#### Medical Care Availability and Reduction of Error Fund | PA Insurance Department

Claims Administration Division | PO Box 12030 | Harrisburg, PA 17108-2030 | Phone: 717.783.3770 | Fax: 717-787-0651

**Primary Carrier's Medicare Secondary Payment Information**

## Case Name\*

Mcare File No.\* Your File No.

## Claimant's Legal Full Name\*

Exactly as it appears on their Social Security or Medicare Card

## Social Security No.\* Medicare HICN

Date of Birth\* MM/DD/YYYY

## Gender\* Male Female

MMSEA REPORTING DETAILS

Injury Code\*

Diagnosis Code(s)

### Date of Incident (DOI) Reported to CMS\* MM/DD/YYYY

ICD-9\*

ICD-9

ICD-9

ICD-9

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Per Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), I submit the following claim payment details that were reported to CMS on behalf of the named carrier's insured health care provider.

### Primary Carrier Name\*

Person Completing Form\*

Mcare Submission Date\* MM/DD/YYYY

Mcare appreciates receiving your reported MMSEA claim payment data elements. Please remember, an incomplete, incorrect or a delay in providing requested data elements may postpone claimant's Mcare payment.

#### PREFERRED METHOD OF SUBMISSION

**Complete form and convert to a PDF format. PRINT, then e-mail to the below address.**

Submit Form by e-Mail:

[RA-IN-MCARE-MSP@pa.gov](mailto:RA-IN-MCARE-MSP@pa.gov)

Print Form