BLUE CROSS AND BLUE SHIELD OF OKLAHOMA (BCBSOK) ANNUAL MEDICARE SECONDARY PAYER (MSP) EMPLOYER ACKNOWLEDGEMENT FORM

BlueCross BlueShield of Oklahoma

Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. Please refer to the enclosed document titled "Instructions – Completing the MSP Employer Acknowledgement Form" for more details. **In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare.**

Please complete this form, sign, date, and return to BCBSOK as soon as possible.

Employer Name – Legal Name of Company:		Employer Identification Number (EIN):	
Physical Address (number & street), City, State, ZIP:			
Contract/Policy Effective Date (new clients, only): ______ month/day/year	Contract/Policy Anniversary Date (renewing clients, only): ______ month/day/year	Group Number(s):	Account Number(s):
Do you have any affiliates or subsidiaries? ☐ Yes ☐ No If "yes", list name of each:			

Question	Yes	No
1. Do you file a separate federal tax return, i.e. not consolidated with another individual or entity?	☐ Yes	☐ No
2. How many employees did all the entities on the tax return have on the payroll (whether full-time, part-time, seasonal, or partners) during the prior calendar year? Enter number of employees in space provided. If the total number of employees entered is 100 or more, skip to question 6.	______ (# of employees)	
3. Are you part of a multi-employer group health plan? The term "multi-employer group health plan" means any trust, plan, association or any other arrangement made by one or more employers or by employers and unions to offer, contribute to, sponsor, or directly provide health benefits.	☐ Yes	☐ No
4. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding year? Please note: If you answered "No", you must promptly notify BCBSOK if your answer changes to "Yes" at any time.	☐ Yes	☐ No
5. If you are part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding year?	☐ Yes	☐ No
6. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the previous calendar year? Please note: If you answered "No", you must promptly notify BCBSOK if your answer changes to "Yes" at the beginning of a calendar year.	☐ Yes	☐ No
7. If you are part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the previous calendar year?	☐ Yes	☐ No

I understand that BCBSOK is relying on my answer to the above questions to determine whether Medicare will be the primary payer of claims for my Medicare eligible insured(s). I certify that the answers are true to the best of my knowledge and belief. I also understand that I am responsible to promptly notify BCBSOK, as indicated above, if my answers to the above questions change because we have increased the number of employees.

______________________________ Signature of company officer or authorized representative

______________________________ Print Name

______________________________ Title

______________________________ Date

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