PSHB Senior Advantage 2 Proof of Part B Premium Instructions

We will automatically reimburse you for the standard Medicare Part B premium. You only need to submit proof of the total amount you pay for Part B if you pay extra charges for the late enrollment penalty or Income Related Monthly Adjustment (IRMAA) and indicate the amount on the attached form. You must submit this proof once each plan year.

Below is a list of sample documents we accept as proof of the total amount you pay for Part B, along with how you can get each document. The document must include the amount you pay for IRMAA or the late enrollment penalty. We cannot accept credit card billings, bank statements or IRS Form 1099.

How do you pay your Part B premium?	Documentation you should submit	How you may obtain documentation
Withheld from my Social Security check	**Benefit Verification Letter** from Social Security[1]	• Download a copy online at http://www.ssa.gov/myaccount • Call Social Security at **1-800-772-1213** (TTY **1-800-325-0778**) between 7 a.m. and 7 p.m. Monday through Friday. • Visit your local Social Security office
Withheld from my federal retirement check	**Notice of Annuity Adjustment** from the Office of Personnel Management (OPM).	• Download a copy online at www.servicesonline.opm.gov • Contact OPM's Retirement Information Center by phone at 1-888-767-6738 (TTY: 1-855-887-4957) or by email at retire@opm.gov.
Medicare premium bill	**Medicare Premium Bill**	• Call Social Security at **1-800-772-1213** (TTY **1-800-325-0778**) between 7 a.m. and 7 p.m. Monday through Friday. • Visit your local Social Security office

Submit your documentation, along with the attached form, to Kaiser Permanente Health Payment Services.

[1] The Benefit Verification Letter may be called a "budget letter", "benefits letter", "proof of income letter" or "proof of award letter".

PSHB Senior Advantage 2 Proof of Part B Premium Form

Please complete and send a separate cover sheet for each Senior Advantage 2 member in your family.

Member Name (Last, First, MI)*			
Address*			
City*	State*	Zip*	Telephone*
E-mail*			
Medical/Health Record Number*	Social Security Number*		Date of Birth*
Extra monthly amount you pay for late enrollment penalty or IRMAA*	$		

* Required Fields

Attach your proof to this cover sheet and send to us by mail, fax or email:

Mail	Kaiser Permanente Health Payment Services PO Box 1540 Fargo, ND 58107-1540
Fax	1-877-535-0821
Email	kp@healthaccountservices.com

Make sure the documentation you submit contains your name and address. Do not highlight documents. Missing information may result in the denial or delay of your request.

Attestation

To the best of my knowledge the provided information is complete and accurate. I understand that I am submitting this form to be reimbursed for specified expense(s). I certify that the requests I am submitting are eligible expenses for an eligible individual as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Kaiser Permanente including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I understand that I should retain a copy of all submitted documentation. If there are any changes in the provided information, I understand it is my responsibility to notify Kaiser Permanente.

Signature _____ Date _____

Questions about this form or reimbursement?

Please call the Health Payment Services team at 877-761-3399 (Monday through Friday, 5:00 a.m. to 7:00 p.m. Pacific Time).