MEDICARE
Centers for Medicare and Medicaid Services

PURPOSE
Medicare is a federal health insurance plan administered by the Centers for Medicare Services (CMS) for persons age 65 and older, and for eligible individuals with disabilities. The Social Security Administration (SSA) helps CMS by enrolling people in Medicare and by collecting Medicare premiums. Eligibility is NOT based on need or income/asset limits.

Medicare - Part A covers hospital and related health care.

Medicare - Part B is a voluntary medical insurance program that provides assistive technology (AT) purchased as Durable Medical Equipment (DME) and must be "necessary and reasonable."

Medicare - Part D is a voluntary insurance for prescription drugs.

CONTACT
For information about applying for Medicare, eligibility, or replacing a lost Medicare card contact the Social Security Administration:
(800) 772-1213
www.medicare.gov

For general Medicare information call the Medicare Hotline: (800) 633-4227

ELIGIBILITY
- Individuals 65 years of age or older;
- have been receiving Social Security Disability Insurance (SSDI) payments for twenty-four months as a result of being blind or have a permanent disability;
- have End Stage Renal Disease; or
- Amyotrophic Lateral Sclerosis (ALS).

AT SERVICES PROVIDED/COVERED
- Assessments & Evaluations
- Maintenance & Repairs

AT DEVICES PROVIDED/COVERED

 Aids for Daily Living

 Mobility/Seating & Positioning

 Aids for Vision Impaired

 Speech Communication

APPLICATION PROCESS
- Applications for a Medicare health insurance card are taken at all local offices of the Social Security Administration. For eligibility information and to locate the Social Security Office nearest you, call the Social Security information hotline at (800) 772-1213.
- Apply on-line at www.medicare.gov

APPEALS PROCESS
1. If Medicare makes a decision you disagree with, you can file an appeal. If you disagree with the decision made at any level of the process, you can generally go to the next level. After each level, you will be given instructions on how to proceed to the next level of appeal.
2. Level 1 is a redetermination by the company that handles claims for Medicare. A redetermination is a second look at a claim. If you disagree with the decision made on your claim, you must request a redetermination within 120 days from the date you got your Medicare Summary Notice (MSN). Follow the directions on the MSN to do this. You will get a response called a "Medicare Redetermination Notice" about 60 days after the company gets your appeal request.
3. If you disagree with the redetermination decision in level 1, you have 180 days after you get your decision to ask for a reconsideration. This is the second level of appeal.
4. Level 2 is a reconsideration by the Qualified Independent Contractor (QIC).
5. To check the status of your reconsideration you can call 1-800-Medicare (800 633-4227).
6. For assistance, contact the Office of the Medicare Ombudsman's (OMO) by calling the above number. They can receive and provide help regarding complaints, grievances, and requests for information from people with Medicare.