



Medicare Coverage of Durable Medical Equipment & Other Devices

This official government booklet explains:

- What durable medical equipment is
- Which durable medical equipment, prosthetic, and orthotic items are covered by Original Medicare
- Where to get help with your questions



Does Medicare cover durable medical equipment (DME) or other types of medical equipment?

Definitions of blue words are on pages 18–19.

This booklet explains [Original Medicare](#) coverage of [DME](#) and what you might need to pay. DME includes items like:

- Home oxygen equipment
- Hospital beds
- Walkers
- Wheelchairs

This booklet also explains coverage for prosthetic devices (like ostomy supplies, urinary catheters, enteral nutrition, and certain eyeglasses and contact lenses), leg, arm, neck, and back braces (“orthotics”), and artificial legs, arms, and eyes. It’s important to know what Medicare covers and what you may need to pay. Talk to your doctor if you think you need some type of DME.

If you have questions about the cost of DME or coverage after reading this booklet, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

“Medicare Coverage of Durable Medical Equipment & Other Devices” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Paid for by the Department of Health & Human Services.

CMS Accessible Communications

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. Call us:

For Medicare: 1-800-MEDICARE (1-800-633-4227)

TTY: 1-877-486-2048

2. Email us: altformatrequest@cms.hhs.gov

3. Send us a fax: 1-844-530-3676

4. Send us a letter:

Centers for Medicare & Medicaid Services Offices of Hearings
and Inquiries (OHI)

7500 Security Boulevard, Mail Stop S1-13-25

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare Prescription Drug Plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State or local Medicaid office.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare Prescription Drug Plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. Online:

hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

2. By phone:

Call 1-800-368-1019. TDD user can call 1-800-537-7697.

3. In writing: Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

What's durable medical equipment (DME)?

DME is reusable medical equipment, like walkers, wheelchairs, or hospital beds.

If I have Medicare, can I get DME?

Anyone who has [Medicare Part B \(Medical Insurance\)](#) can get DME as long as the equipment is [medically necessary](#).

When does Original Medicare cover DME?

Part B covers DME when your doctor or other health care provider (like a nurse practitioner, physician assistant, or clinical nurse specialist) prescribes it for you to use in your home. A hospital or nursing home that's providing you with Medicare-covered care can't qualify as your "home" in this situation. However, a long-term care facility can qualify as your home.

Note: If you're in a [skilled nursing facility \(SNF\)](#) as part of a stay covered under [Medicare Part A \(Hospital Insurance\)](#), the facility is responsible for providing any DME you need while you're in the facility for up to 100 days.

What if I need DME and I'm in a Medicare Advantage Plan?

[Medicare Advantage Plans](#) must cover the same medically necessary items and services as Original Medicare (Parts A and B). Your specific costs will depend on which Medicare Advantage Plan you have.

If you're in a Medicare Advantage Plan and you need DME, call your Medicare Advantage Plan's primary care provider to find out if your plan will provide the DME. If your Medicare Advantage Plan won't cover a DME item or service that you believe you need, you can appeal your Medicare Advantage Plan's denial of coverage and get an independent review of your request for coverage. You can also find a description of your Medicare Advantage Plan cost-sharing obligation for all Medicare covered services, including supplemental benefits offered by your Medicare Advantage Plan, in its "Evidence of Coverage" document.

If you're getting home care or using medical equipment and you choose to join a new Medicare Advantage Plan, you should call your new primary care provider as soon as possible to make sure they will continue to cover any Medicare DME items or services you're using.

Definitions of [blue](#) words are on pages 18–19.

Note: If your plan leaves Medicare and you're using medical equipment like oxygen or a wheelchair, call the phone number on your [Medicare Advantage Plan](#) card and ask about DME coverage options. They can tell you how to get care under [Original Medicare](#) or a new Medicare Advantage Plan.

If I have Original Medicare, how do I get the DME I need?

If you need DME in your home, your doctor or treating provider (like a nurse practitioner, physician assistant, or clinical nurse specialist) must prescribe the type of equipment you need by filling out an order. For some equipment, Medicare may also require your doctor to provide additional information documenting your medical need for the equipment. Your supplier will work to make sure your doctor submits all required information to Medicare. If your needs and/or condition changes, your doctor must complete and submit a new, updated order.

Medicare only covers DME if you get it from a supplier enrolled in Medicare. This means that the supplier has been approved by Medicare and has a Medicare supplier number.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

Starting January 1, 2021, if you live in or visit a competitive bidding area and need a DMEPOS item included in the DMEPOS Competitive Bidding Program, you generally must use specific suppliers called “contract suppliers,” if you want Medicare to help pay for the item. Contract suppliers are required to provide the item to you and accept assignment as a term of their contract with Medicare.

Visit [Medicare.gov/supplierdirectory](https://www.Medicare.gov/supplierdirectory) to see if you live in a competitive bidding area, or to find suppliers who accept assignment. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also call 1-800-MEDICARE if you're having problems with your DME supplier, or you need to file a complaint.

Definitions of blue words are on pages 18–19.

What questions could I ask when I'm looking for a supplier?

Asking questions like these may help you when you're choosing a supplier:

- Are you a Medicare-enrolled supplier?
- Do you accept Medicare [assignment](#)?
- If not, will you consider assignment in my case?
- If not, what's your non-assignment charge?
- Will you bill Medicare for me?

A supplier enrolled in Medicare must meet strict standards to qualify for a Medicare supplier number. **If your supplier doesn't have a supplier number, Medicare won't pay your claim**, even if your supplier is a large chain or department store that sells more than just DME.

Does Medicare cover power wheelchairs & scooters?

For Medicare to cover a power wheelchair or scooter, your doctor must state that you need it because of your medical condition. Medicare won't cover a power wheelchair or scooter that you only need and use outside of the home.

Most suppliers who work with Medicare are honest. However, there are a few who aren't. For example, some suppliers of medical equipment try to cheat Medicare by offering expensive power wheelchairs and scooters to people who don't qualify for these items.

For more information about Medicare's coverage of power wheelchairs or scooters, visit [Medicare.gov/coverage/wheelchairs-scooters](https://www.medicare.gov/coverage/wheelchairs-scooters) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What if my equipment needs maintenance or repairs?

It's important to know how to get maintenance and repairs for your durable medical equipment.

- If you **own** your equipment, the supplier who sold it to you isn't required to repair it. To find a supplier who may be able to maintain or repair your equipment, visit [Medicare.gov/supplierdirectory](https://www.medicare.gov/supplierdirectory).
- If you **rent** equipment, your supplier must maintain and repair the equipment and keep it in good working order at all times. Your supplier must answer your calls and service, repair, or replace rented equipment whenever necessary. If your supplier doesn't respond to your requests, call 1-800-MEDICARE.

What if my equipment or supplies are lost or damaged in a disaster or emergency?

If [Original Medicare](#) already paid for [durable medical equipment \(DME\)](#) or supplies lost or damaged due to an emergency or disaster:

- In certain cases, Medicare will cover the cost to replace your equipment or supplies.
- Generally, Medicare will also cover the cost of loaned equipment for items (like wheelchairs) during the time your equipment is being repaired.

If you're in a [Medicare Advantage Plan](#) or other [Medicare health plan](#), contact your plan directly to find out how it replaces DME or supplies lost or damaged in an emergency or disaster.

You can also call 1-800-MEDICARE (1-800-633-4227) to get more information about how to replace your equipment or supplies. TTY users can call 1-877-486-2048.

What's covered, & how much does it cost?

See pages 9–11 for some of the items Medicare covers and how much you have to pay for these items. This list doesn't include all covered durable medical equipment (DME). For questions about whether Medicare covers a particular item, visit [Medicare.gov](https://www.Medicare.gov) or call 1-800-MEDICARE. If you have a [Medigap policy](#), it may help cover some of the costs listed on pages 9–11.

Definitions
of [blue](#)
words are
on pages
18–19.

Durable medical equipment (DME)

What Medicare covers

- Pressure-reducing beds, mattresses, and mattress overlays used to prevent bed sores
- Blood sugar monitors
- Blood sugar (glucose) test strips
- Canes (however, white canes for the blind aren't covered)
- Commode chairs
- Continuous passive motion (CPM) machines
- Crutches
- Hospital beds
- Infusion pumps and supplies (when necessary to administer certain drugs)
- Manual wheelchairs and power mobility devices (power wheelchairs or scooters needed for use inside the home)
- Nebulizers and some nebulizer medications (if reasonable and necessary)
- Oxygen equipment and accessories
- Patient lifts (a medical device used to lift you from a bed or wheelchair)
- Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories
- Suction pumps
- Traction equipment
- Walkers

What you pay

Generally, you pay 20% of the [Medicare-approved amount](#) after you pay your Part B [deductible](#) for the year. Medicare pays the other 80%. The Medicare-approved amount is the lower of the actual charge for the item or the fee Medicare sets for the item.

However, the amount you pay may vary because Medicare pays for different kinds of DME in different ways. You may be able to rent or buy the equipment.

Prosthetic & orthotic items

What Medicare covers

- Arm, leg, back, and neck braces (orthotics)
- Artificial limbs and eyes
- Breast prostheses (including a mastectomy bra) after a mastectomy
- Ostomy bags and certain related supplies
- Urological supplies
- Therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease.

The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. A podiatrist or other qualified doctor must prescribe the shoes and inserts. A doctor or other qualified individual (like a pedorthist, orthotist, or prosthetist) must fit and provide the shoes. Part B covers the furnishing and fitting of either one pair of custom-molded shoes and inserts or one pair of extra-depth shoes each calendar year. Medicare also covers 2 additional pairs of inserts each calendar year for custom-molded shoes and 3 pairs of inserts each calendar year for extra-depth shoes. Medicare may cover shoe modifications instead of inserts.

What you pay

You pay 20% of the [Medicare-approved amount](#) after you pay your Part B [deductible](#) for the year. Medicare pays the other 80%. These amounts may be different if the supplier doesn't accept [assignment](#). See page 12.

Corrective lenses

What Medicare covers

Prosthetic lenses

- Cataract glasses (for Aphakia or absence of the lens of the eye)
- Conventional glasses or contact lenses after surgery with insertion of an intraocular lens
- Intraocular lenses

Important: Only standard frames are covered. Medicare will only pay for contact lenses or eyeglasses provided by a supplier enrolled in Medicare, no matter who submits the claim (you or your supplier).

What you pay

You're covered for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. You pay 20% of the [Medicare-approved amount](#) after you pay the Part B [deductible](#) for the year. Medicare pays the other 80%. Costs may be different if the supplier doesn't accept [assignment](#). See page 12. If you want to upgrade the frames, you pay any additional cost.

Definitions
of [blue](#)
words are
on pages
18–19.

What's assignment?

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the **Medicare-approved amount** as full payment for covered services.

If your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less.
- They agree to charge you only the Medicare **deductible** and **coinsurance** amount and usually wait for Medicare to pay its share before asking you to pay your share.
- They have to submit your claim directly to Medicare and can't charge you for submitting the claim.

Some providers haven't agreed and aren't required by law to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services. The providers who haven't agreed to accept assignment for all services are called "non-participating." You might have to pay more for their services if they don't accept assignment for the care they provide to you.

How will I know if I can buy DME or whether Medicare will only pay for me to rent it?

If your supplier is a Medicare-enrolled supplier, they'll know if Medicare allows you to buy a particular kind of DME, or just pays for you to rent it. Medicare pays for most DME on a rental basis. Medicare only buys inexpensive or routinely bought items, like canes, walkers, and blood sugar monitors, or complex rehabilitative power wheelchairs. For some more expensive equipment, like wheelchairs and hospital beds, Medicare pays to rent the item for 13 months of continuous use. Once the 13th month of rental ends, the supplier must transfer ownership of the equipment to you.

Definitions
of **blue**
words are
on pages
18–19.

Buying equipment

If you **own** Medicare-covered DME and other devices, Medicare may also cover repairs and replacement parts. Medicare will pay 80% of the **Medicare-approved amount** (up to the cost of replacing the item) for repairs. You pay the other 20%. Your costs may be higher if the supplier doesn't accept **assignment**.

Note: The equipment you buy may be replaced if it's lost, stolen, damaged beyond repair, or used for more than the reasonable useful lifetime of the equipment, which is generally 5 years from the date you start using the item.

Renting equipment

If you **rent** DME and other devices, Medicare makes monthly payments for use of the equipment. The rules for how long monthly payments continue vary based on the type of equipment. Total rental payments for inexpensive or routinely bought items are limited to the fee Medicare sets to buy the item. If you'll need these items for more than a few months, you may decide to buy these items rather than rent them. Monthly payments for frequently serviced items, like ventilators, are made as long as the equipment is **medically necessary**. You pay 20% of the Medicare-approved amount after you pay your Part B **deductible** for the year. Medicare pays the other 80%.

The supplier will pick up the equipment when you no longer need it. Any costs for repairs or replacement parts for the rented equipment are the supplier's responsibility. The supplier will also pick up the rented equipment if it needs repairs. You don't have to bring the rented equipment back to the supplier.

Do I need to tell my supplier if my needs change?

There are times when you may need to tell your supplier about changes in your life that will affect how and when you get your durable medical equipment. Let your supplier know if:

- You're changing insurance companies.
- You're changing doctors.
- You're in the hospital or will soon be admitted to the hospital.
- You're in a nursing home or will soon be admitted to a nursing home.
- You're traveling.
- You're moving.
- You or your secondary contact have changed your phone number.

If you use oxygen and you'll need a portable oxygen concentrator (POC) for travel, let your supplier know weeks in advance.

How does Medicare pay the supplier for oxygen equipment & related supplies?

If you have Medicare and use oxygen, you can rent oxygen equipment from a supplier for as long as you have a medical need, but payments for the equipment stop after 36 months of continuous use. After 36 months, your supplier must continue to provide oxygen equipment and related supplies for an additional 24 months. Your supplier must provide equipment and supplies for up to a total of 5 years, as long as you have a medical need for oxygen.

What do I pay the supplier? What does the rental payment cover?

The monthly rental payments to the supplier cover your oxygen equipment, and any supplies and accessories, like tubing or a mouthpiece, oxygen contents, maintenance, servicing, and repairs. If you use portable oxygen equipment, there's a separate monthly payment made in addition to the general monthly payment, which also ends after 36 months. In both cases, you pay 20% of the [Medicare-approved amount](#) after you pay your Part B [deductible](#) for the year. Medicare pays the other 80%.

What happens with my oxygen equipment & related services after the 36 months of rental payments?

Your supplier must continue to maintain the oxygen equipment (in good working order) and provide the equipment and any necessary supplies and accessories, as long as you need it until the 5-year period ends. The supplier can't charge you for performing these services.

If you use oxygen tanks or cylinders that need delivery of gaseous or liquid oxygen contents, Medicare will continue to pay each month for the delivery of contents after the 36-month rental period. The supplier that delivers this equipment to you in the last month of the 36-month rental period must provide these items, as long as you medically need them, up to 5 years. The supplier owns the equipment during the entire 5-year period.

If you use either an oxygen concentrator or equipment used to fill portable tanks in your home, you may have to pay a maintenance and servicing payment every 6 months if the supplier comes to your house to inspect and service the equipment. The supplier can't charge you for this service unless they come to your home to inspect and service the equipment.

Definitions of [blue](#) words are on pages 18–19.

What happens to my oxygen equipment after 5 years?

If your medical need continues past the 5-year period, your supplier no longer has to continue providing your oxygen and oxygen equipment, and you may choose to get replacement equipment from any Medicare-enrolled supplier. A new 36-month payment period and 5-year supplier obligation period starts once the old 5-year period ends for your new oxygen and oxygen equipment.

My oxygen equipment doesn't allow me to move around like I want to inside and/or outside my home. What should I do?

If your doctor determines that your oxygen equipment doesn't meet your needs, he or she may notify the oxygen supplier with a new letter of medical necessity. The letter should explain your mobility needs both inside and outside your home. If you switch from using stationary oxygen to portable oxygen, a new 36-month payment period and a new 5-year supplier obligation period begins once the 5-year contract for the stationary oxygen expires.

What happens if the equipment I have is no longer effective for me?

If your doctor decides that your oxygen equipment is no longer effective for you, he or she may notify the oxygen supplier with a new letter of medical necessity for different equipment. The oxygen supplier must give you equipment that fits your needs.

What if my oxygen supplier tells me they'll no longer provide liquid oxygen?

If your supplier tells you they'll no longer provide your prescribed therapy, and you haven't completed your 5-year contract, you can:

- Get the oxygen supplier to put their intentions in writing.
- Call 1-800-MEDICARE (1-800-633-4227) to file a complaint. TTY users can call 1-877-486-2048.

Can my oxygen supplier decide to change the terms of my contract for my equipment or the number of tanks I get each month?

Your supplier can't change the type of equipment or number of tank refills you get unless your doctor orders a change. Your oxygen supplier must provide all your oxygen equipment and supplies, including all necessary tank refills.

If I travel by plane, is my oxygen supplier required to provide a portable oxygen concentrator?

Your oxygen supplier isn't required to give you an airline-approved portable oxygen concentrator, and Medicare won't pay for any oxygen related to air travel. You may be able to rent a portable oxygen concentrator from your supplier if you give them several weeks' notice before your travel date. Also, rentals are available through online companies that work with most airlines. These companies can give the documentation needed for your travel.

What if I'm away from home for an extended period or I move to another area during the 36-month period?

If you travel away from home for an extended period (several weeks or months) or permanently move to another area during the 36-month rental period, ask your current supplier if they can help you find a supplier in the new area. If your supplier can't help you find an oxygen supplier in the area where you're visiting or moving to, visit [Medicare.gov/supplierdirectory](https://www.medicare.gov/supplierdirectory) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What if I'm away from home for an extended period or I move to another area after the 36-month period?

If you travel or move after the 36-month rental period ends, your supplier is responsible for making sure that you have oxygen and oxygen equipment in the new area. You can't be charged for oxygen equipment after month 36 even in these situations.

If you use either an oxygen concentrator or equipment used to fill portable tanks in your home, you may have to pay a maintenance and servicing payment every 6 months if the supplier comes to your house to inspect and service the equipment. The supplier can't charge you for this service unless they come to your home to inspect and service the equipment.

Your supplier may arrange for you to get oxygen and oxygen equipment from a different supplier in your new area. For more information, visit [Medicare.gov/supplierdirectory](https://www.Medicare.gov/supplierdirectory) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What if my supplier refuses to continue providing my oxygen equipment & related services as required by law?

If your supplier isn't following Medicare laws and rules, call 1-800-MEDICARE. A customer service representative will refer your case to the appropriate area.

Definitions

Assignment — An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Coinsurance — An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment — An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

Deductible — The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Durable medical equipment (DME) — Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Medically necessary — Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C) — A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, excluding hospice. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for by Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount — In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan — Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private companies and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Part A (Hospital Insurance) — Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance) — Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medigap policy — Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Original Medicare — Original Medicare is a fee-for-service health plan that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Skilled nursing facility (SNF) — A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Official Business
Penalty for Private Use, \$300

CMS Product No. 11045
Revised August 2020



This booklet is available in Spanish. To get your copy, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en Español. Para obtener una copia, llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.