NEW YORK STATE OF OPPORTUNITY. | Department of Civil Service

Medicare Part B
Income Related Monthly Adjustment Amount (IRMAA)
Reimbursement Application

IRMAA 1/2022APPL

Please complete this form ONLY if you and/or your dependent were subject to the Medicare Part B Income Related Monthly Adjustment Amount (IRMAA).

ENROLLEE INFORMATION

Name (Last) (First) (MI)	**Last four digits of SSN** X X X – X X – __ __ __ __

Mailing Address ☐ **Check here if this is a change of address**

Street: _____

City: _____ State: _____ Zip Code: _____

Personal Email Address _____

Telephone Home: (____) _____ Cell: (____) _____

DEPENDENT INFORMATION

Name (Last) (First) (MI)	**Last four digits of SSN** X X X – X X – __ __ __ __

Application is for (check all that apply) ☐ Self ☐ Dependent

Application is for which year? (check all that apply) ☐ 2021 ☐ 2020 ☐ 2019 ☐ 2018*

*Applications requesting reimbursement of 2018 amounts must be received by 4/15/2022

2021 Medicare Part B premium including IRMAA ☐ $207.90 ☐ $297.00 ☐ $386.10 ☐ $475.20 ☐ $504.90

REQUIRED DOCUMENTATION

Please enclose all required documentation for each person for which you are applying.

☐ A copy of the notice from Social Security Administration outlining your premium for Medicare Part B including IRMAA for each year you are applying for reimbursement, **and**

☐ Proof of Payment for ALL months of Medicare Part B premiums for each eligible person. (See the reverse side of this form for acceptable proofs)

SIGNATURE (Required)

By completing and signing this application, I certify that I and/or my dependent(s) were required to pay an Income Related Monthly Adjustment Amount (IRMAA) for Medicare Part B, and were not reimbursed by another source.

Enrollee Signature: _____ **Date:** _____

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Form Submission

Send this form and all required documentation to our secure fax number at (518) 485-5590

or mail to:
NYS Department of Civil Service, Employee Benefits Division
Empire State Plaza, Core Bldg 1
Albany, NY 12239

Please Note: IRMAA reimbursement for both the enrollee and dependent will be issued to the enrollee only. In order for the Employee Benefits Division to speak with a dependent regarding the IRMAA application, the enrollee must complete and sign the NYSHIP Authorization for Release of Protected Health Information Form (EBD-543). You may obtain this form online at www.cs.ny.gov.

Acceptable Proof of Payment Chart

Documentation is required for each person for whom you are applying. Proof of payment must indicate payments made for all months of each year.

Did you collect Social Security or Railroad Retirement benefits?	Enclose Proof of Payment of Medicare Part B premium:	Where can you obtain this proof?
Yes	**Form SSA-1099** or **RRB-1099** (Retirement Benefit Statement)	Social Security Administration, or Railroad Retirement Board
No	**CMS-500** Medicare Premium Bill (Submit bill for each period paid)	Centers for Medicare and Medicaid Services (CMS)
Partial Year	**SSA-1099 and CMS-500** or **RRB-1099 and CMS-500**	(See above)

Contact Information

Social Security Administration (SSA)	Centers for Medicare and Medicaid Services (CMS)	Railroad Retirement Board (RRB)
www.ssa.gov/onlineservices	www.cms.gov	www.rrb.gov/Benefits/Medicare
1-800-772-1213	1-800-633-4227	1-877-772-5772

Personal Privacy Protection Law Notification: The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law. Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director of the Employee Benefits Division, Department of Civil Service, Albany, NY 12239; telephone (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.