Medicare Secondary Payer Change Form

2550 Denali Street, Suite 1404
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PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Important information to assist your group in complying with the Medicare Secondary Payer ("MSP") laws.
See the back of this sheet for relevant MSP definitions. Refer to the Medicare Secondary Payer Overview for information on the purpose of this form.

If you answer "No" to questions 2, 3 and 4 below you do not need to submit this form.

GROUP INFORMATION

1. A. *Group Name* _____
   B. *Group ID* _____
   C. *Address* _____
   D. *City, State, Zip* _____
   E. *Contact Person Name* _____
   F. *Contact Person Phone* _____
   G. *Are you part of a Multiple Employer Group Health Plan?* ❑ *Yes* ❑ *No*

2. Since submission of your last Group Master Application, are you reporting a change in group size? ❑ *Yes* ❑ *No*
   If no, skip to section 3.
   A. My group had less than 20 employees under MSP rules and now has 20 or more employees under MSP rules. ❑ *Yes* ❑ *No*
   B. My group had 20 or more employees under MSP rules and now has less than 20 employees under MSP rules. ❑ *Yes* ❑ *No*
   C. My group had less than 100 employees under MSP rules and now has 100 or more employees under MSP rules ❑ *Yes* ❑ *No*
   D. My group had 100 or more employees under MSP rules and now has less than 100 employees under MSP rules. ❑ *Yes* ❑ *No*
   E. If you answered yes to any of the above, complete the following:
      - Total employee count reported previously _____
      - Current total employee count _____
      - Effective date of change in employee count _____

3. Since submission of your last Group Master Application, are you reporting changes to employee work status for any of your Medicare-eligible employees? ❑ *Yes* ❑ *No*
   If the answer is "yes", please complete the following:

Change of Enrollee Work Status:

Enrollee Name (Last, First, Middle Initial):			Enrollee Social Security Number:		
Prior Enrollee Status: (check one)	❑ Current Employment Status: (see back for definition)	❑ Retired as of: / /	❑ Disabled as of: / /	❑ COBRA as of: / /	
New Enrollee Status: (check one)	❑ Current Employment Status: (see back for definition)	❑ Terminated as of: / /	❑ Retired as of: / /	❑ Disabled as of: / /	❑ COBRA as of: / /

4. Since submission of your last Group Master Application, do you have additional Medicare-eligible employees? ❑ *Yes* ❑ *No*
   If the answer is "yes", please complete the following:

Enrollee Name (Last, First, Middle Initial):			Enrollee Social Security Number:	
Enrollee Status: (check one)	❑ Current Employment Status: (see back for definition)	❑ Retired as of: / /	❑ Disabled as of: / /	❑ COBRA as of: / /

I certify that the information provided above is true. If there is a change to this status, I understand that it is the group health plan's responsibility to advise Premera Blue Cross Blue Shield of Alaska promptly of the change.

Print Name: _____ Title: _____

Signature of Group Health Plan Representative: _____ Date Signed: _____

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Medicare Secondary Payer Definitions

"Current Employment Status" means when an individual (1) is actively working as an employee; (2) is the employer; (3) is associated with the employer in a business relationship (e.g., as a supplier or contractor who does business with the employer); (4) is not actively working but is receiving disability benefits from an employer for up to six months; or (5) is not actively working but meets all of the following conditions: the individual (a) retains employment rights in the industry; (b) has not had his/her employment terminated by the employer where the employer provides the coverage or has not had his/her membership in an employee organization terminated where the employee organization provides the coverage; (c) is not receiving disability benefits from an employer for a period of more than six months; (d) is not receiving disability Social Security benefits, and (e) has Group Health Plan coverage that is not pursuant to COBRA continuation benefits. 42 U.S.C. § 1395y(b)(1)(E)(ii); 42 C.F.R. § 411.104.

An employer employs **"20 or More Employees"** if the employer employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. 42 C.F.R. § 411.170(a)(2)(i). The 20 calendar weeks do not have to be consecutive. COB News, Vol. 5 (March 2004). (Please note that this test differs from the 20 employee test for COBRA purposes). In determining whether employees are treated as employees of a single employer for purposes of the MSP rule, and whether leased employees are considered employees, the MSP regulations look to Internal Revenue Code provisions and guidance (as evidenced in the "aggregation rules" set forth in regulation and the CMS MSP Manual). See 42 C.F.R. § 411.106.

An employer (or employee organization) is considered to meet the **"100 or more employees"** requirement where the employer or employee organization employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year. This requirement is also met where a multi-employer group health plan has two or more employers, or employee organizations, at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year. 42 C.F.R. § 411.101 (Definitions).