Medicare FAQ

What is Medicare?
Medicare is a Federal health insurance program for people 65 years or older, certain people with disabilities, and people with end-stage renal disease (ESRD). Medicare has two parts -- Part A, which is hospital insurance, and Part B, which is medical insurance.

How do I get a new Medicare card if my card is lost, stolen, or damaged?
You can now request a replacement red, white, and blue Medicare card online on Social Security's web site. Your card will be mailed within 30 days to the address SSA has on record. This service can be accessed during the following hours:
- Monday-Friday: 5 a.m. until 1 a.m.
- Saturday : 5 a.m. until 11 p.m.
- Sunday : 8 a.m. until 10 p.m.
- Holidays : 5 a.m. until 11 p.m.

To make an online request, you will need the following information:
- Your last (exact) payment amount or the month and year you last received a payment if you have received benefits in the last 12 months
- Your name as it appears on your most recent Social Security card
- Your Social Security Number
- Your Date of Birth
- Your phone number in case we need to contact you about your request
- Your e-mail address (optional)

You may also need:
- Your Place of Birth
- Your Mother's Maiden Name (to help identify you)

This new service can be accessed via the Social Security Administration website. If you prefer, or if you are unable to use the online request to obtain a replacement Medicare card, call Social Security's toll-free number, 1-800-772-1213. Their representatives there will be glad to help you. You can also visit a local social security office. For the office closest to you try their Field Office Locator.

How can I get my name and address changed?
You may report a change of name or address by calling the Social Security Administration at 1-800-772-1213 or by visiting your local field office. Addresses and directions to the Social Security field offices may be obtained from the Social Security Office Locator. You can get more information on changing your name on Social Security's web site. If you get benefits from the Railroad Retirement Board, call your local RRB office, or call 1-800-808-0772.

How do I report the death of a beneficiary?
A family member or other person responsible for the beneficiary's affairs should do the following:
- Promptly notify Social Security of the beneficiary's death by calling SSA toll-free at 1-800-772-1213.
- If monthly benefits were being paid via direct deposit, notify the bank or other financial institution of the beneficiary's death. Request that any funds received for the month of death and later be returned to Social Security as soon as possible.
- If benefits were being paid by check, DO NOT CASH any checks received for the month in which the beneficiary died or thereafter. Return the checks to Social Security as soon as possible.

A one-time payment of $255 is payable to the surviving spouse if he or she was living with the beneficiary at the time of death, OR if living apart, was receiving Social Security benefits on the beneficiary's earnings record. If there is no surviving spouse, the payment is made to a child who was eligible for benefits on the beneficiary's earnings record in the month of death.

What is "assignment" in the Original Medicare Plan and why is it important?
Assignment is an agreement between Medicare and doctors, other health care providers, and suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies).

Doctors and suppliers who agree to accept assignment accept the Medicare-approved amount as payment in full for Part B services and supplies. You pay the coinsurance and deductible amounts. In some cases (such as if you have both

Medicare and Medicaid), your health care providers and suppliers must accept assignment.

If assignment is not accepted, charges are often higher. This means you may pay more. In addition, you may have to pay the entire charge at the time of service. Medicare will then send you its share of the charge.

There is a limit on the amount your doctors and providers can bill you. The highest amount of money you can be charged for a covered service by doctors and other health care providers who don?t accept assignment is called the limiting charge. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Why is assignment important when choosing a power wheelchair or scooter supplier?
Assignment is an agreement between Medicare and doctors, other health care providers, and suppliers of health care equipment and supplies (like wheelchairs, oxygen, braces, and ostomy supplies). Doctors, providers, and suppliers who agree to accept assignment accept the Medicare-approved amount as full payment. You pay the coinsurance (usually 20 percent of the approved amount) and deductible amounts. Using a power wheelchair or scooter supplier that accepts Medicare assignment can save you money.

If your power wheelchair or scooter supplier doesn't accept assignment, there is no limit to what they can charge. You may have to pay the entire bill (your share and Medicare's share) at the time you get your power wheelchair or scooter. Always ask a supplier if they are enrolled in Medicare. Suppliers who are enrolled in Medicare must accept assignment. If they aren?t enrolled in Medicare, Medicare won't pay your claim.

Is a power wheelchair or scooter supplier supposed to waive my coinsurance or Part B deductible?
The Medicare Part B deductible is the amount you must pay for health care before Medicare begins to pay. The coinsurance is the percent of the Medicare-approved amount that you have to pay after you pay the Part B deductible. In the Original Medicare Plan, the Medicare Part B coinsurance is generally 20 percent of the Medicare-approved amount for the item.

Medicare law requires a supplier of durable medical equipment, such as power wheelchairs and scooters, to bill Medicare for the supplier?s actual charge. Medicare pays 80 percent of the lesser of the supplier?s actual charge or the fee schedule amount, and you pay the remaining 20 percent. It is unlawful for a supplier to routinely waive the Medicare Part B coinsurance and deductible, because that results in Medicare paying 100 percent of the supplier's actual charge. However, a supplier may waive your coinsurance and/or deductible if you have a financial hardship and can?t pay your Medicare Part B deductible or coinsurance. If this applies to you, the supplier must document and show that an effort was made to collect your deductible and coinsurance.

Note: If your power wheelchair or scooter supplier routinely waives Medicare copayments and deductibles, you should report these actions to the appropriate Durable Medical Equipment Regional Carrier (DMERC) or by contacting the Inspector General's Hotline at 1-800-HHS-TIPS.

What is a Medicare deductible?
A deductible is the amount you must pay each year before Medicare begins paying its portion of your medical bill. There are deductibles for both the Part A (Hospital Insurance) and Part B (doctor services) portions of Medicare. Your deductible is taken out of your claims when Medicare receives them. Medicare will not start paying on your claims until you have met your annual deductible. The Medicare Part A deductible for 2005 is $912.00 per benefit period. The Medicare Part B deductible for 2005 is $110.00. If you have any questions on the status of your deductible please contact 1-800-MEDICARE (1-800-633-4227).

What is Durable Medical Equipment?
Durable Medical Equipment (or DME) is equipment which meets all of the following requirements:
- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Is generally not useful to a person in the absence of an illness or injury
- Is appropriate for use in the home

Often a physician will prescribe special equipment for use by a beneficiary in his/her home. The equipment may provide therapeutic benefits or enable the beneficiary to perform certain tasks that s/he is unable to undertake due to certain

medical conditions and/or illnesses.

What is included in the DME Category?
Some of the items included in the Durable Medical Equipment category, but not limited to:
- Diabetic supplies
- Canes, crutches, walkers
- Commode chairs
- Home oxygen equipment
- Hospital beds
- Power Operated Vehicles (POVs or scooters)
- Seat lift mechanisms
- Traction equipment
- Wheelchairs

Do I need a prescription to get a supply?
Certain covered items can be reimbursed by Medicare only if the doctor has furnished the supplier with a written prescription for the item before delivery. Supplies that require a prescription are listed below:
- Decubitus care cushions/mattresses
- Power Operated Vehicles (POVs), or scooters
- Seat lift mechanisms
- Transcutaneous electronic nerve stimulators (TENS)

Important Note: If the item is prescribed after the purchase date, the claim will be denied. Another words, you must have your prescription in hand before the item!

What is a Certificate of Medical Necessity?
A Certificate of Medical Necessity (CMN) is a form required by Medicare authorizing the use of certain durable medical items and equipment prescribed by a physician. This form is to be completed by your doctor or the doctor's employee. Your supplier will coordinate with your doctor to see that all the necessary information is submitted to Medicare. A change in prescription and/or a change in your condition requires that an updated certificate be completed and submitted.

What supplies require a certificate of medical necessity (CMN)?
The following items require a CMN:
- Air-fluidized beds
- Continuous Positive Airway Pressure (CPAP) devices
- Hospital beds
- External infusion pumps
- Lymphedema pumps/pneumatic compression devices
- Osteogenesis stimulators
- Parenteral and enteral nutrition
- Oxygen
- Power Operated Vehicles (POVs), or Scooters
- Seat lift mechanisms
- Transcutaneous electronic nerve stimulators (TENS Units)
- Wheelchairs

What is a "capped rental" item?
A capped rental category consists of any item which meets the following qualifications:
- Not customized
- Not oxygen or oxygen related
- Not routinely purchased
- Not service intensive

The capped rental program enables beneficiaries to spread their share of the rented item's cost (i.e. coinsurance) over an extended time period rather than paying in a lump sum. This also protects the beneficiary from making an incorrect purchase decision.

What are some "capped rental" products?
Some examples of capped rental items include, but are not limited to, the following items:
- Continuous Positive Airway Pressure (CPAP) devices
- External infusion pumps
- Hospital beds
- Nebulizers
- Air-fluidized beds
- Wheelchairs

Information provided by Medicare and gathered from the Official U.S. Government Site for people with Medicare. All of the answers above can be found at http://www.medicare.gov/.