MEDICARE PART A REIMBURSEMENT FORM

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

STEP 1: Personal Information

Social Security Number ___ — ___ — ____

-OR-

OPERS ID ____

Beneficiary Social Security Number
(Only if you are receiving a survivor benefit)
___ — ___ — ____

First Name ____ MI ____ Last Name ____

STEP 2: Reimbursement Options

- ◯ I am requesting Medicare A reimbursement for myself only.
- ◯ I am requesting Medicare A reimbursement for my spouse only.
- ◯ I am requesting Medicare A reimbursement for both my spouse and me.

STEP 3: Acknowledgment

- ◯ I have enclosed documentation that confirms the complete Medicare claim number, effective date of coverage, and premium amount for myself, or my spouse for whom I am requesting reimbursement. Acceptable document(s) that may include all or part of this information are: a statement issued by Social Security, a copy of your Medicare ID card, a notice of Medicare Premium Payment Due issued by Social Security.

I understand that reimbursement will be effective the month all proper documentation has been received by OPERS.

I certify the Medicare Part A premium for which I am seeking reimbursement is not being paid or reimbursed by any other organization.

I understand I am only entitled to this reimbursement as long as I, and/or the spouse for whom I am seeking reimbursement, am actively enrolled in Medicare Part A coverage and enrolled in a medical plan through the OPERS Medicare Connector or the OPERS group health plan.

I agree to notify OPERS immediately if I become ineligible for the Medicare Part A reimbursement or if the Medicare Part A premium amount changes.

Recipient Signature _____ Today's Date ___/___/___
Do not print or type name