QUALIFIED MEDICARE BENEFICIARY (QMB) REFERRAL

APPLICANT NAME:			ADDRESS:
SSN:	DOB:	SEX:	
MEDICARE HIC#:			
PHONE:			

The person named above is an applicant for the Qualified Medicare Beneficiary (QMB) Program. Medicare eligibility status must be confirmed before the State can begin paying his/her Medicare premiums, deductibles and coinsurance.

INSTRUCTIONS: COUNTY WELFARE DEPT. – Please complete Part I.
SSA – Please enroll applicant in Medicare and complete Part II. Have the applicant return this form to the county.

PART I COMPLETED BY COUNTY DEPARTMENT OF SOCIAL SERVICES/WELFARE.

- ☐ Currently eligible for Part B; however, must apply for **conditional** Part A.
- ☐ Not currently enrolled in either Medicare Part A or Part B. Please enroll the applicant in **conditional** Part A and Part B (if eligible)
- ☐ Medicare status unknown

COUNTY WELFARE ADDRESS:	EW NAME/EW#:	PHONE:	DATE:

PART II COMPLETED BY SOCIAL SECURITY ADMINISTRATION

- ☐ Eligible for **conditional** Medicare Part A effective _____. Please evaluate for QMB eligibility.
- ☐ Currently receiving Medicare Part A.
- ☐ Must reapply during the general enrollment period.
- ☐ Not eligible for Part A or B because:

SSA SIGNATURE:	TITLE:	PHONE:	DATE: