DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1230
Expires: 02/20

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number

2. Do you wish to sign up for Medicare Part B (Medical Insurance)? ☐ YES

3. Your Name (Last Name, First Name, Middle Name)

4. Mailing Address (Number and Street, P.O. Box, or Route)

5. City State Zip code

6. Phone Number (including area code)
( ) -

7. Written Signature (DO NOT PRINT)

8. Date Signed
/ /

IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW.

9. Signature of Witness

10. Date Signed
/ /

11. Address of Witness

12. Remarks

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1230. The time required to complete this information is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.