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

Reset Form

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.* Date of Birth* MM/DD/YYYY

Medicare HICN Gender* Male Female

MMSEA REPORTING DETAILS

Injury Code* Date of Incident (DOI) Reported to CMS* MM/DD/YYYY

Diagnosis Code(s)

ICD-9*	ICD-9	ICD-9
ICD-9	ICD-9	ICD-9
ICD-9	ICD-9	ICD-9
ICD-9	ICD-9	ICD-9
ICD-9	ICD-9	ICD-9

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

Print Form

Reset Form