may bill the lower of the limiting charge amount (115% times the Medicare non-participating amount or the billed amount).
* Non-participating with Medicare only – You may bill an amount up to the primary insurer’s allowed amount.

Claim submission instructions

[CMS IOM Pub 100-05, Medicare Secondary Payer Manual, Chapter 3](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf)

MSP file information

The CMS is the central processor for all beneficiary information including insurance that is primary to Medicare. Medicare secondary claims process using the data stored on the Common Working File (CWF). The primary insurance CWF file, which is maintained by the MSP Contractor, contains the name, address, and effective/termination dates of the patient's primary insurance company.

Services improperly submitted to Medicare for secondary payment consideration will deny when the file shows that the patient has an insurance plan primary to Medicare. Consideration of secondary benefits will be made when the EOB information is submitted with the claim.

Patients are responsible for ensuring that CWF has current information on file. They can [contact](https://www.cms.gov/medicare/coordination-benefits-recovery/overview/contacts) the MSP Contractor by phone, mail, or fax to update the file.

The MSP Contractor became responsible for updating the Medicare MSP files, answering general MSP questions or responding to COB concerns. MSP data may be updated, as necessary, based on additional information received from patients, providers, attorneys, or third parties. Development may be required in order to confirm the information.

Patients or their representatives may contact the MSP Contractor at:

Ph: 855-798-2627 /TDD/TYY 855-797-2627  
Monday-Friday, 8 a.m. - 8 p.m.

Fax: 734-957-9598

Address general written inquiries to:

Medicare - MSP General Correspondence  
P.O. Box 138897  
Oklahoma City, OK 73113-8897

Fax: 405-869-3307

Special projects:  
(e.g., all product liability case inquiries and special project checks)

Special Projects  
P.O. Box 138868  
Oklahoma City, OK 73113

Fax: 405-869-3309

Self-calculated conditional payment amount option and fixed percentage option:

Self-Calculated Conditional Payment Amount/Fixed Percentage Option  
P.O. Box 138880  
Oklahoma City, OK 73113

Fax: 405-869-3309

Please mail voluntary data sharing agreement (VDSA) correspondence to:

Voluntary Data Sharing Agreement Program  
P.O. Box 660  
New York, NY 10274-0660

Fax: 405-869-3306

Please mail workers’ compensation set-aside arrangement (WCMSA) proposal/final settlement to:

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

Fax: 405-869-3306

Use the MSP general correspondence address above if you do not see your special project.

References

* [CMS IOM Pub. 100-05 Medicare Secondary Payer Manual](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html)
* [MSP specialty page](ddocname:00134388)
* [Medicare secondary payer booklet](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/msp_fact_sheet.pdf)

[Medicare secondary payer: Don’t deny services & bill correctly](https://www.cms.gov/files/document/mln7748519-medicare-secondary-payer-dont-deny-services-bill-correctly.pdf)