Medicare Minute Teaching Materials
Medicare Summary Notices

Q: What is a Medicare Summary Notice (MSN)?
A: Your Medicare Summary Notice is a summary of claims for health care services Medicare processed for you in the past three months, which your doctor submitted to Medicare. A claim is a bill that your doctor sends to Medicare that asks for payment for the services you got. Your doctor has one calendar year after you received a service to send the claim to Medicare, although many doctors submit claims shortly after providing a service. Your MSN will list all of the claims your doctor submitted to Medicare. Your MSN is not a bill.

MSNs are mailed four times a year and contain information about submitted charges, the amount that Medicare paid, and the amount you are responsible for.

The most important fields on your MSN explain:

- **The maximum amount your doctor or other provider may bill you:** The "You May Be Billed" field indicates the total amount the provider is allowed to bill you. It does not include what your supplemental insurer might pay. If you have supplemental insurance, Medicare forwards your MSN to your supplemental insurer, which may pay part or all of your costs. You will be responsible for the balance after Medicare and your supplemental insurance have paid.
- **Non-covered charges, if any:** The "Non-Covered Charges" field on the Part A portion of your MSN shows charges for services Medicare denied coverage for or that are excluded (never covered) by Medicare. A $0.00 in this field means there were no denied or excluded services. If you disagree with a non-covered charge, you can appeal.
- **Medicare paid provider:** The “Medicare paid provider” field on the Part B portion of your MSN shows the amount Medicare paid to the provider for a service. If your claim is denied then this section will be $0.00 and you should check the notes section for details of why the claim was denied. Note that for unassigned claims, this column is called “Medicare Paid You.”
- **Notes:** The “notes” section gives important details about the claims listed on the MSN. For example, it may say if a claim is being sent to your supplemental insurance.

Q: Do I need to save my MSNs?
A: Try to save your MSNs for about seven years. You might need them in the future to prove that payment was made or that services were received if you claimed a medical deduction on your taxes. If you lost an MSN or need a duplicate copy, call 800-MEDICARE. You will be redirected to the Medicare carrier who originally sent the MSN, which can send you a copy.
Q: Can I check my Medicare Summary Notice online?

A: You can access your Medicare Summary Notice online at www.mymedicare.gov. The e-MSN lets you look at your MSNs on the web and print copies from your computer, 24 hours a day, seven days a week. You can view your claims online usually within 24 hours of being processed.

Q: I think the Medicare Summary Notice is hard to understand. Is anything being done to change that?

A: The Medicare Summary Notice is being redesigned, so the MSN you get in the mail will soon look a little different. This redesigned paper version will be sent starting in 2013. The new design is already available to people who look at their MSNs online at mymedicare.gov.

According to CMS, the redesigned MSN will include these new features:

- Information about how to check the notice for important facts and potential fraud
- An easy-to-understand snapshot of the beneficiary’s deductible status, a list of providers they saw, and whether their claims for Medicare services were approved or denied
- Clearer language, including consumer-friendly descriptions for medical procedures
- Definitions of all terms used in the form
- Larger fonts to make it easier to read
- Information on preventive services available to people with Medicare

You can see how the new design looks in comparison to the current MSN design at this link: http://www.cms.gov/apps/files/msn_changes.pdf

Q: I have a Medicare Advantage plan. Will I get a Medicare Summary Notice?

A: No, MSNs are only for people with Original Medicare. When Original Medicare processes a claim for health care services you received, the claim is detailed in a Medicare Summary Notice (MSN). People who have a Medicare Advantage plan may get a different document that details the health care services they’ve received. This is called an Explanation of Benefits (EOB). Like an MSN, an EOB is not a bill. It shows how much a provider charged for a service, how much your plan paid and how much you owe. It will also show if a service was denied. Currently, Medicare Advantage plans aren’t required to send you an EOB but many do.
Q: What does a Medicare Summary Notice look like?

A: The following pages show a sample MSN broken down by section. This is what the current MSN looks like. Starting in 2013, MSNs that you get in the mail will look different.

Here’s the top portion of a Medicare Summary Notice (MSN). The top portion of the MSN is the same for both Part A and B services.

1. **Date:** Date MSN is sent.

2. **Customer Service Information:** Who to contact with MSN questions. When calling someone with questions about your MSN, give your Medicare number (3), date of the MSN (1), and date of service you have a question about (9).

3. **Medicare Number:** The number on your Medicare card.

4. **Name and Address:** If incorrect, contact the Social Security Administration at 800-772-1213 immediately. If you have Railroad Retirement Board benefits, call your local RRB office or 800-808-0772.

5. **Be Informed:** Messages about ways to protect yourself and Medicare from fraud and abuse. If you think you’ve been the victim of fraud – for example, if your doctor billed Medicare for services you didn’t receive – you can call 800-MEDICARE to report it.
**Part A portion of an MSN**

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Benefit Days Used</th>
<th>Non-Covered Charges</th>
<th>Deductible and Coinsurance</th>
<th>You May Be Billed</th>
<th>See Notes Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim number 12345-6956-9556</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Hospital Name, Street Address, City, State ZIP Code</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred by: Paul Jones, M.D.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04/07/06 - 05/09/06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTES SECTION:**

a. You have 46 full days remaining in this benefit period.

b. $876.00 was applied to your inpatient deductible.

**Deductible Information:**

You have met the Part A deductible for this benefit period.

**General Information:**

Please notify us if your address has changed or is incorrect as shown on this notice.

**Appeals Information - Part A (Inpatient)**

If you disagree with any claims decisions on Part A of this notice, your appeal must be received by **November 1, 2006**.

Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the “Customer Service Information” box on Page 1. (You may also send any additional information you may have about your appeal.)

3) Sign here ___________________________ Phone Number (___) ____________
6. **Part A Hospital Insurance—Inpatient Claims:** Type of service. See the back of the MSN for additional information. Note that outpatient services are listed separately in the section called “Part B Medical Insurance—Outpatient Facility Claims.”

7. **Claim Number:** Number that identifies this specific claim.

8. **Provider’s Name and Address:** Facility’s name and billing address. The referring doctor’s name may also be shown. The address shown is the billing address, which may be different from where you receive the service(s).

9. **Dates of Service:** Date service was provided. You may use these dates to compare with the dates shown on your hospital bill.

10. **Benefit Days Used:** Number of days used in the benefit period. See the back of your MSN for an explanation of benefit periods. (For outpatient services, this column is called "Amount Charged").

11. **Non-Covered Charges:** Charges for services denied or excluded by Medicare for which you may be billed. If a $0.00 appears in this field, it means that there were no services denied or excluded by Medicare for which you may be billed.

12. **Deductible and Coinsurance:** The amount applied toward your deductible and coinsurance. Your deductible is the amount you must pay before Medicare begins paying for your health care. A coinsurance is the amount you pay for each service after you reach your deductible.

13. **You May Be Billed:** Total amount provider can bill you. It includes the deductible, coinsurance, and any non-covered charges. If you have supplemental insurance, it may pay all or part of this amount.

14. **See Notes Section:** If letter appears, refer to "Notes Section" (15) for explanation

15. **Notes Section:** Explains letters in (14) for more detailed information about your claim.

16. **Deductible Information:** How much of your deductible you have met for the current benefit period.

17. **General Information:** Important Medicare news and information.

18. **Appeals Information:** How and when you can appeal.
## Part B portion of an MSN

### PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Services Provided</th>
<th>Amount Charged</th>
<th>Medicare Approved</th>
<th>Medicare Paid Provider</th>
<th>You May Be Billed</th>
<th>See Notes Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim number 12345-84956-84556</td>
<td>1 Office/Outpatient Visit, ES (99214)</td>
<td>$55.00</td>
<td>$44.35</td>
<td>$0.00</td>
<td>$44.35</td>
<td>a</td>
</tr>
</tbody>
</table>

THIS IS NOT A BILL – Keep this notice for your records.

### Notes Section:

- a  This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.
- b  This approved amount has been applied toward your deductible.

### Deductible Information:

You have now met $44.35 of your $100 Part B deductible for 2006.

### General Information:

Please notify us if your address has changed or is incorrect as shown on this notice.

### Appeals Information - Part B

**If you disagree with any claims decisions on this notice, your appeal must be received by November 1, 2006.**

Follow the instructions below:

1. Circle the item(s) you disagree with and explain why you disagree.
2. Send this notice, or a copy, to the address in the “Customer Service Information” box on Page 1.
3. Sign here ___________________________ Phone Number (____) __________________
6. **Part B Medical Insurance - Assigned Claims:** Type of service. See back of MSN for information about assignment. Note that for services you received from a nonparticipating provider (“unassigned claims”) will be shown in the “Part B Medical Insurance—Unassigned Claims” section.

7. **Claim Number:** Number that identifies this specific claim.

8. **Provider’s Name and Address:** Doctor (may show clinic, group, and/or referring doctor) or provider’s name and billing address.

9. **Dates of Service:** Date service or supply was received. You may use these dates to compare with the dates shown on the bill you get from your doctor.

10. **Amount Charged:** Amount the provider billed Medicare.

11. **Medicare Approved:** Amount Medicare approves for this service or supply.

12. **Medicare Paid Provider:** Amount Medicare paid to the provider. Note that for unassigned claims, this column is called “Medicare Paid You.” If your claim is denied then this section will be $0.00 and you should check the notes section for details of why the claim was denied.

13. **You May Be Billed:** Total amount provider may bill you, including deductibles, coinsurance, and non-covered charges. Supplemental insurance such as retiree insurance or Medigap policy may pay all or part of this amount.

14. **See Notes Section:** If letter appears, refer to (16) for explanation.

15. **Services Provided:** Brief description of the service or supply received.

16. **Notes Section:** Explains letters in (14) for more detailed information about your claim.

17. **Deductible Information:** How much of your yearly deductible you have met. The deductible is the amount you must pay before Medicare starts paying for your care.

18. **General Information:** Important Medicare news and information.

19. **Appeals Information:** How and when to request an appeal.
Q: What do I do if I disagree with anything on my MSN?

A: If Original Medicare will not pay for care you received, you will find this out when you get your Medicare Summary Notice (MSN). It will be listed in the “Non-Covered Charges” or “Medicare Paid Provider” sections on your MSN. It will say that Medicare paid nothing and you are responsible for the full cost. If this happens, you can appeal to ask Medicare to cover the services it denied. These are the steps you should take:

1. **Find out if there was a billing mistake.**

   Before you appeal, find out if there was a billing error. Medicare uses a set of service codes, called CPT codes, for processing medical claims. Each service has a specific code. Sometimes providers accidentally use the wrong codes when filling out Medicare paperwork, and this can cause Medicare denials.

   A denial can sometimes be easily resolved by asking your doctor to double check that your claim was submitted with the correct codes. Your doctor's billing office can call 800-MEDICARE to get in touch with the company that processes Medicare claims. If the wrong code was used, ask your doctor to resubmit the claim with the correct code.

2. **If the provider says the claim was correctly coded or won’t refile the claim, consider appealing.**

   **Appealing is easy and many people win.** Your Medicare Summary Notice will have instructions for how to appeal. Follow these instructions. If the MSN lists several items and you are not disputing all of them, circle the one you want to appeal. Write “Please Review” on the bottom and sign the back. Make a copy for your files. Then mail the signed original to Medicare at the address on the MSN. **Make sure you mail your appeal within 120 days of the date on the upper right corner of the MSN.**

   If possible, get a letter from your health care provider saying that you needed the service and why. Send this with your MSN.

   **Keep copies and records of all communication,** whether written or oral, with Medicare concerning your denial. Send your appeal certified mail or delivery confirmation. Medicare has 60 days to respond to your appeal. If your appeal is denied, you can appeal to a higher level. Keep in mind, however, that if it’s a service that’s excluded from Medicare coverage by law (such as routine dental, vision or hearing care), you’re unlikely to win the appeal.