**Provider Tracking Tool**

**Provider Name**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Resident Name** | **Medicare  Number** | **Medicare  Part A Y or N** | **Medicare  Part B Y or N** | **Date Applied and  Type (A / B)** | **Date of Response** | **Response and Comments** |
| **Column 1** | **Column 2** | **Column 3** | **Column 4** | **Column 5** | **Column 6** | **Column 7** |
| Mary Medicare | 123-45-6789-A | N | Y | 1/10/XX – Part A | 1/29/XX | Part A Approved |
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**Provider Tracking Tool**

**Open Enrollment for 2023**

|  |  |  |  |
| --- | --- | --- | --- |
| **Steps** | **Action** | **Responsible Person** | **Deadline Date** |
| **Step 1** | Assemble your team to include: Administrator, MDS Coordinator, Business Office Manager, Social Worker, Director of Nursing, Therapy Representative. | Administrator |  |
| **Step 2** | Complete the attached roster (columns 1-4) for **ALL current residents and any new admissions**. Add new admissions on an ongoing basis. | Business Office Manager |  |
| **Step 3** | Obtain the Medicare Enrollment form from your local Social Security office. | Social Service |  |
| **Step 4** | If resident is determined not to have Medicare, research the resident’s financial folder and eligibility status. | Business Office Manager |  |
| **Step 5** | Discuss with resident or Responsible party the benefits of completing an application for enrollment in Medicare and the financial implications to the resident and/or responsible party. | Social Service |  |
| **Step 6** | Complete applications for ALL residents without Medicare. | Social Service |  |
| **Step 7** | Submit the Application to Social Security. | Social Service |  |
| **Step 8** | File all completed applications in financial folder. | Business Office Manager |  |
| **Step 9** | Follow-up with Social Security Office following submission of applications. | Social Service |  |
| **Step 10** | Update roster (column 6 & 7) with responses from Social Security Office. | Social Service |  |
| **Step 11** | Complete the process for **any** new admissions (without Medicare benefits) **admitted between October 15th-December 7th.** | Medicare/MDS Coordinator |  |

**Request for Information from Social Security Records**

Individual’s Name:

first middle last

Social Security Number: – –

Date of Birth: / /

Medicare Claim Number:

I authorize Social Security to release verification of my Medicare claim number, Medicare eligibility dates, or date of birth to:

Name of Provider Requesting Information

Signature of Individual Date

Please Provide (check appropriate lines)

1) Verification of eligibility to Medicare

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Part A Hospital | Part A date = |  |  |
|  | Part B Medical | Part B date = |  |  |
|  |  |  |  |  |
|  |  | for SSA use only | | |

2) Verification of Medicare Claim Number

|  |
| --- |
|  |
| for SSA use only |

3) Verification of Date of Birth:

|  |
| --- |
|  |
| for SSA use only |

Name of Person Requesting Information:

Phone Number: ( ) –

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  | Signature of SSA employee providing information |
|  |  |  |