# **UNDERSTANDING THE "NOTICE OF MEDICARE PREMIUM PAYMENT DUE" FORM (CMS-500)**

### **BILLING NOTICE DATE**

The date the notice was selected for printing for this billing period.

### YOUR CLAIM NUMBER

Your Medicare claim number. \*Please write this number on your check or money order.

### **BILLING INFORMATION**

- Current amount due for Part A and/or Part B, \*if this is the first billing you received, it may also include premiums owed for previous months not already billed.
- Past due amount and period already billed for Part A and/or Part B.
- · Current amount and period due for Part D IRMAA.
- Past due amount and period already billed for Part D IRMAA.

### **TERMINATION DATE**

The date your Medicare insurance will end if you do not send the 'past due amount' by the due date shown. The termination date is shown only on final 'delinquent' notices.

### **PAYMENT PORTION**

Cut or tear off the bottom portion of the notice and return it with your payment (or credit card information).

### **AMOUNT PAID**

Write in the exact amount of your check, money order, or credit card payment.

# VISA/MASTERCARD/AMERICAN EXPRESS/DISCOVER NUMBER

You may pay premiums with a Visa, Mastercard, American Express or Discover credit card. To use this option write in your credit card account number, expiration date, and sign the form. *Credit card payments require a signature and must be returned in the envelope provided.* 

,	
	CMS-500 (09/11)  U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)  NOTICE OF MEDICARE PREMIUM PAYMENT DUE  DILLING NOTICE DATE: mm/dd/yyyy  YOUR CLAIM NUMBER:  Use Visa/MasterCard/American Express/Discover or make check/money order payable to "CMS Medicare Insurance." Send payment with the bottom portion of this notice in the enclosed envelope to:  Medicare Premium Collection Center P.O. Box 790355  St. Louis, MO 63179-0355  Hospital Medical Insurance + IRMAA = Total Amount  Current amount due for Part A and/or Part B mm/dd/yyyy - mm/dd/yyyy \$00.00 \$00.00 \$00.00  Past due amount for Part A and/or Part B mm/dd/yyyy - mm/dd/yyyy \$00.00 \$00.00 \$00.00  \$00.00
	Current amount due for IRMAA Part D mm/dd/yyyy - mm/dd/yyyy \$00.00 \$00.00 \$00.00 \$06.00 past due amount for IRMAA Part D mm/dd/yyyy - mm/dd/yyyy \$00.00 \$00.
	Last payment received:
1	▼ Please tear at dotted line and return bottom portion with payment ▼
	If your name or address has changed or is incorrect, check here and complete the back of this notice.  If the person is deceased, check here.  CLAIM NUMBER:
	Show claim number on check or money order.  AMOUNT PAID: \$   AMOUNT DUE: \$ \$00.00 DUE BY: mm/dd/yyyy
	VISA/MASTERCARD/AMERICAN EXPRESS/DISCOVER NUMBER:  Make check/money order payable to: CMS MEDICARE INSURANCE  DO NOT SEND CASH OR STAMPS.  SEND PAYMENT TO:  MEDICARE PREMIUM COLLECTION CENTER
	SIGNATURE: P.O. BOX 790355 ST. LOUIS, MO 63179-0355  (over)

# **NOTICE TYPE**

Some people with Medicare are billed either monthly or quarterly. If you are billed for Part A or IRMAA Part D, you will be billed monthly. If this box says:

- **FIRST NOTICE**, it means payments are received timely or this is your initial bill.
- **SECOND NOTICE**, it means a payment is late by at least 60 days.
- **DELINQUENT NOTICE**, it means a payment is late by at least 90 days and you could lose your Medicare coverage.
- **ESTATE NOTICE**, it means a payment is due for a deceased beneficiary.
- THIS IS NOT A BILL, it means a payment will be deducted from your bank account (usually occurs on the 20th of the month).

### PART A, PART B, & PART D PARTICIPATION

Some people with Medicare pay for:

- · Hospital Insurance (Part A) only,
- Medical Insurance (Part B) only, \*Some people pay more than the standard Part B Premium because they enrolled late; they disenrolled from the Medicare Program and later reenrolled; they have a higher yearly income (and are subject to an Income Related Monthly Adjusted Amount or IRMAA).
- Part D IRMAA only, this extra amount for Part D is in addition to the Medicare Part D premium.
- More than one part (Part A, Part B, Part D IRMAA).

### **TOTAL AMOUNT DUE**

This is the amount you now owe. It is the total of the current and past due amounts due for this billing period.

# **PAYMENT DUE BY**

Your premium payment is due by the 25th of the month.

### **CHECK BOXES**

Check any box that applies.

### **PAYMENT ADDRESS**

Send your check or money order with the lower, tear-off portion of the notice (or credit card information) in the return envelope provided.

# **IMPORTANT MEDICARE CUSTOMER INFORMATION**

Please read this information carefully. It provides important information about Medicare coverage, termination and rules for reapplying.

### **SPECIAL MESSAGES**

CMS uses this box to share important news about the Medicare program or Medicare premiums. Please read this information carefully each time you receive your "Notice of Medicare Premium Payment Due." Do not write messages to CMS in this box.

### **CHANGE OF NAME OR ADDRESS**

To change or correct your name or address, write the new information in the boxes provided. Use capital (upper case) letters when writing in the new information, and write only one letter or number in each box.

### IMPORTANT MEDICARE CUSTOMER INFORMATION

- If you do not pay your Part A or Part B premium, your Medicare insurance will be terminated. Even if your Medicare insurance ends, you must still pay the total premium amount you owe. You can reapply for Medicare only during the General Enrollment Period from January March each year. If you reapply, your coverage will start on July 1 of the year you reapply, and your payment amount may be higher because your coverage was interrupted.
- This bill may include an Income Related Monthly Adjustment Amount (IRMAA) for Part B based on your income.
- If you have questions about this notice, your Medicare Part A or Part B insurance, or the amount you have to pay, please write or visit any Social Security office, or call 1-800-772-1213. TTY users should call 1-800-325-0778.
- This bill may include an IRMAA for Part D based on your income. If you do not pay the IRMAA for Part D, you will be disenrolled from your Part D prescription drug plan, even if it is part of your employer coverage or Medicare Advantage plan. If your coverage is terminated and you re-enroll in Part D later, you will still have to pay any IRMAA for Part D you owed. Also, your Part D plan monthly premium may be higher because your coverage was interrupted.
- The IRMAA you pay for Part D may be higher than it was before because of new income or enrollment information
  we received from Social Security or other agencies. If you have questions about your IRMAA Part D bill amount,
  please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### SPECIAL MESSAGES

### ABOUT THIS BILL

This bill shows the current amount you owe. The dates in the "Current Amount Due" line show the months that this bill normally covers. If this is the first bill you have received, it may also include premiums owed for previous months not already billed. Please send your payment promptly.

### MEDICARE EASY PAY

Sign up to have your Medicare premiums automatically deducted from a bank account each month and you will not have to worry about late or lost payments.

To sign up for Automated Clearing House (ACH), automated premium payment deductions from your checking or savings account, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### **PAYMENTS BY CHECK**

When you pay by check, you authorize the Medicare Premium Collection Center (MPCC) to use the information from your check to make a one-time electronic funds transfer from your bank account. When the MPCC uses information from your check to make an electronic funds transfer, funds may be withdrawn from your bank account as soon as the same day your payment is received. You will not get your check back from your bank. If the MPCC cannot process your payment electronically, it will be processed as a check transaction. Your bank statement will show the transaction as "CMS Medicare" and this is your proof of payment.

• IF YOUR NAME OR ADDRESS HAS CHANGED OR IS DIFFERENT FROM THE NAME OR ADDRESS SHOWN ON THE FRONT OF THE FORM, PLEASE PRINT CORRECT INFORMATION BELOW:

Last Name:	First Name: MI:
Street Number:	Street Name:
P.O. Box:	Apartment Number:
City:	State: Zip Code:

# Understanding "The Notice of Medicare Premium Payment Due" Form

(CMS-500)



**Centers for Medicare & Medicaid Services**