HEALTH MAINTENANCE ORGANIZATION (HMO) COPAYMENT RECEIPT / Request for Medicare Secondary Payment		
Beneficiary Name:		
Address:		
Medicare Beneficiary ID Number:		
Provider Name:		
Medicare Provider ID Number:		
HMO Insurer Name and Address:		
Date of Service	**Procedure Code**	**Copayment Amount Received**
Beneficiary Signature:		
Date:		
Note: Submit with a completed HCFA-1500 claim form. Leave Blocks 24F and 28 on the claim form blank.		