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Description of document: Railroad Retirement Board (RRB) Retirement Claims Manual (RCM) Sections RCM 3 and RCM 9, 2016, and section DCM 12 of the Disability Claims Manual (DCM), 2017

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UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
844 NORTH RUSH STREET
CHICAGO, ILLINOIS 60611-2092

BOARD MEMBERS:

(VACANT), CHAIRMAN

WALTER A. BARROWS, LABOR MEMBER

STEVEN J. ANTHONY, MANAGEMENT MEMBER

APR - 4 2017

Re: FOIA Appeal of C. 2017-1171
C. 2017-1669

In further response to our March 24, 2017 letter regarding your FOIA appeal, I have enclosed, on CD, a copy of the following sections of the Retirement Claims Manual (RCM) and the Disability Claims Manual (DCM):

RCM 3

RCM 9

DCM 12

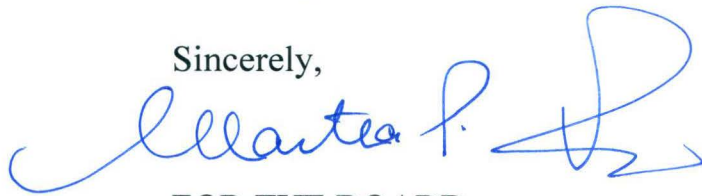
The Railroad Retirement Board (RRB) is restricted with respect to the disclosure of information and records that pertain to an individual or identify the individual to whom they pertain by section 12(d) of the Railroad Unemployment Insurance Act (45 U.S.C. § 362(d)), which is incorporated into the Railroad Retirement Act by section 7(b)(3) of that Act (45 U.S.C. § 231f(b)(3)). Because section 12 of the RUIA and the Privacy Act (5 U.S.C. § 552a) prevent the disclosure of any documents or information concerning an individual without that individual's express written authorization, all personally identifiable information has been removed from the enclosed copy of RCM sections 3 and 9, and DCM section 12.

Please note that other than the removed personally identifiable information, the manual sections contained on the enclosed CD-ROM are the entirety of RCM section 3, RCM section 9, and DCM section 12 currently in use by the agency.

Portions which are no longer in use or never existed, and which therefore do not appear in the current manual in use by the RRB (for example, RCM subsections 3.1.2; 3.1.121 exhibits 8, 9, 12, 13 and 15; RCM 3.9.10; 3.9.20; 3.9.30; 3.9.91; 3.9.92; 3.11; 9.1 Appendix A; 9.3 Appendix A; 9.7.40; 9.7.50; 9.7.60; 9.10.90; 9.10.112; 9.10.114; 9.10.118; and 9.10.123; etc.), have not been included on the CD.

Because the entirety of current manual sections RCM 3, RCM 9, and DCM 12 in use by the RRB are enclosed, less any personally identifiable information, we believe this represents the fulfillment of your FOIA appeal.

Sincerely,

A handwritten signature in blue ink, appearing to read "Martha P. Rico", with a stylized flourish at the end.

FOR THE BOARD

Martha P. Rico

Secretary to the Board

Retirement Claims Manual (RCM)

Section RCM 3

3.1.1 Background

By the mid 1960's, it had become apparent to the Federal government that the medical needs of individuals over 65 were being met either inadequately or with great financial difficulty. This was attributable to the fact that income at this age is often reduced substantially, while at the same time medical expenses are likely to increase. Though insurance coverage through individual policies could partially meet the needs of our senior citizens, Congressional opinion was that some form of Government aid on a national level was necessary.

Therefore, by an act of Congress, in July 1966, legislation establishing a national health insurance program, the Medicare program, (Title XVIII of the Social Security (SS) Act) was enacted (the 1965 amendments to the SS Act), with most of its benefits taking effect as of July 1, 1966. The Medicare program has two parts. They are the hospital insurance (Part A) part and the medical insurance (Part B) part. Both parts of the program have been modified and liberalized several times since its enactment.

In May 1966, the Social Security Administration (SSA) delegated authority to the Railroad Retirement Board (RRB) for administering certain provisions of the Medicare program for qualified railroad retirement beneficiaries (QRRB's). These included enrolling, premium collection and selecting a carrier to process Medicare Part B claims.

In July 1966, RRB had a Medicare population of approximately 560,000 beneficiaries who were age 65 or older. From 1966 to 1972, QRRB's who were also eligible for SS benefits could have had their Medicare jurisdiction with either agency. Usually, the agency that processed the beneficiary's application first assumed Medicare jurisdiction.

This changed with the enactment of Public Law (PL) 92-603 in October 1972. The 1972 amendments to the SS Act brought about several changes. It provided that RRB would have jurisdiction of all QRRB's who were receiving both railroad retirement (RR) and SS Act benefits. This increased RRB's Medicare population by approximately 330,000. These amendments also gave RRB legislative authority to contract with a carrier(s) to process Part B claims, collect Part B premiums and allowed for reimbursement of administrative costs. In addition, PL 92-603 also expanded Medicare coverage, effective July 1, 1973, to certain disabled people and people of any age with chronic kidney disease. This legislation also provided equitable relief for individuals whose entitlement or reentitlement rights were prejudiced by error, misrepresentation or inaction of an employee or agent of the government.

Effective January 1, 1983, the "working aged provision" made employer group health plans (EGHP) the primary payer of benefits and Medicare secondary payer for individuals age 65 or over who were covered under an EGHP that covers 20 or more employees by reason of their own or their spouses current employment. The "working age provision" was modified and liberalized several times since its enactment.

The Deficit Reduction Act of 1984 (PL 98-369) included a provision to provide special enrollment periods and premium surcharge relief to individuals covered by the "working aged provision." The "working aged provision" were further amended to make Medicare the secondary payer for disabled individuals who were covered as an active individual under a large employer group health plan (LGHP) or a plan that covers 100 or more employees and also provided special enrollment periods and premium surcharge relief to the disabled individuals who were covered as an active individual under a LGHP.

Currently, the special enrollment periods and premium surcharge relief provisions are the same for the aged and the disabled primary beneficiary and his/her spouse. However, any other disabled family member, e.g., a disabled child, must be covered on the basis of an LGHP to qualify for the special enrollment periods and premium surcharge relief.

The Medicare Catastrophic Coverage Act of 1988 mandated major changes in the coverage and payment of benefits. Effective January 1, 1989, the Act provided for increased coverage under Part A and mandated the collection of additional premiums to cover these expanded benefits.

The Medicare Catastrophic Coverage Repeal Act of 1989 eliminated major provisions of the Medicare Catastrophic Coverage Act and restored Medicare benefits to the levels available prior to January 1, 1989.

The Balanced Budget Act of 1997 (P.L. 105-33) established the Medicare Advantage (MA) Programs. The Medicare Advantage plan is also referred to as Medicare Part C. Medicare Advantage plans first became available as an option for receiving Medicare benefits on February 1, 1985 (Public Law 97-248). The plans were originally referred to as Health Maintenance Organizations or HMOs, then as Medicare + Choice plans, and beginning in 2004 as Medicare Advantage plans.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 added a prescription drug benefit to Medicare effective January 2006. The prescription drug benefit is referred to as Part D.

3.1.3 General Assignment Of Responsibility

The overall responsibility for the administration of the Medicare program rests with the Secretary of the U.S. Department of Health and Human Services (HHS). The Secretary has delegated certain administration functions to various components of the Department. In addition, as provided by the SS Act, a major role in the administration of the Medicare program has been given to public and private organizations.

Medicare was initially the responsibility of SSA and RRB coordinated their efforts with their Bureau of Health Insurance. However, as the program expanded, a decision was made to delegate responsibility for both Medicare and Medicaid to one agency.

In March 1977, the Centers for Medicare & Medicaid Services (CMS) was established. In 1977 and 1978, SSA delegated the authority to administer Title XVIII of the SS Act - "Health Insurance for the Aged and Disabled" to CMS. RRB now coordinates their efforts with CMS's Bureau of Programs Operations.

CMS's Regional Offices are responsible for a wide range of administrative activities. They include administrative coordination and operation appraisals as well as program interpretation and evaluation.

SSA has the responsibility for general management and operational aspects of the Medicare program. SSA determines if an IRMAA is applied to a beneficiary's Part B or Part D premium rate.

3.1.4 Role Of CMS

Some of the functions of CMS are:

- maintains entitlement and utilization records; the RRB sends the HMRUNT file to the CMS, the CMS sends back the HDRRBEX file;
- collects premiums via direct bill from non-QRRB's;
- establishes, maintains and administers agreements and systems to meet the needs of State agencies, providers of services, intermediaries, carriers, RRB and other administrative agents involved in the program;
- formulates major policies involving technical issues; and
- oversees general financial management of the program;
- Sends the RRB the monthly Part C/D Request file for QRRB's;
- Sends the RRB the monthly Part B reduction file For QRRB's.

3.1.5 Role Of RRB

Persons covered by the RR system participate in Medicare on the same basis as those under the SS system. The RRB's authority to administer the Medicare program for RR beneficiaries is contained in the Railroad Retirement Act of 1974, Title XVIII of the Social Security Act and certain agreements entered into between the CMS and the RRB.

The RRB certifies and enrolls QRRB's and deemed QRRB's for Medicare Part A and Part B and determines the beginning and ending dates of such coverage. The RRB also:

- collects Part B and IRMAA B premiums by deductions from monthly payments or by direct billing on a quarterly or yearly basis ;
- issues Medicare health insurance identification cards;
- selects and enters into contracts with a Part B carrier to process Part B claims for payment to QRRB's and deemed QRRB's and monitors the carrier's action (an RRB employee is on-site at Palmetto GBA);
- establishes and maintains Medicare Part A and Part B entitlement records;
- maintains identification and entitlement information;
- collects only via deductions for Part C and Part D premiums as determined by CMS;
- collects IRMAA D premiums by direct billing through PAR. The RRB will deduct Part D IRMAA premiums beginning with the January 2015 check for beneficiaries whose annuity rate is large enough. If the annuity rate is not large enough the RRB will bill monthly for Part D IRMAA premiums.
- assists beneficiaries and providers in receiving Medicare-related services;
- assists intermediaries and carriers in resolving claims payment related problems as they pertain to QRRB's and deemed QRRB's; and
- investigates complaints of fraud and abused involving QRRB's and deemed QRRB's.

3.1.6 Role Of RRB's Medicare Section (MS)

The Medicare Section (MS) within the Unemployment and Program Support Division (UPSD), is the focal point for the RRB's Medicare activities. Its' major functions are enrollment in and maintenance of Part A and B, and premium collection of B, C and D premiums. Maintenance includes working referrals, disenrollments, responding to inquiries, premium adjustments, and payment of Part A Canadian claims.

3.1.7 Role Of RRB's Field Offices

Field offices are responsible for furnishing information and assistance relative to the Medicare program to QRRBs before, during and after the enrollment process. In addition, field offices furnish information and assistance to any intermediary, carrier, provider or supplier relative to coverage or claims of RR beneficiaries. When field offices do not have requested information immediately available, they should contact the MS by e-mail, or by telephone if expedited action is required for assistance.

3.1.8 Financing The Part A Program

- A. Taxes and Appropriations - The Part A program is financed by special contributions from employees and self-employed persons, with employers paying an equal amount. These contributions are collected with regular RR or SS contributions from the wages and self-employment income earned during a person's working years. Funds from general tax revenues are used to finance Part A benefits for people who are covered under the program but are not entitled to monthly SS or RR benefits. And, for individuals enrolled in premium Part A, the cost of Part A benefits is paid by the monthly premium paid.

NOTE: An employee or self-employed person who pays both social security and railroad retirement taxes may, as a result, pay excess taxes. Effective in 1968, excess HIB taxes may be claimed as a credit on federal income tax return. RR employers are required to notify employees who are also employed outside the RR industry that they may be entitled to a refund of excess taxes. The employee can ask the employer to furnish a breakdown of the amount of regular and Part A taxes deducted from RR compensation.

- B. Federal Hospital Insurance Trust Fund - The taxes collected, the amounts appropriated from general revenues and the premiums paid are put into the Federal Hospital Insurance Trust Fund. Payments are made from this fund for all services covered by Part A except services for RRB Canadian Part A claims, which are paid from the Railroad Retirement Trust Fund.

3.1.9 Financing The Part B Program

- A. Premiums - The Part B program is financed by a monthly premium paid by the Part B enrollee and subsidized by the Federal government from general revenues. During 1989, the monthly Part B premium consisted of two components; the basic monthly rate and the catastrophic coverage monthly premium. Effective January 1, 1990, the catastrophic coverage monthly premium component was dropped and the monthly premium was restored to a single amount.
- B. Medical Insurance Trust Fund - The premiums deducted by the RRB from enrollees monthly payments are periodically transferred by the Secretary of Treasury from the SSEB to the appropriate portion of the Supplementary Medical Insurance Trust Fund. This fund is divided into the aged portion and the disability portion. Premiums collected by the RRB from enrollees who pay by direct remittance are deposited directly into the aged portion of the fund and, if appropriate, they are later transferred to the disability portion of the fund.

3.1.10 What is Medicare

The Medicare program is a Federal health insurance program for people 65 or older and certain disabled people. It is run by the CMS of the U.S. Department of Health and Human Services. RRB field offices across the country take applications for Medicare and provide general information about the program. Headquarters activities include establishing and maintaining the person's Medicare records.

3.1.11 The Four Parts Of Medicare

There are four basic parts to the Medicare program:

- A. Part A - Medicare hospital insurance (Part A) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care. Part A has deductibles and coinsurance, but most people do not have to pay premiums for Part A. Part A may also be referred to as hospital insurance benefits, HIB or HI.
- B. Part B - Medicare medical insurance (Part B) helps pay for doctors' services, outpatient hospital services, durable medical equipment and a number of other medical services and supplies that are not covered by Part A of Medicare. Part B of Medicare has premiums, deductibles and coinsurance amounts that the enrollee must pay. Participation is voluntary, that is, qualified persons must be enrolled in the plan and have the right to refuse or terminate their coverage. Part B may also be referred to as supplementary medical insurance benefits, SMIB or SMI.
- C. Part C – Medicare Advantage Plans (Part C), also known as MA plans, are health plan options like Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). These plans are offered by private companies approved by Medicare. If an individual joins a Medicare Advantage Plan, they will still have Medicare. The person will receive Part A and Part B coverage from the Medicare Advantage Plan, not Original Medicare. All Medicare Advantage plans cover emergency and urgent care, but do not cover hospice care and some care in qualifying clinical research studies. Medicare Advantage plans may offer extra coverage, like vision, hearing, dental, and/or other health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to the Part B premium, there is a monthly premium for the Medicare Advantage plan. An enrollee must have both Part A and Part B in order to enroll in a Medicare Advantage Plan.

New MOLI screens were created to provide information about a beneficiary's Medicare Part C coverage and payment history if the beneficiary requested the deduction of the Part C premium from their RRB benefit. Refer to FOM-I-1540.15.8.

- D. Part D – Medicare prescription drug coverage (Part D) is offered to everyone with Medicare. If a beneficiary decided not to enroll in a prescription drug plan when he is first eligible, he may have to pay a late enrollment penalty if he joins a plan later. The enrollee must live in the service area of the Medicare drug plan that he wants to join. It is not required for the beneficiary to be enrolled in Medicare Part B in order to enroll in a prescription drug plan. The person is required to be enrolled in Medicare Part A.

New MOLI screens were created to provide information about a beneficiary's Medicare Part D coverage and payment history if the beneficiary requested the deduction of the Part D premium from their RRB benefit. Refer to FOM-I-1540.15.10.

NOTE: If the person is enrolled in a Medicare Advantage Plan (Part C) that includes prescription drug coverage and joins a Medicare Prescription Drug Plan (Part D), he will be disenrolled from the Medicare Advantage Plan (Part C) and returned to Original Medicare (Medicare Part A and Medicare Part B).

Medicare premium, deductible and coinsurance amounts are set each year according to formulas established by law. New payment amounts begin each January 1. Exhibit 7 reflects the Part A deductible and coinsurance amounts. Exhibits 3 through 6 reflect the premium amounts.

3.1.12 Who Can Get Medicare Part A

Generally, people age 65 and over can get premium-free Medicare Part A benefits, based on their own or their spouse's employment. Premium-free means there are no monthly premiums. Most people do not pay premiums for Part A. A person can get premium-free Part A if they are 65 or over and any of the three statements are true:

- they receive benefits under the SS or RR system;
- they could receive benefits under the SS or RR system; or
- they or their spouse has Medicare-covered government employment.

If a person is under 65, they can get premium-free Part A benefits if they have been rated disabled under the SS Act and has received or be deemed entitled to receive payments from the RRB or SSA for the prescribed period of time.

Certain government employees and certain members of their families can also get Medicare when they are disabled for more than 29 months. Others may be able to get premium-free Part A benefits if they receive continuing dialysis for permanent kidney failure or if they have had a kidney transplant. Both of these categories of beneficiaries have to file with the SSA to obtain Medicare coverage.

If either the person or their spouse has 10 years of RR service or less than 10 years but has at least 5 years of service after 1995, they will be able to get premium-free Part A benefits. The Railroad Retirement and Survivors Improvement Act of 2001 (RRSIA) lowered the number of years of RR service required for RR benefits and RR Medicare. The earliest entitlement date based on RRSIA is January 1, 2002, see 3.2.20.

3.1.13 Who Can Get Medicare Part B

Any person who can get premium-free Part A benefits based on work can enroll for Part B, pay the monthly Part B premium and get Part B benefits.

3.1.13.1 Who Can Get Medicare Part C

In order to enroll in a Medicare Advantage Plan, a person must meet the following requirements:

- Must be enrolled in Medicare Part A and Medicare Part B
- Live in the service area of the plan
- Must not have end-stage renal disease (except when special circumstances exist)

3.1.13.2 Who Can Get Medicare Part D

In order to enroll in Medicare Part D, a person must be entitled to or enrolled in Medicare Part A only or Medicare Part A & Part B. It is not required to be enrolled in both. A beneficiary must obtain prescription drug coverage in one of the following ways:

- Choose or remain in Original Medicare and enroll in Part D through a participating and approved prescription drug provider (PDP), or
- Join a Medicare Advantage plan that offers prescription drug coverage (MA-PD), or
- Be enrolled by CMS (i.e., CMS will facilitate the enrollment of deemed eligible and subsidy eligible beneficiaries who do not enroll in Part D on their own). These beneficiaries will still be able to change the plan selected for them or to opt out of Part D when they receive notice of the plan selection from CMS.

3.1.14 Buying Medicare Part A And Part B

If a person does not have enough work credits to be able to get Part A benefits and they are 65 or over, they may be able to buy Part A and B or just Part B, by paying monthly premiums. These beneficiaries should file at SSA to obtain Medicare coverage.

Others may be able to buy Part A and B if they are disabled and lost their premium-free Part A solely because they are working.

3.1.15 Enrollment In Medicare

If a person is already getting a SS or RR benefit payment when they turn 65, they will automatically get a Medicare card (RL-865) in the mail. The card will show that they can get both Part A and Part B benefits. If they do not want Part B, they must follow the instructions that come with the card and return it to RRB.

The above process also applies when a person has been rated disabled under the SS Act and has received or be deemed to receive disability payments from the RRB or SSA for the prescribed period of time. A Medicare card will automatically be sent to the person.

Some people do not automatically get a Medicare card. They must file an application to get Medicare benefits. If a person has not applied for SS or RR benefits, or if government employment is involved, or if they have kidney disease, they must file an application for Medicare.

If a person must file an application for Medicare, they should do so during their initial enrollment period (IEP), to avoid late enrollment penalties under Part B, unless they qualify for a special enrollment period (SEP). A person's IEP is a seven-month period that starts three months before the month the person first meets the requirements for Medicare and ends at the end of the third month after they meet the requirements for Medicare. If they do not sign up for Medicare during the first three months of their IEP there will be a delay in starting their Part B coverage. Their coverage will be delayed from one to three months after enrollment, if they file in the remaining 4 months of their IEP.

If they do not enroll for Part B at any time during their IEP, they will not get another chance to enroll until the next general enrollment period (GEP). A GEP is held each year from January 1 through March 31. They may also be charged a premium penalty for late enrollment, unless they qualify for a SEP.

The enrollment period requirements and penalties for late enrollment described above for Part B also applies to people who buy Part A.

3.1.16 Medicare Card

The Medicare health insurance card is the person's proof of Medicare coverage. It shows the Medicare coverage a person has, Part A and Part B, Part A only, etc., and the date the coverage started. The Medicare health insurance card also shows the person's Medicare health insurance claim number, name and sex. Headquarters initially issues Medicare cards when a beneficiary becomes entitled to Medicare. Any field office or headquarters personnel can issue a duplicate Medicare card.

3.1.17 Intermediaries And Medicare Administrative Contractors

The Federal government contracts with private insurance organizations call intermediaries and Medicare Administrative Contractors to process claims and make Medicare payments.

- A. Intermediaries - Intermediaries process claims submitted on a person's behalf by hospitals. They also handle inpatient and outpatient claims submitted by skilled nursing facilities, home health agencies, hospices and other providers of services.

Generally, a person does not need to get in touch with the intermediaries because the intermediaries pay most hospital, skilled nursing facilities, home health agencies, hospices and other providers of services directly. But, if a person has a question about a Part A bill, they should ask someone who works at the facility where the services were rendered for help. If they cannot answer the person's questions, they should then ask someone in the billing office at the facility where the services were rendered to help them get in touch with the Medicare intermediary that processes their Medicare Part A claims.

- B. Medicare Administrative Contractor (MAC) - MACs process claims for services by doctors and other suppliers covered under Part B. The RRB is authorized by law to contract with a MAC to serve its beneficiaries enrolled in Part B. Accordingly, Palmetto GBA was selected to act as the sole Part B MAC for all QRRBs and deemed QRRBs. Part B claims are filed at the Railroad Medicare Claim Service Centers of Palmetto GBA. Palmetto GBA determines the amount payable and pays the claims on behalf of the RRB in accordance with their agreement with the RRB. If a person has any questions about a Part B claim, they should call or write Palmetto GBA.

Adequate provisions are made in the contract with Palmetto GBA for prompt, fair and equitable action on all claims. Palmetto GBA's performance under the contract is subject to supervision by the RRB. The RRB is responsible for evaluating the MAC's performance and providing them with funds for administrative costs and benefits. The administrative costs paid to Palmetto GBA are charged to the Supplementary Medical Insurance Trust Fund. The Railroad Retirement Trust Fund is not used for this purpose.

In addition, Palmetto GBA also:

- determines benefit amounts and make benefit payments to beneficiaries and/or physicians, suppliers and others who furnish covered Part B services and supplies;
- maintains records of payments made to physicians, suppliers and beneficiaries;
- assists and supports the RRB's Office of Inspector General (OIG) in areas concerning fraud and abuse; and
- provide the RRB/CMS with various fiscal and claims-related reports required to administer the program.

For more information on Palmetto GBA, see RCM 3.1.107.

3.1.18 State Health Agencies

State health departments obtain the information used to determine whether facilities meet the conditions for participation in the Medicare program. As part of this process, they advise the facilities of any necessary corrective actions. They also provide consultative services to assist facilities in meeting and maintaining the Medicare program requirements.

3.1.19 Peer Review Organizations (PRO's)

PRO's are groups of practicing doctors and other health care professionals who are paid by the Federal government to review the care given to Medicare patients. Each State has a PRO that decides, for Medicare payment purposes, whether care is reasonable, necessary and provided in the most appropriate setting. PRO's also decide whether care meets the standards of quality generally accepted by the medical profession. PRO's have the authority to deny payments if care is not medically necessary or not delivered in the most appropriate setting.

PRO's investigate individual patient complaints about the quality of care. PRO's also respond to requests for review of notices of non-coverage issued by hospitals to beneficiaries; and PRO's respond to beneficiary, physician and hospital requests for reconsideration of PRO decisions.

When a person is admitted to a Medicare participating hospital, they will receive "An Important Message From Medicare" which explains their rights as a hospital patient and provides the name, address and phone number of the PRO for their State. See Exhibit 11 for a sample of An Important Message From Medicare.

If a person feels that they were improperly refused admission to a hospital or that they were forced to leave the hospital too soon, they should ask for a written explanation of

the decision. Such a written notice must fully explain how the person can appeal the decision and it must give the name, address and phone number of the PRO where the person's appeal or request for review can be submitted.

PRO's are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospital, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; ambulatory surgical center; and certain health maintenance organizations.

If a person believes that they received poor quality care provided by one of these facilities, they may complain to the PRO. The PRO will investigate written complaints. The complaint must be in writing. The PRO will help the person put their complaint in writing by taking the information from the person over the telephone and writing the complaint. If someone other than the PRO makes a complaint for a Medicare patient, the Medicare patient must give written permission for that person to represent them in the complaint.

3.1.20 A Medicare Beneficiary's Right To Decide About Their Medical Care

Under the Medicare law, when a person is admitted to a Medicare hospital or skilled nursing facility, gets Medicare home health care or enrolls in a Medicare-certified hospice or health maintenance organization, the person must be given information about their rights to make decisions about their medical care.

Generally, the person will be told about their rights to accept or refuse medical or surgical treatment. They will also be told about their right to make, if they choose, an "advance directive." An "advance directive" contains written instructions that states the person's choices for health care or names someone to make those choices for them. The instructions are to be used if the person is too sick or otherwise unable to talk. The paper giving the person's health care choices may be called a "living will" or "a durable power of attorney for health care."

A person does not have to have any "advance directive." But, if the person has one they can say "yes" in advance to treatment they want if they get too sick to talk to their health care provider. The person can also say "no" in advance to treatment they do not want.

Laws governing "advance directives" vary from State to State. The person's treatment choices will depend on what is legal in their State. The person can contact the health care professionals in their State about the State's rules for "living rules" or durable powers of attorney. They can also contact someone in their local State's attorney's office for this information.

3.1.21 Maintenance Of Program Integrity

- A. Fraud and Abuse - If a person has reason to believe that a doctor, hospital or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services that they did not receive, they should call RRB's Inspector General's toll-free Hotline. The toll-free number is 1-800-772-4258; in Illinois, they should call 1-312-751-4336. They may also send complaints in writing to RRB-OIG, Hotline Officer, 844 North Rush Street, Chicago, Illinois 60611-2092. They should not call the Hotline with questions about Medicare policy or delayed claims or payments.

Problems encountered with HMO's should also be reported to the RRB's Inspector General's toll-free hotline.

- B. MAC Performance Evaluation - A program to evaluate the MAC's performance has been established by CMS. SSA is responsible for the evaluation of the area's MACs' performance and RRB is responsible for the evaluation of the Part B MAC's performance.

The RRB's contractor operations specialist at Palmetto GBA is Ms Sylvia Looper. Her mailing address is:

Ms. Sylvia Looper
Palmetto GBA
Augusta Corporate Center
Building 200
2743 Parameter Parkway Augusta, Georgia 30909

If you need to contact Ms. Looper by phone, her telephone number is 706/855-3099.

3.1.22 Assistance For Low-Income Beneficiaries

By Federal law, State Medicaid programs must pay Medicare costs for certain elderly and disabled people who have low incomes and very limited resources. Each State still maintains their own eligibility requirements for a person to receive Public Assistance.

A person may qualify for this assistance even if they did not work long enough to be able to get premium-free Part A. If they did work long enough to be able to get premium-free Part A, and they qualify in all other ways, the State will pay the Part A premium.

- A. To Qualify

- a person must be able to get Part A;

- the person's annual income level must be near the national poverty guidelines (poverty guidelines for 2014 are set at \$11,490 for one person and \$15,510 for a family of two); and
- the person cannot have resources such as bank accounts or stocks and bonds worth more than the established amounts (in 2014, they range from \$1,000 to \$4,000 for an individual and up to \$6,000 for a couple).

B. Where the Person Should Apply - If a person thinks they may qualify for assistance and they already have Medicare Part A, they should file an application at their State or local welfare, social service or public health agency that serves people on Medicaid. All of these agencies are State, not Federal agencies.

If a person thinks they may qualify for assistance but they do not have Part A, they should first file an application for Part A.

C. What a Person Should Ask For - When the person contacts their State or local Medicaid office, they should ask about the Qualified Medicare Beneficiary (QMB) program or the Medicare Buy-In program. They should explain that they think they qualify for help in paying their Medicare costs and they want to know when and where they can file an application.

3.1.23 Medicare Beneficiary's Rights Under Data Matching

In 1988, Congress passed a law that allows computer matching of the information that a person gives to the government. They should be aware that when the government collects or uses information about them, it must act under specific guidelines to protect the person's privacy. The government must:

- tell the person, at the time the information is collected, why the information is needed and how it will be used;
- make sure personal information is used only for the reasons given, or seek the person's permission when another purpose for its use is considered necessary or desirable;
- allow the person to see the records kept on them; and
- provide the person with the opportunity to correct inaccuracies in the records kept about them.

3.1.30 Medicare Advantage (Part C) Plans

Refer to Article 8 of FOM-I for information	Medicare Advantage Plans (Part C)
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about Medicare Advantage (Part C) plans. Here are links to pertinent sections:805.30	
805.30.1	Election of Medicare Advantage Plan
805.30.2	Medicare Advantage Election Periods
805.30.3	Disenrollment from a Medicare Advantage Plan
805.30.4	Disenrollment Effective Date
805.30.5	Resolving Beneficiary Problems with Medicare Advantage Plans

The following links refer to the new MOLI screens that display Medicare Part C information:

1540.15.8	MOLI Part C History (CH) Screen
1540.15.9	MOLI Part C Adjustment (CA) Screen

3.1.35 Medicare Prescription Drug (Part D) Plans

Refer to Article 8 of FOM-I for information about Medicare Prescription Drug (Part D) plans. Here are links to pertinent sections:

860.10	Description of Medicare Part D Program
860.10.1	Part D Eligibility Requirements
860.10.2	Part D Enrollment Periods
860.15.3	Part D Subsidy Eligibility Requirements
860.20	Processing Part D Inquiries

The following links provide information regarding Medicare Part D MOLI screens:

1540.15.10	MOLI Part D History (DH) Screen
1540.15.11	MOLI Part D Adjustment (DA) Screen

3.1.40 Buying Health Insurance To Supplement Medicare (MEDIGAP)

Medicare provides basic protection against the high cost of health care, but it will not pay all of the person's medical expenses, nor most long-term care expenses. For this reason, many private insurance companies sell insurance to supplement Medicare (Medigap insurance) as well as separate long-term care insurance. The Federal government does not sell or service such insurance.

- A. Shopping for Medigap Insurance - If a person is thinking about buying a new private insurance policy or replacing an old policy to supplement their Medicare protection or cover long-term care costs, they should shop carefully. The person can also secure a copy of the "Guide to Health Insurance for People with Medicare (507-X)," to help them make Medicare supplement decisions.
- B. New Open Enrollment Period for Medigap Policies - A new open enrollment period for selecting Medigap policies guarantees that for six months immediately following enrollment in Medicare Part B, people age 65 or older cannot be denied Medigap insurance or be charged higher premiums because of health problems. Even if they buy a Medigap policy and switch to another within the six-month open enrollment period (they may switch as many times as they wish) they can still get the open enrollment guarantee. All Medigap policies becoming effective after November 5, 1991, are covered by this law.

No matter how the person enrolls in Part B, whether by automatic notification or through an IEP, SEP or GEP, they are covered by the new guarantees if both of the following are true:

- the person is age 65 or older and is enrolled in Medicare based on age rather than disability; and
- the date the person gets by adding six months to the effective date for their Part B coverage, printed on their Medicare card, is in the future. The date arrived at is when the person's Medigap open enrollment ends.

Even though a person is guaranteed enrollment, their Medigap policy may not provide services for a preexisting condition until a six-month waiting period has passed.

- C. New Standardized Medigap Policies - During 1992, most States will adopt regulations limiting the sale of Medigap insurance to no more than 10 standard policies. One of the 10 will be a basic policy offering a "core package" of benefits. The other nine will each have a different combination of benefits, but they will all include the core package. The basic policy, offering the core package of benefits, will be available in all States.

A person can call their State insurance department to find out when the new standardized policies will be available in their State and how many of the 10 have been or are likely to be approved for sale. The telephone number of their State insurance department is listed under "State agencies" in their telephone book.

If a person already has a Medigap policy, they may want to keep it. They do not have to switch to one of the new standard policies. But, if they buy a new policy, they will probably be required to choose from one of the new standard plans.

- D. Medicare SELECT - In 1992, a new kind of Medigap insurance was introduced in 15 States. It is called Medicare SELECT. The difference between Medicare SELECT and standard Medigap insurance is that Medicare beneficiaries who buy a Medicare SELECT policy will be charged a lower premium in return for agreeing to use the services of certain designated health care professionals. These health care professionals, called "preferred providers," will be selected by the insurers.

Insurers, including some HMO's, offer Medicare SELECT in the same way standard Medigap insurance is offered. The policies are required to meet certain Federal standards and are regulated by the States in which they are approved.

The States in which Medicare SELECT policies were expected to be available are Alabama, Arizona, California, Florida, Indiana, Kentucky, Michigan, Minnesota, Missouri, North Dakota, Ohio, Oregon, Texas, Washington and Wisconsin. If a person lives in one of these States, they can ask their State insurance department about the Medicare SELECT policies that have been approved for sale in the State.

- E. Coordinated Care Plans Instead of Medigap - Coordinated care plans that contract with Medicare are not Medigap plans. But they can be an alternative to standard Medigap insurance. See RCM 3.1.30 for more information about coordinated care plans.
- F. Rules for Selling Medigap Insurance - Both State and Federal laws govern sales of Medigap insurance. Companies or agents selling Medigap insurance must

avoid certain illegal practices. Federal criminal and civil penalties (fines) may be imposed against any insurance company or agent that knowingly:

- sells a policy that duplicates Medicare coverage, Medicaid coverage or a private health insurance coverage;
- tells a person that they are employees or agents of the Medicare program or of any government agency;
- makes a false statement that a policy meets legal standards for certification when it does not;
- sells a policy that is not one of the approved standard policies, after the new standards have been put in place in their State;
- denies a person a Medigap open enrollment period by refusing to issue a policy, placing conditions on the policy or discriminating in the price of a policy because of a person's health status, claims experience, receipt of health care or medical condition; or
- uses the U.S. mail in a State for advertising or delivering health insurance policies to supplement Medicare if the policies have not been approved for sale in that State.

G. When Illegal Sales Practices are Suspected - When a person suspects that they have been a victim of illegal sales practices, they should report these practices to their State insurance department. States are responsible for the regulation of insurance policies issued within their boundaries. Since there are also Federal laws governing Medigap sales practices, it should also be reported to the appropriate Federal officials.

The State insurance department should be listed in the telephone book. To talk to Federal officials about suspected illegal sales practices, a person may call 1-800-638-6833.

A person may inquire about the necessity of securing additional insurance to supplement Medicare coverage. Detailed discussions of merits, recommendations, or endorsements of different overages or plans should not be made. Headquarters and field offices should not stock, display or distribute any material about private supplementary health insurance plans.

If a person seeks advice concerning a specific insurance plan, refer him to the insurance company for information or assistance. The responsibility for completion of claims for complementary insurance rests with the individual; if he requests your assistance, encourage him to seek other sources of help, if possible. There must be no indication on the complementary insurance claim or accompanying data that an RRB employee assisted the claimant, if the person is

so assisted per their request. Any person making a complaint concerning a specific insurance plan should be referred to that company for explanation; if he has contacted the company and has not gained satisfaction, explain that his recourse is to contact the State agency responsible for regulating insurance activities.

3.1.41 When Other Insurance Pays Before Medicare

If any of the following insurance situations applies to a person, they should notify their doctor, hospital and all other providers of services.

- A. Person or Person's Spouse Continues to Work - Medicare has special rules that apply to beneficiaries who have group health plan (GHP) coverage through their employment or the employment of a spouse.

Effective January 1, 1983, group health plans of employers with 20 or more employees are primary payers and Medicare is secondary payer for workers age 65 or over, and workers' spouses age 65 or over. Group health plans must offer these people the same health insurance benefits under the same conditions offered to younger workers and spouses. The worker and the spouse of the worker have the option to reject the plan offered by the employer. If they reject the employer's health plan, Medicare will remain the primary health insurance payer. In that case, the employer plan is not permitted to offer the person coverage that supplements Medicare covered services.

An individual has the right to take legal action against a GHP which is primary to Medicare and fails to pay primary benefits. The authority for such legal action is under Section 1862 (b) of the Act.

Any problem regarding who is the primary payer will occur with the group health plan, not the employer. Inquiries should be referred to the appropriate CMS regional office. See Exhibit 17.

Under the law, the government recovers incorrect primary Medicare benefits from any EGHP which is primary payer. To recover Medicare payment, the government will take legal action against the GHP and may collect double damages.

The person also has a recourse. Any claimant, including an individual who received services, and the provider or supplier, has the right to take legal action against an EGHP that fail to pay primary benefits for services covered by both the EGHP and Medicare and to collect double damages.

It is also in the employer's best interest to have the EGHP pay primary benefits since the employer is hit with a tax penalty for contributing to a nonconforming EGHP.

EGHPs do not have any appeal rights. The EGHP would advise the Medicare intermediary they will not pay primary benefits. The Medicare intermediary would then contact CMS who would check out if it is a -GHP that should pay primary benefits. If CMS determines it is, CMS would instruct the Medicare intermediary not to pay primary benefits.

A person covered by a GHP should be encouraged to apply for Part A at age 65 since it is free and can help pay some of the expenses not paid by the -GHP.

If a person questions whether it is advantageous to apply and pay for Part B, advise of the following considerations so that the individual can decide what is best for his/her situation.

- He/she must consider how fully the -GHP covers the doctor's and other health services that Part B covers.
- He/she must also consider whether the secondary benefits that Part B would pay are worth the cost of paying the monthly premium.

The person's employer should provide him/her with an explanation of the options available under the GHP and how Medicare coverage is affected. The employer should also give the person an opportunity to make a choice.

If an employer plan denies a person coverage, offers a different type of coverage or pays benefits that are secondary to Medicare, the person should notify the Medicare Part B MAC.

- B. Disabled and Under Age 65 - Medicare is the secondary payer for certain disabled people who have premium-free Medicare Part A and are covered under an employer's health plan or the employer health plan of an employed family member. This secondary payer provision applies to large group health plans (LGHP) of employers that employ 100 or more people.

Refer to A above for other information on EGHPs.

- C. Other Situations Where Medicare Is the Secondary Payer.

- If a person has a work-related illness or injury it should be covered by workers' compensation or Federal black lung benefits. It is important that the Medicare claim form note that the treatment is related to a work-related illness or injury, even if the injury or illness occurred in the past.
- Medicare is a secondary payer during a period, generally 18 months, for beneficiaries who have Medicare solely on the basis of permanent kidney failure, if they have a group health plan based on current employment status themselves or through a family member.

- Medicare also serves as the secondary payer in cases where no-fault insurance or liability insurance is available as the primary payer.

Although Medicare benefits are secondary to benefits paid by liability insurers, Medicare may make a conditional payment if it receives a claim for services covered by liability insurance. In those cases, Medicare may pay the claim; then, when a liability settlement is reached, Medicare recovers its conditional payment from the settlement amount.

D. Medicare and Veterans Benefits - If a person has or can get both Medicare and veterans benefits, they may choose to get treatment under either program. But Medicare:

- cannot pay for services the person receives from Veterans Affairs (VA) hospitals or other VA facilities, except for certain emergency hospital services; and
- generally cannot pay if the VA pays for VA-authorized services that you get in a non-VA hospital or from a non-VA physician.

Since July 1986, the VA has been charging coinsurance payments to some veterans who have non-service connected conditions for treatment in a VA hospital or medical facility, or for VA-authorized treatment by non-VA sources. The VA charges coinsurance payments when the veteran's income exceeds a particular level. If VA charges a coinsurance payment for VA-authorized care by a non-VA physician or hospital, Medicare may be able to reimburse the person, in whole or in part, for the VA coinsurance payment obligation.

Medicare cannot reimburse a person for VA coinsurance payments for services furnished by VA hospitals and facilities, unless the services are emergency inpatient or outpatient hospital services. Then, the Medicare payment is subject to Medicare deductible and coinsurance amounts.

If questions arise about whether the VA or Medicare should pay the doctor or other services covered under Medicare Part B, the Medicare Part B carrier should be contacted. If questions arise about whether the VA or Medicare should pay for hospital or other services covered under Medicare Part A, the provider of services should check with the Medicare intermediary.

E. Data Match - In 1989, Congress passed a law that will help Medicare get back an estimated \$1 billion in taxpayer money. The law will enable Medicare to get accurate information about beneficiaries' health insurance.

The law authorizes CMS, the agency that administers the Medicare program, the Internal Revenue Service, SSA and RRB to share information about whether Medicare beneficiaries or their spouses are working and whether they have employment-related health insurance.

The process for sharing information from other agencies is called the Data Match. The Data Match will help Medicare find cases where another insurer should have paid first on Medicare beneficiaries' health care claims. A designated Medicare contractor will contact employers to confirm health insurance coverage information. For more information about a person's rights under the data match, see RCM 3.1.23.

3.1.50 What Medicare Does Not Pay

Medicare does not pay for custodial care when that is the only kind of care a person needs. Care is considered custodial when it is primarily for the purpose of helping the person with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. Much of the care provided in nursing homes to people with chronic, long-term illnesses or disabilities is considered custodial care. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine. Even if the person is in a participating hospital or skilled nursing facility, Medicare does not cover the stay if all a person needs is custodial care.

3.1.51 Care Not Reasonable And Necessary Under Medicare Program Standards

Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. These services include drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA; and services, including drugs or devices, not considered safe and effective because they are experimental or investigational. Some services are not covered by Medicare even when FDA has approved them.

If a doctor admits a person to a hospital or skilled nursing facility when the kind of care they need could be provided elsewhere, for example, at home or in an outpatient facility, that stay will not be considered reasonable and necessary, and Medicare will not pay for the stay. If a person stays in a hospital or skilled nursing facility longer than they need to be there, Medicare payments will end when inpatient care is no longer reasonable and necessary.

If a doctor, or the practitioner comes to treat a person, or the person visits the doctor or practitioner for treatment, more often than is medically necessary, Medicare will not pay for the "extra" visits. Medicare will not pay for more services than are reasonable and necessary for the treatment.

Medicare always bases decisions about what is reasonable and necessary on professional medical advice.

3.1.52 Services Medicare Does Not Pay For

Medicare, by law, cannot pay for certain services. These include services performed by immediate relatives or members of a person's household, and services paid for by another government program. If a person has questions about whether Medicare pays for a particular service, they should contact the Medicare Part B MAC.

3.1.53 Limitation Of Liability

Under the Medicare law, a person will not be held responsible for payment of the cost of certain health care services for which they were denied Medicare payment if they did not know or could not reasonable be expected to know, that is, the person had not received a written notice, that the services were not covered by Medicare. This provision is called limitation of liability and is often referred to as a "waiver of liability". This protection from financial liability applies only when the care was denied because it was one of the following:

- custodial care;
- not "reasonable and necessary" under the Medicare program standards for diagnosis or treatment; or
- for home health services, the patient was not homebound or not receiving skilled nursing care on an intermittent basis.

This limitation of liability provision does not apply to Medicare Part B services provided by a non-participating supplier who did not accept assignment of the claim.

This limitation of liability provision does not apply under most circumstances to Part B services furnished by a non-participating physician who did not accept assignment of the claim. However, in certain situations the Medicare law will protect a person from paying for services provided by a non-participating physician on a non-assigned basis that are denied as "not reasonable and necessary". If the physician knows or should know that Medicare will not pay for a particular service as "not reasonable or necessary", the physician must give the patient a written notice, before performing the service, or the reasons why the physician believes Medicare will not pay. The physician must get a written agreement to pay for the services from the patient. If the patient did not receive this notice, the patient is not required to pay for the services. If the patient did pay, they may be entitled to a refund.

3.1.60 Scope of Part A Benefits

Medicare Part A helps pay for four kinds of medically necessary care:

- inpatient hospital care;

- inpatient care in a skilled nursing facility following a hospital stay;
- home health care; and
- hospice care.

There is a limit on how many days of hospital or skilled nursing facility care Medicare helps pay for in each benefit period. But a person's Part A protection is renewed every time they start a new benefit period, see RCM 3.1.61.

Skilled nursing facility care is the only type of nursing home care that Medicare covers. Medicare does not pay for care that is primarily custodial, see RCM 3.1.50 for more information about custodial care.

The following sections are applicable for Part A service provided prior to January 1, 1989 and after December 31, 1989. See Exhibit 10 for Part A services provided in 1989 and exceptions for Part A services provided in 1990.

3.1.61 Benefit Periods

A benefit period is a way of measuring the person's use of services under Medicare Part A. The person's first benefit period starts the first time they enter a hospital on or after their Part A effective date. A benefit period ends when the person has been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row, including the day of discharge. If the person remains in a facility, other than a hospital, that primarily provides skilled nursing or rehabilitation services, a benefit period ends when they have not received any skilled care there for 60 days in a row.

There is no limit to the number of benefit periods a person can have for hospital and skilled nursing facility care. However, special limited benefit periods apply to hospice care, see RCM 3.1.72.

Here are two examples of how the benefit period works:

- Ms. Jones enters the hospital on January 5. She is discharged on January 15. She has used 10 days of her first benefit period. Ms Jones is not hospitalized again until July 20. Since more than 60 days elapsed between her hospital stays, she begins a new benefit period, her Part A coverage is completely renewed, and she will again pay the hospital deductible. The hospital deductible is explained in RCM 3.1.63.
- Mr. Smith enters the hospital on August 14. He is discharged on August 24. He also has used 10 days of his first benefit period. However, he is then readmitted to the hospital on September 20. Since fewer than 60 days elapsed between hospital stays, Mr. Smith is still in his first benefit period and will not be required to pay another hospital deductible. This means that the first day of his second admission is counted as the 11th day of hospital care in that benefit period. Mr. Smith will not

begin a new benefit period until he has been out of the hospital, and has not received any skilled care in a skilled nursing facility, for 60 consecutive days.

3.1.62 How Medicare Pays For Part A Services

Medicare Part A helps pay for most but not all of the services rendered in a hospital or skilled nursing facility or from a home health agency or hospice program. There are covered services and non-covered services under each kind of care. Covered services are services and supplies that Medicare Part A will pay for.

Hospitals, skilled nursing facilities, home health agencies and hospices are called "providers" under the Medicare Part A program. Providers submit their claims directly to the Medicare intermediary. The person cannot submit claims for their Part A services. The provider will charge the person for any part of the Part A deductible they have not met and any coinsurance payment they may owe. Providers cannot require the person to make a deposit before being admitted for inpatient care that is or may be covered under Part A of Medicare.

EXCEPTION: If emergency inpatient services were provided by a nonparticipating hospital that does not bill for Medicare patients, the beneficiary will have to file a claim for payment. Such beneficiaries should be referred to the SSA district office for development and filing of a claim.

When a hospital, skilled nursing facility, home health facility or hospice sends the intermediary a Part A claim for payment, the person will get a Notice of Utilization that explains the decision Medicare made on the claim. This notice is not a bill. If the person has any questions about the notice, they should get in touch with the people (intermediary) who sent them the notice.

The intermediary also sends a notice when Part B benefits are performed by a Part A provider.

If the person is requesting information about, or requesting a duplicate notice, the person should contact the intermediary. However, if the person wishes to request this information directly from CMS, they can write to:

Centers for Medicare & Medicaid Services
Correspondence Branch, OMB. RM B3
1717 Equitable Building
6325 Security Boulevard
Baltimore, Maryland 20207

Any inquiry sent to CMS should contain the beneficiary's full name, address and Medicare claim number.

Although the intermediary issues the Notice of Utilization, the Entitlement Database (EDB) is maintained by CMS. Problems concerning utilization should be sent to:

Centers for Medicare & Medicaid Services
 Division of Medicare Operations Support
 Post Office Box 11981
 Baltimore, Maryland 21207

- A. Claim for Payment - Before a payment can be made for Medicare service, a written request for payment must be signed by the patient. Each of the provider billing forms contains a patient's signature line incorporating the patient's request for payment of benefits and authorization to release information. If, because of his/her physical and mental condition, the patient is unable to transact business at the time of admission, another person qualified to act on his/her behalf may sign the form. If necessary, an authorized official of the provider may sign the claim.
- B. Filing Timely Claims - Claims for Medicare benefits must be filed on or before December 31 of the calendar year following the year in which the services were furnished. The Patient Protection and Affordable Care Act (PPACA) of 2010 amended the timely filing requirements for submitting Medicare Fee-for-Service claims to one calendar year after the date of service
- C. Late Filing Due to Administrative Error - When an error by the RRB, the SSA, the CMS, an intermediary or a MAC caused the failure of the provider to file a timely request for payment, the time limit for filing is extended through the last day of the sixth calendar month following the month in which the error is corrected, but not beyond December 31 of the third calendar year after the year in which the services were furnished.

3.1.63 Inpatient Hospital Services

Medicare Part A helps pay for inpatient hospital care if all of the following four conditions are met:

- a doctor prescribes inpatient hospital care for treatment of a illness or injury;
- the kind of care that is required can be provided only in a hospital;
- the hospital is participating in Medicare; and
- the Utilization Review Committee of the hospital, a Peer Review Organization or an intermediary does not disapprove the stay.

If all of the four above conditions are met, Medicare will help pay for up to 90 days of medically necessary inpatient hospital care in each benefit period. Medicare pays for only limited care in a psychiatric hospital, see RCM 3.1.66.

From the first day through the 60th day in a hospital during each benefit period, Part A pays for all covered services except the inpatient hospital deductible. The deductible is

an amount the person owes before Medicare will begin to pay for services and supplies covered by the Medicare program. The hospital may charge the person the deductible only for the first admission in each benefit period. If the person is discharged and then readmitted before the benefit period ends, they do not have to pay the deductible again. See Exhibit 7 for a list of the deductible amounts.

From the 61st through the 90th day in a hospital during each benefit period, Part A pays for all covered services except for the daily coinsurance amount. See Exhibit 7 for a list of the daily coinsurance amounts.

Hospital reserve days, explained in RCM 3.1.64, can help with the persons expenses if they need more than 90 days of inpatient hospital care in a benefit period.

Medicare Part A does not pay for the services of doctors and certain other practitioners, even though the person received these services in a hospital. Instead, those services are covered under Medicare Part B, see RCM 3.1.80.

- COVERED HOSPITAL INPATIENT SERVICES

- a semiprivate room, two to four beds in a room
- all meals, including special diets
- regular nursing services
- costs of special care units, such as intensive care or coronary care units
- drugs furnished by the hospital during the person's stay
- blood transfusions furnished by the hospital during the person's stay, see RCM 3.1.65 for information about coverage of blood
- lab tests included in the hospital bill
- X-rays and other radiology services, including radiation therapy, billed by the hospital
- medical supplies such as casts, surgical dressings and splints
- operating and recovery room costs
- rehabilitation services, such as physical therapy, occupational therapy and speech pathology services

- HOSPITAL INPATIENT SERVICES NOT COVERED

- personal convenience items that the person requests such as a telephone or television in their room

- a private duty nurse
- any extra charges for a private room unless it is determined to be medically necessary

If a person disagrees with a decision on the amount Medicare Part A paid on a claim or whether services they received are covered by Medicare Part A, they always have the right to appeal the decision, see RCM 3.1.110.

3.1.64 Hospital Inpatient Reserve Days

Medicare helps pay for a person's care in a hospital for up to 90 days in each benefit period. And Medicare Part A includes an extra 60 hospital days the person can use if they have a long illness and have to stay in the hospital for more than 90 days. These extra days are called reserve days. Once the person uses a reserve day they never get it back. Reserve days are not renewable.

Medicare Part A will pay for all covered services except for the coinsurance for each reserve day used. See Exhibit 7 for a list of the coinsurance amounts for reserve days. The person is responsible for paying the coinsurance.

The person has only 60 reserve days in their lifetime, and they can decide when they want to use them. After the person has been in the hospital 90 days, they can use all or some of their 60 reserve days right away if they do not want to.

If the person does not want to use their reserve days, they must tell the hospital in writing, either when they are admitted to the hospital or any time afterwards up to 90 days after they are discharged. If the person uses reserve days and then decides that they did not want to use them, they must request approval from the hospital to get them restored.

All Medigap plans pay some part of hospital bills after they person has used all of their reserve days. See RCM 3.1.40 for more information about Medigap insurance.

3.1.65 Coverage Of Blood Under Part A

Part A helps pay for blood, whole blood or units of packed red blood cells, blood components and the cost of blood processing and administration. If the person receives blood as an inpatient of a hospital or skilled nursing facility, Part A will pay for these blood costs, except for any non-replacement fees charges for the first three pints of whole blood or units of packed red cells per calendar year. The non-replacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

The person is responsible for the non-replacement fees for the first three pints or units of blood furnished by a hospital or skilled nursing facility. When the person is charged non-replacement fees, they have the option of either paying the fees or having the blood

replaced. If the person chooses to have the blood replaced, they can either replace the blood personally or arrange to have another person or an organization replace it for them. A hospital or skilled nursing facility cannot charge the person for any of the first three pints of blood they replace or arrange to replace. If the person has already paid for or replaced blood under Medicare Part B during the calendar year, they do not have to meet those costs again under Medicare Part A. See RCM 3.1.81 for an explanation of coverage of blood under Medicare Part B.

3.1.66 Care In A Psychiatric Hospital

Part A helps pay for no more than 190 days of inpatient care in a participating psychiatric hospital in the person's lifetime. Once the person has used these 190 days, Part A does not pay for any more inpatient care in a psychiatric hospital.

3.1.67 Care Outside The United States

Medicare generally does not pay for hospital or medical services outside the U.S. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the U.S. However, it can help pay for care in qualified Canadian or Mexican hospitals under certain conditions.

Payment can be made to a RR beneficiary for all covered hospital services furnished by a qualified Canadian hospital, regardless of where the beneficiary lives. The RRB acts as the Medicare Part A intermediary and makes payment for Medicare Part A claims for covered Part A benefits.

In Mexico, Part A benefits for covered inpatient hospital services can be paid in two situation. They are:

- the person is in the U.S. when an emergency occurs and a Mexican hospital is closer than the nearest U.S. hospital which can provide the emergency services they need; or
- the person lives in the U.S. and a Mexican hospital is closer to their home than the nearest U.S. hospital which can provide the care the person needs, regardless of whether or not an emergency exists.

If the person is planning to travel outside the U.S., they may want to buy special short-term health insurance for foreign travel. If the person has other health insurance in addition to Medicare, they should check to see if health care in a foreign country is covered under their policy.

See RCM 3.8 for payment of Medicare services outside the U.S.

3.1.68 Care In A Christian Science Sanatorium

Medicare Part A helps pay for inpatient hospital and skilled nursing facility services a person receives in a participating Christian Science Sanatorium if it is operated or listed and certified by the First Church of Christ, Scientist, in Boston. However, Medicare Part B will not pay for the practitioner.

3.1.69 The Prospective Payment System

Medicare pays for most inpatient hospital care under the Prospective Payment System (PPS). Under PPS, hospitals are paid a predetermined rate per discharge for inpatient services furnished to Medicare beneficiaries. The predetermined rates are based on payment categories called Diagnosis Related Groups, or DRG's. In some cases, the Medicare payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high or the length of stay is unusually long, the hospital receives additional payment. But even if Medicare pays the hospital less than the cost of the person's care, the person does not have to make up the difference.

It is important to remember that the PPS system does not change the person's Medicare Part A protection. PPS does not determine the length of the person's hospital stay or the extent of care they receive. The law requires participating hospitals to accept Medicare payments as payments in full, and those hospitals are prohibited from billing the Medicare patient for anything other than the applicable deductible and coinsurance amounts, plus any amounts due for non-covered items or services, such as television, telephone or private duty nurses.

3.1.70 Skilled Nursing Facility Care

Medicare Part A can help pay for certain inpatient care in a

Medicare-participating skilled nursing facility following a hospital stay if the person's condition requires daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility, and the skilled care they receive must be based on a doctor's order.

- A. What is a Skilled Nursing Facility? - A skilled nursing facility is a specially qualified facility that specializes in skilled care. It has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist.

Most nursing homes in the U.S. are not skilled nursing facilities that participate in Medicare. In some facilities, only certain portions participate in Medicare. If the

person is not sure whether a facility participates in Medicare as a skilled nursing facility, they should ask someone in the facility's business office.

B. When Can Medicare Pay For Care in a Skilled Nursing Facility? - Medicare Part A can help pay for care in a Medicare-participating skilled nursing facility if all of the following six conditions are met:

- the person's condition requires daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility;
- the person was in a hospital at least three days in a row, not counting the day of discharge, before they are admitted to a participating skilled nursing facility;
- the person is admitted to the facility within a short time, generally within 30 days after they leave the hospital;
- the care in the skilled nursing facility is for a condition that was treated in the hospital, or for a condition that arose while the person was receiving care in the skilled nursing facility for a condition which was treated in the hospital;
- a medical professional certifies that the person needs and received skilled nursing or skilled rehabilitation services on a daily basis; and
- the Medicare intermediary does not disapprove the person's stay.

All six conditions must be met. Remember, the person must need skilled nursing care or skilled rehabilitation services on a daily basis. Part A will not pay for a person's stay if they need skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if they do not need to be in a skilled nursing facility to get skilled services. Also, Medicare will not pay for a person's stay if they are in a skilled nursing facility mainly because they need custodial care.

When a person's stay in a skilled nursing facility is covered by Medicare, Part A helps pay for a maximum of 100 days in each benefit period, but only if the person needs daily skilled nursing care or rehabilitation services for that long.

If the person leaves a skilled nursing facility and they are readmitted within 30 days, they do not have to have a new three day stay in the hospital for their care to be covered. If they have some of the 100 days left and they need skilled nursing or rehabilitation services on a daily basis for further treatment of a condition treated during their previous stay in the facility, Medicare will help pay.

In each benefit period, Part A pays for all covered services for the first 20 days a person is in a skilled nursing facility. For the 21st through 100th day, Part A pays

for all covered services except the daily coinsurance amount. See Exhibit 7 for a list of the daily coinsurance amounts.

Medicare Part A does not cover the person's doctor's services while they are in a skilled nursing facility. Medicare Part B covers doctors' services, see RCM 3.1.80.

- COVERED SERVICES IN A SKILLED NURSING FACILITY

- a semiprivate room, two to four beds in a room
- all meals, including special diets
- regular nursing services
- physical, occupational and speech therapy
- drugs furnished by the facility during the person's stay
- blood transfusions furnished during the person's stay, see RCM 3.1.65 for information about coverage of blood
- medical supplies such as splints and casts furnished by the facility
- use of appliances such as a wheel chair furnished by the facility

- SERVICES NOT COVERED IN A SKILLED NURSING FACILITY

- personal convenience items that the person requests such as a television in their room
- a private duty nurse
- any extra charges for a private room, unless it is determined to be medically necessary

If a person wants to complain about a skilled nursing facility's treatment of patients or other conditions that concern them, they can contact the State survey agency. Each skilled nursing facility can give the person the telephone number and address of the State survey agency. The person can also look at a copy of the skilled nursing facility's latest certification survey report. The survey report will tell the person the results of the State survey agency's review of how well the agency thinks the facility followed the rules about the patient's rights, safety and quality of care.

If a person disagrees with a decision on the amount Medicare Part A paid on a claim or whether services they received are covered by Medicare Part A, the person always has the right to appeal the decision, see RCM 3.1.110.

3.1.71 Home Health Care

If a person needs skilled health care in their home for the treatment of an illness or injury, Medicare pays for covered home health services furnished by a participating home health agency. A home health agency is a public or private agency that specialized in giving skilled nursing services and other therapeutic services, such as physical therapy in their home. A hospital or other facility that mainly provides skilled nursing or rehabilitation services cannot be consider the person's home.

Medicare pays for home health visits only if all of the following conditions are met:

- the care the person needs includes intermittent skilled nursing care, physical therapy or speech therapy;
- the person is confined to their home, homebound;
- the person is under the care of a physician who determines they need home health care and sets up a home health plan for them; and
- the home health agency providing services is participating in Medicare.

Once all four of the above conditions are met, either Medicare Part A or Medicare Part B will pay for all medically necessary home health services. When the person no longer needs intermittent skilled nursing care, physical therapy or speech therapy, Medicare will pay for home health services if the person continues to need occupational therapy.

Medicare home health services do not include coverage for general household services such as laundry, meal preparation, shopping or other home care services furnished mainly to assist people in meeting personal, family or domestic needs.

For a person to determine whether they can get services under the Medicare home health benefit, they should ask their physician to refer them to a Medicare participating home health agency. The home health agency will evaluate the person's case and advise them about whether they meet the requirement for Medicare coverage. Home health agencies do not charge for the evaluation.

- COVERED HOME HEALTH SERVICES
 - part-time or intermittent skilled nursing care. This can include eight hours of reasonable and necessary care per day for up to 21 consecutive days - or longer in certain circumstances.
 - physical therapy
 - speech therapy

- if the person also needs intermittent skilled nursing care, or physical or speech therapy, Medicare will also pay for:
 - occupational therapy
 - part-time or intermittent services of home health aides
 - medical social services
 - medical supplies
 - durable medical equipment, 80 percent of approved amount
- HOME HEALTH SERVICES NOT COVERED
 - 24-hour-a-day nursing care at home
 - drugs and biologicals
 - meals delivered to a person's home
 - homemaker services
 - blood transfusions

Medicare pays the full approved cost of all covered home health visits. The person may be charged only for any services or costs that Medicare does not cover. However, if the person needs durable medical equipment, they are responsible for a 20 percent coinsurance payment for the equipment.

The home health agency will submit the claim for payment. The person does not have to send in any bills.

If a person disagrees with a decision on the amount Medicare Part A paid on a claim or whether services they received are covered by Medicare Part A, they always have the right to appeal the decision, see RCM 3.1.110.

3.1.72 Hospice Care

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people.

Hospice care is a special type of care for people who are terminally ill. It includes both home care and inpatient care, when needed, and a variety of services not otherwise covered under Medicare. Under the Medicare hospice benefit, Medicare pays for

services every day and also permits a hospice to provide appropriate custodial care, including homemaker services and counseling.

Medicare Part A helps pay for hospice care if all three of the following conditions are met:

- a doctor certifies that the patient is terminally ill;
- the patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness; and
- care is provided by a Medicare-participating hospice program.

Special benefit periods apply to hospice care. Part A pays for two 90-day periods, followed by a 30-day period, and when necessary, an extension period of indefinite duration. Hospice benefit periods may be consecutive. If a beneficiary cancels hospice care during one of the first three benefit periods, any days left in that period are lost, but the remaining benefit period(s) are still available. And, a beneficiary may disenroll from the hospice during any benefit period, return to regular Medicare coverage, then later re-elect the hospice benefit if another benefit period is available.

Two Hospice Benefit Period Examples:

- Mr. Jones canceled his hospice care at the end of 59 days during his first 90-day benefit period. He lost the 31 remaining days of the first 90-day period. But if he wants to, he can choose hospice care again. He still have a 90-day period, a 30-day period and the indefinite extension period.
- Ms. Smith canceled hospice care during her final extension period. She cannot use the Medicare hospice benefit again.

There are no deductibles under the hospice benefit. The person does not pay for Medicare-covered services for the terminal illness, except for small coinsurances amounts for outpatient drugs and inpatient respite care.

The patient is responsible for five percent of the cost of outpatient drugs or \$5 toward each prescription, whichever is less. For inpatient respite care, the patient pays five percent of the Medicare-allowed rate. The rate varies slightly depending on the area of the country.

Respite care under the hospice program is a short term inpatient stay in a facility. The Medicare beneficiary's inpatient stay gives temporary relief, a respite, to the person who regularly assists with home care. Each inpatient respite care stay is limited to no more than five days in a row.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

- COVERED HOSPICE SERVICES

- nursing services
- doctor's services
- drugs, including outpatient drugs for pain relief and symptom management
- physical therapy, occupational therapy and speech language pathology
- home health aid and homemaker services
- medical social services
- medical supplies and appliances
- short-term inpatient care, including respite care
- counseling

The Medicare Part A hospice benefit does not pay for treatments other than for pain relief and symptom management of a terminal illness. Regular Medicare can usually help pay for treatments not related to the terminal illness.

If a person disagrees with a decision on the amount Medicare Part A paid on a claim or whether services they received are covered by Medicare Part A, they always have the right to appeal the decision, see RCM 3.1.110.

3.1.80 Scope of Part B Benefits

Medicare Part B helps pay for:

- doctors' services;
- outpatient hospital care;
- diagnostic tests;
- durable medical equipment;
- ambulance services; and
- many other health services and supplies which are not covered by Medicare Part A.

The following sections tell more about these different kinds of care, the services that are and are not covered by Medicare Part B and what part of the person's medical expenses Medicare will pay.

3.1.81 Deductible And Coinsurance Amounts Under Part B

- A. The Annual Deductible - The person must pay an annual deductible before Medicare begins paying approved charges for covered medical expenses. This is called the Medicare Part B annual deductible. The person needs to meet this deductible only once during the year, and the deductible can be met by any combination of covered expenses. The person does not have to meet a separate deductible for each different kind of covered service they receive.
- B. The Blood Deductible - The person must pay any non-replacement fees charged for the first three pints or units of blood and blood components they use each year. The nonreplacement fee is the charge that some practitioners and facilities make for blood which is not replaced. This is called the Medicare Part B blood deductible. After the person has replaced or paid for the first three pints of blood and they have met the annual deductible, Medicare will pay 80 percent of the approved amount for blood, starting with the fourth pint. If the person has already paid for or replaced some units of blood under Medicare Part A during the calendar year, they do not have to pay for or replace that number of units again under Medicare Part B.
- C. Coinsurance - After the person pays the annual deductible, they will owe a share of the Medicare-approved amount for services and supplies. This share is called coinsurance. Usually, the coinsurance share is 20 percent of the Medicare-approved amount.

Medicare determines the approved amount for each service covered under Part B. If the services were provided "on assignment," the person pays only the coinsurance, see RCM 3.1.100 for an explanation of assignment.

If the services were not provided "on assignment," and the charges for the services were more than the Medicare-approved amount, the person usually owes the Medicare coinsurance plus certain charges above the Medicare-approved amount. See Medicare-Approved Amounts in RCM 3.1.104. There are limits on the amount a doctor can charge a patient.

This explanation of the deductible and coinsurance amounts describes Medicare's payments system for most services covered by Medicare Part B. In cases where the payment for services is handled in a different way, the person will be given an explanation along with the description of services covered.

3.1.82 Doctors' Services Covered By Medicare Part B

Medicare Part B helps pay for covered services a person receives from their doctor in the doctor's office, in a hospital, in a skilled nursing facility, in the person's home or any other location.

- A. Major Doctors' Services Covered by Medicare Part B

- medical and surgical services, including anesthesia
- diagnostic tests and procedures that are part of the person's treatment
- radiology and pathology services by doctors while the person is a hospital inpatient or outpatient
- treatment of mental illness, see RCM 3.1.88 for Medicare payment for nonhospital treatment which are limited
- other services such as:
 - X-rays
 - services of a person's doctor's office nurse
 - drugs and biologicals that cannot be self-administered
 - transfusions of blood and blood components
 - medical supplies
 - physical/occupational therapy and speech pathology services

B. Some Doctors' Services Not Covered by Medicare Part B

- routine physical examinations, and tests directly related to such examinations, except some Pap smears and mammograms
- most routine foot care and dental care
- examinations for prescribing or fitting eyeglasses or hearing aids
- immunizations, except pneumococcal pneumonia vaccinations or immunizations required because of an injury or immediate risk of infection and Hepatitis B for certain persons at risk
- cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body

C. Types of Doctors - Most doctors' services are furnished by a doctor of medicine or a doctor of osteopathy. Other "physicians" that can furnish some covered services include chiropractors, doctors of podiatric medicine (podiatrists), doctors of dental surgery or of dental medicine (dentists) and doctors of optometry (optometrists).

D. Chiropractors' Services - Medicare helps pay for only one kind of treatment furnished by a licensed chiropractor: manual manipulation of the spine to correct

a subluxation that is demonstrated by X-ray. Medicare Part B does not pay for any other diagnostic or therapeutic services, including X-rays, furnished by a chiropractor.

- E. Podiatrists' Services - Medicare Part B helps pay for any covered services of a licensed podiatrist to treat injuries and diseases of the foot. Examples of common problems include ingrown toenails, hammer toe deformities, bunion deformities and heel spurs.

Medicare generally does not pay for routine foot care such as cutting or removal of corns and calluses, trimming of nails, and other hygienic care. But, Medicare does help pay for some routine foot care if the person is being treated by a medical doctor for a medical condition affecting the person's legs or feet, such as diabetes or peripheral vascular disease, which requires that the routine care be performed by a podiatrist or by a doctor of medicine or osteopathy.

- F. Dentists' Service - Medicare Part B generally does not pay for care in connection with the treatment, filling, removal or replacement of teeth; root canal therapy; surgery for impacted teeth; or other surgical procedures involving the teeth or structures directly supporting the teeth. However, Medicare does help pay for services of a dentist in certain cases when the medical problem is more extensive than the teeth or structures directly supporting them. If a person needs to be hospitalized because of the severity of a dental procedure, Medicare Part A will pay for their inpatient hospital stay even if the dental care itself is not covered by Medicare.
- G. Optometrists' Services - Medicare helps pay for Medicare-covered vision care, including the services of an optometrist if the optometrist is legally authorized to perform those services by the State in which he or she performs them. However, Medicare will not pay for routine eye exams, and it will usually not pay for eyeglasses. Medicare will pay for cataract spectacles, cataract contact lenses or intraocular lenses that replace the natural lens of the eye after cataract surgery. Medicare will also pay for one pair of conventional eyeglasses or conventional contact lenses if necessary after insertion of an intraocular lens.

3.1.83 Second Opinion Before Surgery

Sometimes a doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, Medicare recommends that the person get an opinion from a second doctor to help the person decide about surgery. Medicare will help pay for a second opinion. Medicare will also help pay for a third opinion if the first and second opinions contradict each other.

The person's own doctor is the best source for referral to another doctor. But, if the person wishes, they can call the Medicare Part B carrier for the names and phone numbers of doctors in their area who provide second opinions.

3.1.84 Services Of Special Practitioners

Medicare Part B helps pay for covered services a person receives from certain specially qualified practitioners who are not physicians. The practitioners must be approved by Medicare. Medicare-approved practitioners are listed below:

- certified registered nurse anesthetist
- certified nurse midwife
- clinical psychologist
- clinical social worker, other than in a hospital or skilled nursing facility
- physician assistant, a physician assistant can furnish certain services in a hospital or certain other facilities; can serve as an assistant-at-surgery; and can furnish services in any location that is designated as a rural health professional shortage area
- nurse practitioner and clinical nurse specialist in collaboration with a physician, a nurse practitioner can furnish services in a skilled nursing facility or a Medicaid nursing facility in any area. In addition, a nurse practitioner or clinical nurse specialist can furnish services in a rural area.

3.1.85 Outpatient Hospital Services

Medicare Part B helps pay for covered services a person receives as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury. Under certain conditions, Medicare helps pay for emergency outpatient care they receive from a non-participating hospital.

When a person receives outpatient hospital services, they are responsible for the annual Medicare Part B deductible. In addition to the deductible, they are responsible for a coinsurance of 20 percent of the hospital's charge above the deductible.

When a person goes to a hospital for outpatient services, they are sometimes asked how much of their Part B deductible has been met. One easy way to answer that question is for the person to look at their most recent Explanation of Your Medicare Part B Benefits notice. From this form, it can usually tell how much of the annual deductible the person has met.

If the hospital cannot tell how much of the deductible the person has met and the charge for the services they received is less, the hospital may ask the person to pay the entire bill. The amount they pay the hospital can be credited toward any part of the

deductible they have not met. If the person pays the hospital for deductible amounts they do not owe, the hospital or the Medicare intermediary will refund the amount they overpaid.

- COVERED OUTPATIENT HOSPITAL SERVICES

- services in an emergency room or outpatient clinic, including same-day surgery
- laboratory tests billed by the hospital
- mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- medical supplies such as splints and casts
- drugs and biologicals that cannot be self-administered
- blood transfusions furnished a person as an outpatient

- OUTPATIENT HOSPITAL SERVICES NOT COVERED

- routine physical examinations, and tests directly related to such examination, except some Pap smears and mammograms
- eye or ear examinations to prescribe or fit eyeglasses or hearing aids
- immunization, except pneumococcal pneumonia and Hepatitis B vaccinations, or immunizations required because of an injury or immediate risk of infection
- most routine foot care

3.1.86 Other Services And Supplies Covered By Medicare

- A. Ambulatory Surgical Services - An ambulatory surgical center is a facility that provides surgical services that do not require a hospital stay. Medicare Part B will pay for the use of an ambulatory surgical center for certain approved surgical procedures. However, by law, Medicare can only pay centers that have an agreement with Medicare to participate in the Medicare program. If a person does not know if an ambulatory surgical center participates in Medicare, they should ask someone in the center's business office. If that person does not know, they should call the Medicare Part B carrier.

In addition to helping pay for the use of the ambulatory surgical center, Medicare also helps pay for physician and anesthesia services that are provided in connection with the procedure.

- B. Home Health Services - If a person has both Medicare Part A and Part B, their Part A pays for home health services. However, if a person does not have Part A, Part B will pay for home health services as described in RCM 3.1.71.
- C. Outpatient Physical and Occupational Therapy and Speech Pathology Services - Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy or speech pathology services, if all of the following three conditions are met:
- the person's doctor prescribes the service;
 - the person's doctor or therapist sets up the plan of treatment; and
 - the person's doctor periodically reviews that plan

The person can receive physical therapy, occupational therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency or public health agency. The provider of services may charge the person only for any part of the annual deductible they have not met, 20 percent of the remaining approved amount and any non-covered services.

Also, the person can receive services directly from an independently practicing, Medicare-approved physical or occupational therapist in the therapist's office or in the person's home if such treatment is prescribed by a doctor. But, the maximum amount Medicare pays for each of these services provided by an independently practicing physical or occupational therapist is \$600 a year. This is 80 percent of the maximum approved amount of up to \$750. The Medicare payment would be less than \$600 if charges for these services are used to meet part or all of the person's \$100 annual deductible.

- D. Comprehensive Outpatient Rehabilitation Facility Services - Under certain circumstances, Medicare helps pay for outpatient services a person receives from a Medicare-participating comprehensive outpatient rehabilitation facility (CORF). Covered services include physicians' services; physical, speech, occupational and respiratory therapies; counseling; and other related services. The person must be referred by a physician who certifies that they need skilled rehabilitation services. For most CORF services, the person is responsible only for the annual deductible and 20 percent of the Medicare approved-charges. Medicare helps pay for mental health treatment in a CORF, the Medicare payment limit for mental health treatment in a CORF is discussed in RCM 3.1.88.
- E. Partial Hospitalization for Mental Health - Partial hospitalization means an ambulatory program of active care that lasts less than 24 hours a day. Under certain conditions, Medicare Part B helps pay for partial hospitalization for mental health services furnished by hospital outpatient units and by qualified community mental health centers. If a person is considering mental health treatment, they

should check with the program they have chosen to see if it meets the conditions for Medicare payment.

- F. Rural Health Clinic Services - Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses, under certain conditions, clinical psychologists and clinical social workers furnished by a rural health clinic. The person is responsible only for the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the clinic.
- G. Federally Qualified Health Center Services - Federally qualified health centers are located in both rural and urban areas. As part of the "federally qualified health center benefit," Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses, under certain conditions, clinical psychologists and clinical social workers. Also, as part of the federally qualified health center benefit, Medicare helps pay for certain preventive health services. The person does not have to pay the Medicare Part B annual deductible for services provided under the federally qualified health center benefit. The person is responsible for 20 percent of the Medicare-approved charge for the clinic.

There are some specialized services that may be provided by a federally qualified health center that are not part of the federally qualified health center benefit. For these services, the person does have to meet the annual Part B deductible. As long as the center meets Medicare requirements to provide these specialized services, Medicare Part B can help pay for them. The center will tell the person if the service they need is a specialized service. For example, the center may provide screening mammograms. If the person gets a mammogram at the center, they are responsible for any unmet part of the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the mammogram.

- H. Independent Laboratory Services - Medicare Part B pays the full approved fee for covered clinical diagnostic tests provided by independent laboratories that are approved to perform them. The laboratory must accept assignment for these tests. See RCM 3.1.100 for an explanation of assignment. It may not bill the person for the tests.

Not all laboratories are approved by Medicare and some laboratories are approved only for certain kinds of tests. If a doctor orders tests which the laboratory is not approved to perform, Medicare does not pay for the tests, and the person can be required to pay for them. The person's doctor can usually tell them which laboratories are approved and whether the tests he or she is ordering from an approved laboratory are covered by Medicare. If the person's doctor can not tell, they should call the Medicare Part B carrier.

The person's doctor must accept assignment for covered clinical diagnostic laboratory tests which he or she furnishes. The doctor is not allowed to bill the person for the tests. See RCM 3.1.100 for an explanation of assignment.

- I. Portable Diagnostic X-ray Services - Medicare Part B helps pay for portable diagnostic X-ray services a person receives in their home or other location if they are ordered by a doctor and if they are provided by a Medicare-approved supplier. The person can ask the Part B carrier whether the supplier is Medicare-approved.
- J. Other Diagnostic Tests - Medicare Part B also helps pay for other diagnostic tests, including X-rays, that the person's doctor orders to evaluate the person's medical problems.
- K. Pap Smear Screening - Medicare Part B helps pay once every three years for Pap smears to screen for cervical cancer. Medicare helps pay more frequently for certain women at high risk. Medicare also pays for diagnostic Pap smears as needed when symptoms are present.
- L. Breast-Cancer Screening (Mammography) - Medicare Part B helps pay for X-ray screenings for the detection of breast cancer, if they are provided by a Medicare-approved supplier. Women 65 or older can use the benefit every other year. Younger, disabled women covered by Medicare can use the screening benefit more frequently. Medicare also pays for diagnostic mammograms as needed when symptoms are present.

For accurate up-to-date information on cancer prevention, detection, diagnosis, and treatment for patients, their families and the general public, a person can call the Cancer Information Service at 1-800-4-CANCER.

- M. Radiation Therapy - Medicare Part B helps pay for outpatient radiation therapy given under the supervision of a person's doctor.
- N. Kidney Dialysis and Transplants - Medicare Part B helps pay for kidney dialysis and transplants. For detailed information on this coverage, a person can get a copy of Medicare Coverage of Kidney Dialysis and Kidney Transplant Services by calling 1-800-MEDICARE (1-800-808-0772) or by visiting www.medicare.gov on the Internet.
- O. Heart and Liver Transplants - Under certain limited conditions, Medicare Part B helps pay for heart and liver transplants in a Medicare-approved facility. If the person is considering a heart or liver transplant, the person and their physician can find out about Medicare coverage by contacting the Part B carrier. If they belong to an HMO, the HMO will give them the information they need about Medicare coverage.

P. Ambulance Transportation - Medicare Part B helps pay for medically necessary ambulance transportation, but only if:

- the ambulance, equipment and personnel meet Medicare requirements; and
- transportation in any other vehicle could endanger the person health.

Under these conditions, Medicare helps pay for ambulance transportation but only to a hospital or skilled nursing facility, or from a hospital or skilled nursing facility to the person home. Medicare does not pay for ambulance use from the person's home to a doctor's office or to a dialysis facility.

Medicare usually helps pay only if the ambulance transportation is in the person's local area. But, if there are no local facilities equipped to provide the care the person needs, Medicare helps pay for necessary ambulance transportation to the closest facility outside the person's local area that can provide the necessary care. If there is a local facility equipped to provide the care the person needs but the person chooses to go to another institution that is farther away, Medicare payment is based on the charge for transportation to the closest facility that can provide the necessary care.

Q. Durable Medical Equipment - Medicare Part B helps pay for durable medical equipment such as oxygen equipment, wheelchairs and other medically necessary equipment that the person's doctor prescribes for use in the person's home. A hospital or facility that mainly provides skilled nursing or rehabilitation services cannot be considered the person's home.

To be considered durable medical equipment, the equipment must be able to be used over again by other patients, must primarily serve a medical purpose, must not be useful to people who are not sick or injured and must be appropriate for use in the person's home. Not all types of equipment that a person might find useful can meet all four of these requirements.

Only the person's doctor should prescribe medical equipment for the person. An equipment supplier should not take any of the following actions:

- contact the person first, either by phone or by mail, and offer to get the person's doctor or Medicare to approve an item. It is all right for the supplier to contact the person in response to calls from the person's doctor or other health care workers;
- say he or she works for, or represents Medicare;
- deliver equipment to the person's home that neither the person nor the person's doctor ordered; or
- send the person used items, while billing Medicare for new ones.

Some of these actions may be against the law. If the person believes a supplier has taken any of these actions, the person should alert the Part B carrier. First, the person should ask their doctor whether he or she ordered the item. If the person's doctor did not order the item, the person should file a complaint with the Medicare Part B carrier. They can file the complaint by phone, in person or in writing. The Part B carrier will investigate the complaint.

It is also illegal for a supplier to offer the person items at no cost to the person or offer to pay the Medicare coinsurance on items. If a supplier makes one of these offers, the person should file a complaint with the Part B carrier as described above.

NOTE: The durable medical equipment supplier must have the person's doctor's prescription before delivering any of the following items: seat lift chairs, power-operated vehicles, equipment for care of pressure sores or transcutaneous electrical nerve stimulators. In the case of seat lift chairs, Medicare covers only the lift mechanism, not the chair itself.

Medicare uses three methods of payment for durable medical equipment: Lease-purchase, lump-sum payment for purchase or rental charges. The Part B carrier will be able to provide more specific guidance to the person on which method will be used for a particular item.

- R. Prosthetic Devices - Medicare Part B helps pay for prosthetic devices needed to substitute for an internal body organ. These include Medicare-approved corrective lenses needed after a cataract operation, ostomy bags and certain related supplies and breast prostheses including a surgical brassiere after a mastectomy. Medicare also helps pay for artificial limbs and eyes, and for arm, leg, back and neck braces. Medicare does not pay for orthopedic shoes unless they are an integral part of leg braces and the cost is included in the charge for the braces. Medicare does not pay for dental plates or other dental devices.
- S. Medical Supplies - Medicare Part B helps pay for surgical dressings, splints and casts ordered by a doctor in connection with a person's medical treatment. This does not include adhesive tape, antiseptics or other common first-aid supplies.

3.1.87 Drugs And Biologicals

- A. Pneumococcal Pneumonia Vaccine - Medicare Part B pays the full approved charges for pneumococcal pneumonia vaccine and its administration. Neither the \$100 annual deductible nor the 20 percent coinsurance applies to this service.
- B. Hepatitis B Vaccine - Medicare Part B helps pay for Hepatitis B vaccine administered to beneficiaries considered to be at high or intermediate risk of contracting the disease.

- C. Hemophilia Clotting Factors - Medicare Part B helps pay for blood clotting factors and items related to their administration for hemophilia patients who are able to use them to control bleeding without medical or other supervision. The amount of clotting factors necessary to have on hand for a specific period is determined for each patient individually.
- D. Blood - Medicare Part B helps pay for blood and blood components that a person receives as a hospital outpatient or as part of other services. See RCM 3.1.81 for an explanation of the blood deductible.
- E. Antigens - Under certain circumstances, Medicare Part B helps pay for antigens prepared for the person by their doctor. They can check with the Part B carrier to see if Medicare will pay for their antigens.
- F. Immunosuppressive Drugs - Immunosuppressive drugs are often given to prevent rejection of transplanted organs. Medicare Part B helps pay for drugs used in immunosuppressive therapy for one year beginning with the date of discharge from the inpatient hospital stay during which a Medicare-covered organ transplant was performed.
- G. Epogen - Medicare Part B helps pay for the drug epogen (EPO) when used to treat Medicare beneficiaries with anemia related to chronic kidney failure, or with AIDS. The kidney failure patients are not required to be on dialysis. The EPO must be administered incident to the services of a doctor in the office or in a hospital outpatient department. Part B also helps pay for EPO that is self-administered by home dialysis patients or administered by their caregivers.

3.1.88 Medicare Payments For Non-Hospital Treatment Of Mental Illness

Medicare helps pay for services the person receives for nonhospital treatment of a mental illness. They may get the services from doctors, comprehensive outpatient rehabilitation facilities (CORFs), physician assistants, psychologists and clinical social workers.

These services for nonhospital treatment of a mental illness are subject to a special payment rule. In effect, once the annual deductible is met, Medicare Part B pays only 50 percent, not 80 percent, of approved charges for these services. On assigned claims, beneficiaries are responsible for paying the remaining 50 percent. For unassigned claims, beneficiaries may have to pay more. See RCM 3.1.100 for information about assignment.

Partial hospitalization services for treatment of mental illness are not subject to this special payment rule. Also, brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental illness are not subject to this special payment rule. See RCM 3.1.86 for more information about partial hospitalization services.

3.1.89 Services Rendered Outside The United States

Services received outside the U.S. are generally not payable. Medicare Part B can help pay for services rendered in Mexico and Canada if certain situations exist.

- FOR CANADA THEY ARE:
 - the individual was in the U.S. when an emergency occurred and the Canadian hospital is closer than the nearest U.S. hospital which can provide the emergency services needed; or
 - the individual lives in the U.S. and a Canadian hospital is closer to his or her home than the nearest U.S. hospital which could provide the care needed, regardless of whether or not an emergency existed; or
 - the individual is in Canada traveling by the most direct route between Alaska and another State and an emergency occurs which requires an admission to a Canadian hospital (vacationing in Canada does not apply).
- FOR MEXICO THEY ARE:
 - the individual is in the U.S. when an emergency occurs and a Mexican hospital is closer than the nearest U.S. hospital which could provide the emergency services needed; or
 - the individual lives in the U.S. and a Mexican hospital is closer to his home than the nearest U.S. hospital which could provide the care needed regardless of whether or not an emergency existed.

NOTE: Medicare may not pay if the individual leaves the U.S. for a reason other than to obtain medical treatment (example: vocation), even though the medical emergency occurred within the U.S.

See RCM 3.8 for payment of Medicare services outside the U.S.

3.1.100 The Assignment Payment Method

Under the assignment method, a doctor or supplier agrees to accept the amount approved by the Medicare Part B MAC as total payment for covered services: the doctor or supplier agrees to "take assignment".

The assignment method can save a person money. The doctor or supplier sends the claim to Medicare. Medicare pays the doctor or supplier 80 percent of the Medicare-approved amount, after subtracting any part of the \$100 annual deductible not yet met. The doctor or supplier can charge only for the part of the \$100 annual deductible not met and for the coinsurance, which is the remaining 20 percent of the approved amount.

Of course, the doctor or supplier also can charge for services that Medicare does not cover.

Doctors and certain other practitioners and suppliers must take assignment on all claims for services furnished to Medicare beneficiaries who are eligible for medical assistance through their State Medicaid program, including Qualified Medicare Beneficiaries. See RCM 3.1.22 for Assistance for Low-Income Beneficiaries.

3.1.101 Participating Doctors And Suppliers

Doctors and suppliers may sign agreements to become Medicare participating. Medicare-participating doctors and suppliers have agreed in advance to accept assignment on all Medicare claims. Doctors and suppliers are given the opportunity to sign participation agreements each year. Medicare participating doctors and suppliers can display emblems or certificates which show that they accept assignment on all Medicare claims.

The name and addresses of Medicare-participating doctors and suppliers are listed, by geographic area, in the Medicare-Participating Physician/Supplier Directory. A person can get the directory for their area free of charge from the Medicare Part B MAC; or they can call the toll-free telephone number and ask for names of some participating doctors and suppliers in their area. Also, this directory is available to look at in any RRB field office, SS office, State and area offices of the Administration on Aging and in most hospitals.

3.1.102 When A Doctor Does Not Accept Assignment

If a doctor or supplier does not accept assignment, the patient must pay the doctor or supplier directly. The patient is responsible for the part of the bill that is more than the Medicare-approved amount, up to the limit explained below. The patient must pay this amount because the doctor or supplier did not agree to accept the Medicare-approved amount as payment in full. In this case, Medicare pays the patient 80 percent of the approved amount, after subtracting any part of the \$100 annual deductible the patient has not met.

Even though a doctor does not accept assignment, there are limits on the amount that they can actually charge a patient. In 1992, the most a doctor can charge a patient is 120 percent of the fee schedule amount for non-participating physicians. The fee schedule is explained under Medicare Approved Amounts, see RCM 3.1.104. Doctors who charge more than these limits may be fined. If a person thinks they have been charged more than the acceptable level, they should call or write the Medicare Part B carrier

Special rules for doctors performing elective surgery: In addition to the limit on charges, Medicare law requires doctors who do not take assignment for elective surgery to give the patient a written estimate of the patient's costs before the surgery, if the total charge for the surgical procedure is \$500 or more. If the doctor did not give a written estimate,

the patient is entitled to a refund of any amount they paid the doctor over the Medicare approved-amount.

Many doctors and suppliers who do not take assignment on all claims may take assignment on some or most claims. The patient should ask the doctor or supplier whether they will take assignment on claims.

Examples of two payments for the same service are show below. Dr. A accepts assignment. Dr. B does not accept assignment. In both examples, the patient has already met the \$100 deductible.

TWO PAYMENTS EXAMPLES

THE ANNUAL PART B DEDUCTIBLE HAS BEEN MET

	ACTUAL AMOUNT	MEDICARE AMOUNT	BENEFICIARY PAYS	RESPONSIBLE FOR
DOCTOR A ACCEPTS ASSIGNMENT	\$480	\$400	\$320 (80% OF APPROVED AMOUNT)	\$80 (20% OF APPROVED AMOUNT)
DOCTOR B DOES NOT ACCEPT ASSIGNMENT	\$480	\$400	\$320 (80% OF APPROVED AMOUNT)	\$160 (DIFFERENCE BETWEEN CHARGE AND MEDICARE PAYMENT)

3.1.103 Participating Providers

Hospital, skilled nursing facilities, home health agencies, hospices, comprehensive outpatient rehabilitation facilities and providers of outpatient physical and occupational therapy and speech pathology services are all participating providers under Medicare Part B. They submit their claims to Medicare and must accept the Medicare-approved amount as payment in full for covered services. Medicare subtracts any deductible not met and any coinsurance amount and pays the provider. The provider then bills the patient for only those deductible and coinsurance amounts.

3.1.104 Medicare-Approved Amounts

Medicare Part B payments are based for the most part on Medicare fee schedule amounts. The fee schedule for physicians and certain suppliers lists payments for each Part B service and takes into account geographic variation in the cost of practice. The fee schedule amount is often less than the actual charges billed by doctors and suppliers. Part B usually pays 80 percent of the fee schedule amount, even if it is less than the actual charge.

When a Part B claim is submitted, the Medicare Part B carrier compares the actual charge shown on the claim with the fee schedule amount for that service. The Medicare-approved amount is the lower of the actual charge or the fee schedule amount.

3.1.105 Submitting Part B Claims

- A. Doctors, Suppliers and Other Providers Must Submit Claims For Medicare Patients - Since September 1, 1990, doctors, suppliers and other providers of Part B services have in most cases been required to submit Medicare claims for the patient, even if they do not take assignment. They must submit the claims within one year of providing the service or may be subject to certain penalties. If a person has other health insurance that should pay before Medicare, that person can submit their own claims. See Person Files Their Own Claim, below.

The person should contact the Medicare Part B MAC if their doctor or supplier refuses to submit a Part B Medicare claim for them if the person believes the services may be covered by Medicare.

- B. Doctor or Supplier Submission of Claim - A doctor or supplier must submit a form call a CMS-1500, requesting that Medicare Part B payment be made for covered services, whether or not assignment is taken. The doctor or supplier should complete the CMS-1500 and send it to the Medicare Part B carrier. The claim form should not be sent to RRB because it will delay the payment of the claim. When RRB receives a claim form, they forward it to the Part B MAC. The doctor or supplier orders and pays for a supply of the forms used for submission to Medicare. This is the same form that is used by SS beneficiaries.
- C. Enrollment in a Coordinated Care Plan - If a person is enrolled in a coordinated care plan, a prepaid health care organization such as an HMO, a claim will seldom need to be submitted on their behalf. Medicare pays the HMO a set amount and the HMO provides their medical care. In most cases, the person is required to receive all non-emergency care through their HMO, or through arrangements made before they receive care. However, if a person gets an out-of-plan service, the claim should be submitted directly to the HMO.

The person should consult their HMO membership handbook, or contact the HMO if their doctor or supplier needs an address.

- D. Person Files Their Own Claim - In some cases, a person may need to file their own Medicare Part B claims. They may file their own claims for:
- services covered by Medicare for which a person has other health insurance that should pay first on their claims;
 - services not covered by Medicare for which they want a formal Part B coverage determination;

- services provided that a doctor or supplier refuses to submit for a person, even though it is required by law;
- services provided outside the U.S.; and
- used durable medical equipment purchased from a private source.

The claim form, G-740s, should be sent to the Medicare Part B MAC.

This is a RRB stocked form and has the Medicare Part B carrier's address pre-printed on it.

- E. Time Limits - Under the law, there are time limits for a person submitting their own Medicare Part B claims. For Medicare to make payments on a claims, they must be sent within the time limits. Medicare claims must be filed no later than 12 months (or 1 full calendar year) after the date when services were provided.
- F. Late Filing Due to Administrative Error - When an error by RRB, SSA, CMS, an intermediary or a MAC caused the failure of the provider to file a timely request for payment, the time limit for filing is extended through the last day of the sixth calendar month following the month in which the error is corrected, but not beyond December 31 of the third calendar year after the year in which the services were furnished.
- G. Claims for a Person Who Has Died - When a Medicare beneficiary dies, the way Medicare pays Part B claims depends on whether the doctor's or supplier's bill has been paid. Any Part A payments due to the hospital, skilled nursing facility, home health agency or hospice will be made directly to the provider of services.

If the physician or supplier had agreed to accept assignment before the person's death, payment will be made to the physician or supplier.

If the bill was paid by the patient or with funds from the patient's estate, Medicare's payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person.

If the bill has not been paid and the doctor or supplier does not accept assignment, the Medicare payment can be made to the person who has or assumes legal obligation to pay the bill for the deceased person.

The Part B MAC can provide the person, who is trying to get a Part B claim paid, with additional information about how to claim a Medicare Part B payment after a patient dies.

3.1.106 Explanation Of Your Medicare Part B Benefits Notice

After a doctor, provider or supplier sends in a Part B claim, Medicare will send a notice called Explanation of Your Medicare Part B Benefits (EOMB) to tell the decision of the claim. If payment is being made to the person, the EOMB will accompany the check. In assignment cases, a copy of the EOMB is sent to the person.

For services of a physician, this notice shows what services were covered, what charges were approved, how much was credited toward the \$100 annual deductible, and the amount Medicare paid. For other Part B services the notice shows similar information. The person should examine the notice carefully. If they believe payment was made for a service or supply they did not receive, or the payment is otherwise questionable, they should call or write the Medicare Part B MAC.

Any person needing a duplicate EOMB should be referred to the Medicare Part B MAC. Written requests to the Part B carrier should contain the person's full name, address and Medicare claim number.

The address and toll-free telephone number of the Part B carrier is printed on the EOMB.

3.1.107 The Medicare Part B Carrier now known as the Medicare Administrative Contractor

- A. Background - The Travelers processed Part B claims for QRRB's from 1966 through 1992. For 26 years, the contract with the Travelers was not subject to competitive bidding. In December 1991, a majority of the Board approved publication of its intent to solicit bids for the contract for RRB's Part B carrier for Fiscal Year 1993. The RRB staff developed a Request for Proposals, which solicits bids, which are then evaluated by RRB staff. A recommendation is then made to the Board. Since 1991 The Travelers Insurance Company, Metra Healthcare and United Healthcare have held the contract.

The current Medicare Part B MAC is Palmetto GBA. RRB's arrangement with the Part B carrier is unique in that it is a nationwide operation. The Part B MAC can also process Part B claims for some SS beneficiaries with its agreements with CMS for some States. The Part B carrier can also be a Part A intermediary in several States.

- B. Calling The Part B MAC - The Part B MAC has an automated telephone answering system to help make their responses faster and more accurate. When a person calls, they will be connected to a special automated voice system. If the person has a touch-tone telephone, they should follow the instructions they receive over the phone to get information about the status of their claims.

If a person needs other information or wants to talk about a claim, they can ask the system to connect them with a customer service representative at any time.

If the person does not have a touch-tone telephone, they should stay on the line after they dial and they will be connected to a customer service representative.

The toll-free number is 1-800-833-4455.

If a person advises he is unable to contact the Part B MAC because the toll-free number is busy, suggest the call be made early in the morning or late in the afternoon because the volume of calls are lightest at those times. If repeated inquiries are received, contact the assistance manager or supervisor of beneficiary services.

Any inquiries you have on behalf of a person should be made to the assistant manager or supervisor of beneficiary services.

C. General Processing Procedure by The Part B MAC for Payment of Part B Claims

- Beneficiary Has Part B Coverage - The Part B MAC will determine the Medicare approved amount, subtracting any of the annual deductible that needs to be met, and issue the Medicare payment.

If payment is being made to the person, he/she receives an Explanation of Medicare Benefits (EOMB) with the Medicare benefit payment. In assignment cases, both the physician or supplier and the person are sent EOMB's. The physician or supplier receives a composite check covering payment of several claims on a periodic basis, usually once a week or once a month.

- Beneficiary Has No Part B Coverage - If the person is not entitled to Part B benefits, a denial notice will be released.

If the person advises he/she is entitled, the Part B MAC will check its records to determine if accurate data was used to process the claim the first time. If so, the Part B MAC will contact the MS for verification of coverage. If coverage is verified, the MS will be asked to correct the records at the CMS. The Part B MAC will then ask the MS for authorization to make a payment manually if:

- The claim(s) submitted total \$100, and
- The claim is 90 days old.

If a physician or beneficiary does not cash a Part B benefit check for more than \$5 within approximately 90 days of issue, the Part B MAC will contact the payee to determine why it was not negotiated. If appropriate, a duplicate check will be issued based on the beneficiary's signed statement and the original check will be voided. The Part B MAC may request field office assistance if they are unable to contact the person. When the beneficiary cannot be reached, the Part B MAC will not void the check for at least 6 months.

3.1.108 Field Office Cooperation With Palmetto GBA

- A. General - Field offices are responsible for seeing that QRRB's in their area promptly receive the full benefits they are entitled to under Medicare. In carrying out this responsibility, each field office works with Palmetto GBA to achieve two goals:

- The prompt payment of Part B claims and
- To reduce the number of claims and bills returned to beneficiaries.

Field offices will not instruct Palmetto GBA on the processing of Part B claims. Field offices are expected to keep their regional directors and/or Operations--MS informed of the circumstances when it appears action taken or not taken by Palmetto GBA may not be conducive to the prompt payment of claims, and in keeping with RRB policies regarding the payment of Medicare benefits.

Field offices will not accept an overpayment case directly from Palmetto GBA. After Palmetto GBA has exhausted efforts to collect, the case will be referred directly to Operations-MS for further action.

Some specific situations in which field offices may give assistance are:

- Helping to secure needed information in cases when Palmetto GBA is unable to obtain it by telephone.
- Assisting in obtaining information needed for the payment of claims where the beneficiary has died.

- B. Processing Problems - Palmetto GBA may, at time, request field office assistance in clearing up problem cases. Palmetto GBA is instructed to contact the local RRB field office for any assistance on all cases involving QRRB's. There may be instances when the field office will have to contact the local SSA DO; do not encourage Palmetto GBA to by-pass the field office and directly contact the local SSA DO for assistance.

3.1.110 Appealing a Medicare Decision

If a person disagrees with a decision on the amount Medicare will pay on a claim or whether services they received are covered by Medicare, they have the right to appeal the decision. The notice the person receives from Medicare tells them the decision made on the claim and also tells them exactly what appeal steps they can take. Appealing decision by Part A providers, peer review organization, intermediaries, carriers and health maintenance organizations are discussed in the following sections.

3.1.111 Appealing Decisions Made By Providers Of Part A Services

In many cases the first written notice of non-coverage a person will receive will come from the provider of the services, for example, a hospital, skilled nursing facility, home health agency or hospice. This notice of non-coverage from the provider should explain why the provider believes Medicare will not pay for the services. This notice is not an official Medicare determination, but the person can ask the provider to get an official Medicare determination. If the person asks for an official Medicare determination, the provider must file a claim on their behalf to Medicare. Then, the person will receive a Notice of Utilization, which is the official Medicare determination. If the person still disagrees, they can appeal as shown in RCM 3.1.113.

3.1.112 Appealing Decisions Made By Peer Review Organizations (PRO's)

When a person is admitted to a Medicare-participating hospital, they will be given a notice called An Important Message From Medicare, see Exhibit 11 for a copy of this notice. The notice contains a brief description of PRO's, and the name, address and phone number of the PRO in the person's State. It also describes the person's appeal rights.

PRO's make determinations mainly about inpatient hospital care and ambulatory surgical center care. The PRO's decide whether care provided to Medicare patients is medically necessary, provided in the most appropriate setting, and is of good quality. When a person disagrees with a PRO decision about their case, they can appeal by requesting a reconsideration. Then, if they disagree with the PRO's reconsideration decision, and the amount remaining in question is \$200 or more, they can request a hearing by an Administrative Law Judge. Cases involving \$2,000 or more can eventually be appealed to a Federal Court.

If a person belongs to a Medicare HMO, the HMO will usually make decisions about the medical necessity, the appropriateness of setting and the quality of the care received. In most cases, the person does not have the right to appeal to the PRO, but they always have the right to register complaints about the quality of their hospital care to the PRO. See RCM 3.1.115 for more information about a person's appeal rights for members of HMO's.

NOTE: In the case of elective, non-emergency, surgery, either the hospital or the PRO may be involved in pre-admission decisions. If the hospital believes that the person's proposed stay will not be covered by Medicare, it may recommend, without consulting the PRO, that the person not be admitted to the hospital. If this is the case, the hospital must give the person its decision in writing. If the person or their doctor disagrees with the hospital's decision, they should make a request to the PRO for immediate review. If the person wants an immediate review, they must make their request, by telephone or in writing, within three calendar days after receipt of the notice.

3.1.113 Appealing Decisions Of Intermediaries On Part A Claims

The appeals procedures consists of three steps: reconsideration, hearing and a court review. The beneficiary must request each step within certain time limits and the amount in controversy must meet certain minimum dollar amount criteria.

A. Services Furnished in U.S. or Mexico - Appeals of decisions on most other services covered under Medicare Part A (skilled nursing facility care, home health care, hospice services and a few inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries.

- Reconsiderations - After a person receives the official Medicare determination, the person should first seek assistance from the intermediary. If a beneficiary contacts a field office or headquarters regarding a Medicare payment after having contacted the intermediary, attempt to answer their questions. If necessary, contact the intermediary.

If the beneficiary is still dissatisfied he/she may request further consideration of his Medicare claim. If a person disagrees with the intermediary's initial decision, they have 60 days from the date they received the initial decision to request a reconsideration. The claim in question can be for any amount.

The request can be submitted directly to the intermediary or through any RRB office.

Any inquiry received in a field office or headquarters from a person must be stamped to show the receipt date to protect the filing date for the reconsideration. A request for reconsideration should include the beneficiary's Medicare claim number, name, address, a brief reason for dissatisfaction and a copy of the Notice of Utilization. It should be indicated on the statement whether it was prepared in the field office or in headquarters. Forward the request and a copy of the Notice of Utilization to the intermediary whose address is shown on the Notice of Utilization. If the intermediary cannot be determined, secure the information from the nearest SSA district office. Field offices should not forward the request to headquarters.

- Hearing - If the person disagrees with the intermediary's reconsideration decision and the amount remaining in question is \$100 or more, they have 60 days from the date they receive the reconsideration decision to request a hearing by an Administrative Law Judge.

If an inquiry is received by telephone or in person and an SSA office is conveniently located, advise the person to contact the SSA district office. If the person will contact the SSA district office in person, he/she should take the reconsideration notice along whenever possible.

If an SSA office is not conveniently located, or a written inquiry is received, accept the request for a hearing. The request must include the person's Medicare claim number, name, address, brief reason for dissatisfaction and a copy of the reconsideration notice. Send the material to the SSA district office. Advise the beneficiary that he/she will receive notification from SSA.

- Court Review - If the person is still dissatisfied after the hearing examiner's decision and the amount in controversy is at least \$1,000 or more, they can eventually be appealed to a Federal Court. The action must be initiated within 60 days after the receipt of the notice of the hearing decision.

B. Services Furnished in Canada - Since Canadian claims under Part A are processed and paid by RRB using funds from the RR account, RR Act appeals procedures apply. To initiate the process, a written statement requesting reconsideration must be submitted within 60 days of the decision notice to the beneficiary on the Part A Canadian claim.

3.1.114 Appealing Decisions Made By MAC On Part B Claims

A doctor must provide a person with a written notice if he or she knows or believes that Medicare will not consider a particular service reasonable and necessary and will not pay for it. This written notice must be given to the person before the service is performed and must clearly state the reasons the doctor believes Medicare will not pay. If the doctor does not give this written notice and the person did not know that Medicare would not pay for the services they received, they cannot be held liable to pay for them. However, if the person did receive written notice and signed an agreement to pay for the services so they could be treated, they will be held liable to pay.

This written notice is not an official Medicare determination. If the person disagrees with it, they may ask the doctor to submit a claim for payment to the Medicare Part B carrier to get an official Medicare determination, Explanation of Medicare Benefits (EOMB). The claim must be filed within the specific time periods shown in RCM 3.1.105. In some cases, the person can file the claim.

- Informal Review - When the person receives the EOMB and the person still disagrees, they have the right to appeal that decision. They have six months from the date of the initial decision to ask the Part B MAC to review it.

The person should first seek assistance from the Part B MAC. If a beneficiary contacts a field office or headquarters regarding a Medicare payment after having contacted the Part B MAC, attempt to answer their questions. If necessary, contact the Part B MAC. If the beneficiary is still dissatisfied he/she may request further consideration of his Medicare claim.

The person should complete Form G-790 (original only) or submit a statement with the same facts. If the beneficiary has additional evidence, it should be attached to the G-790 or the statement. Send the request to Palmetto GBA at the address

shown on the EOMB. A review of the entire claim will be done by Palmetto GBA by someone who was not involved in the original decision. A letter will be sent to the person with an explanation and the results of the review.

- Fair Hearing - Then, if they disagree with Palmetto GBA's written explanation of its review decision and the amount remaining in question is \$100 or more, they have six months from the date of the review decision to request a hearing before Palmetto GBA's hearing officer. The request must be in writing. The person may combine claims that have been reviewed or reopened within the past six months, to meet the \$100 requirement.

The person should complete Form G-791 (original only) or submit a statement with the same facts. A copy of the informal review should be attached as should any additional evidence. Send the request to the Palmetto GBA office which conducted the informal review.

Palmetto GBA selects a person to act as a hearing officer. The person is usually an attorney, but does not have had any previous involvement in the case. The hearing officer notifies the beneficiary of the time and place of the hearing, the specific issues to be resolved, the person's right to counsel or other representation, the right to bring witnesses, the importance of bringing all evidence and the necessity of promptly notifying the hearing officer in writing if the person has any objections. After the hearing, the hearing officer will make a decision and a copy will be mailed to the person.

If the person does not wish to appear or have a representative appear at the hearing, he/she must waive this right in writing. The statement of waiver must be sent to the hearing officer. The hearing officer will then make a decision based on the evidence previously submitted. A copy of the decision will be mailed to the person.

- Administrative Law Judge (ALJ) Hearing - If the person disagrees with The Palmetto GBA hearing officer's decision and the amount remaining in question is \$500 or more, they have 60 days from the date they received the decision to request a hearing before an Administrative Law Judge. They may combine claims that have had a hearing decision within the past 60 days to meet the \$500 requirement. Cases involving \$1,000 or more can eventually be appealed to a Federal Court.

A request for an ALJ hearing can be made by submitting a written signed statement. Requests for Part B ALJ hearings should be forwarded to:

Centers for Medicare & Medicaid Services
Medicare Hearing Work Group
P. O. Box 26683
Baltimore, Maryland 21207

CMS controls requests and forwards them to a designated ALJ through SSA's Office of Hearing and Appeals. Any subsequent development will be handled by the ALJ assigned to the case.

3.1.115 Appealing Decisions Made By Medicare Advantage Plans

A beneficiary has the right to a fair, efficient and timely process to resolve differences with their Medicare Advantage plan. This process includes the initial decision made by the plan, an internal review, and an independent external review. The person has the right to ask his or her plan to provide and pay for a service they think should be covered, provided, or continued. They can ask for a fast decision if they believe their health could be seriously harmed by waiting for a decision about service. The plan must then give an answer within 72 hours if the following applies:

- It determines the person's life or health could be seriously harmed if the plan took the normal 14 days to respond, or
- A doctor supports the request and indicates the person could be harmed if the plan takes 14 days to respond.

If the plan denies this request, the plan must tell the beneficiary in writing, why it won't provide or pay for a service, and how to appeal the decision. The person can ask for a copy of their file containing medical and other information about their case. The plan may charge for copying this information. There are five levels of appeal available to beneficiaries in Medicare Advantage plans.

A. Reconsideration

The first level of appeal is called "reconsideration". The plan's initial denial notice will explain how to file this appeal and the plan's address. A request for reconsideration must be filed within 60 days of the date of the plan's initial denial notice. The request must be in writing. Some plans will allow beneficiaries to file the request by telephone. The enrollee, their appointed representative, or their doctor can call or write the plan for an expedited reconsideration. Once the plan receives the request for reconsideration, the plan has 30 days (for a standard service request), 60 calendar days (for a payment request), or 72 hours (for an expedited request) to notify the beneficiary of its decision.

A written request for reconsideration must include the following:

- The person's name, address and Medicare card number.
- The reason why they are appealing and any supporting documentation that they believe may help their case.
- The person's signature or the signature of their appointed representative.

B. Review by an Independent Review Entity (IRE)

If the initial denial is upheld, a beneficiary's appeal is **automatically** sent to an IRE for review. The review will be expedited if the IRE determines that the person's life or health may be seriously jeopardized by waiting for a standard decision. The IRE has 30 calendar days (for standard service request for coverage), 60 calendar days (for a payment request), or 72 hours (for a expedited requests for coverage) to notify the beneficiary of its decision.

C. Hearing with an Administrative Law Judge (ALJ)

If the person disagrees with the IRE's decision, they or their appointed representative can request a hearing with an ALJ. The request must be made in writing within 60 calendar days from the date of the notice of the IRE's decision. The request must be sent to the location specified in the IRE's reconsideration notice. To get an ALJ hearing, the projected value of the denied coverage must meet the minimum dollar amount specified in the reconsideration notice (claims may be combined to meet the minimum dollar amount). If the ALJ decides in the person's favor, the plan has the right to appeal the decision by asking for a review by the Medicare Appeals Council.

D. Review by the Medicare Appeals Council

If the person disagrees with the ALJ's decision, they or their appointed representative can request a review by the Medicare Appeals Council. The request must be made in writing within 60 calendar days from the date of the notice of the ALJ's decision. The request must be sent to the location specified in the ALJ's decision notice. The Medicare Appeals Council doesn't review every case it gets. If they decide not to review a case, the beneficiary or the plan may ask for a review by a Federal court.

E. Review by a Federal Court

If the person disagrees with the Medicare Appeals Council's decision, they or their appointed representative can request a review by a Federal court. The request must be made in writing within 60 calendar days from the date of the notice of the Medicare Appeals Council's decision. The request must be sent to the location specified in the Medicare Appeals Council's decision notice. To get a review by a Federal court, the projected value of the beneficiary's denied coverage must meet the minimum dollar amount stated in the Medicare Appeals Council's decision.

3.1.120 Medicare Related Systems

The RRB's primary Medicare health insurance processing system is the Medicare Information Recorded, Transmitted, Edited and Logged (MIRTEL) system.

MIRTEL records and maintains Medicare health insurance information for all eligible QRRBs and deemed QRRBs, both aged and disabled. Records are accreted to the MIRTEL file by manual input, mechanical attainment selection, applications input through APPLE, and information transmitted from SSA about SS benefits that RRB pays. Information in the MIRTEL file is maintained by manual input, premium payment, validation with the CHICO file, information received from SSA in the screening process, and information received from CMS for the State buy-in operation. MIRTEL generates screening records for jurisdictional clearance with SSA, records their reply, generates bills for the collection of Part B premiums or adjusts the monthly benefit to start, stop or change the deduction of the Part B premium and transmits record changes to the Entitlement Database (EDB) maintained by CMS.

The MIRTEL file contains a record for all eligible aged and disabled beneficiaries regardless of enrollment or monthly payment status. The record contains information about the beneficiary's current and prior enrollment status, State buy-in information and activity. Addresses are maintained on MIRTEL only for beneficiaries who pay their premiums by direct remittance. Those MIRTEL records not containing an address pick up the address from CHICO when it is required for any activity.

The record remains on MIRTEL until the beneficiary dies or there is loss of QRRB status. The MIRTEL record is then dropped 18 months after the date of death or loss of QRRB status.

In addition to the record under the RRB claim number, pseudo numbers are set up as a special cross-reference type record. This cross-reference record is set up mechanically whenever a record is established with a pseudo number. The record will be mechanically dropped whenever the primary record is dropped. The cross-reference record allows activity from SSA to come in under the pseudo number and be mechanically associated with the RR number and processed.

The MIRTEL master file is a "flat" file. Information from the MIRTEL file may be obtained from the following sources:

- MIRTEL On-Line Inquiry (MOLI) allows direct access to selected data in the MIRTEL file and the new Part C and D history tables. MOLI may be used whenever there is a need for current Medicare status information. Any new data entered and processed by MIRTEL during a nightly computer run will appear on MOLI the following day. The Part C and D information is updated monthly.

Both the field office and headquarter's personnel have access to MOLI. See FOM-I-1540 for additional information about MOLI.

- MIRF - MIRF (MIRTEL film) is a monthly film of all records on MIRTEL. Included are both active and inactive records. When the data on MOLI is questionable, verify the information on the MIRF. (**Note:** Production of the MIRF file was discontinued in 2006.)

- MMAC - MMAC (Microfilm of MIRTEL activity) is a weekly record of all activity processed in the MIRTEL file. In addition to the activity, the MIRTEL record is shown both before and after the MIRTEL record was updated with the activity. Effective with MMAC files from January 2007, MMAC files are available on CD-ROM, rather than microfilm.
- MEDDAR – MEDDAR (Medicare Daily Activity Report) is produced on each business day on which there is a MIRTEL run, and provides a cumulative record of all activities processed in the MIRTEL runs from the beginning of the calendar month. The report is in claim number order and shows the most recent and all previous activities processed in MIRTEL in the calendar month to date. The date of the MIRTEL run is also shown for each activity processed. In addition, the report shows the Paid Thru Date and any Excess Premium Amount recorded on the MIRTEL master as of the date of the most current activity processed in MIRTEL.
- MEDMAR – MEDMAR (Medicare Monthly Activity Report) is produced following the last business day of each month and provides a cumulative record all activities processed in the MIRTEL runs during the calendar month. The report is in same format and contains the same information as the MEDDAR reports. Upon completion of each MEDMAR report, the MEDDAR reports for the month are deleted.

Field offices do not have access to MIRF, MMAC, MEDDAR or MEDMAR records. Therefore, if the field office believes that the data on MOLI is questionable, they should call MS to have them verify the information from other sources.

3.1.121 CMS's Systems

The Medicare Section and field offices have access to several CMS systems.

- A. Enrollment DataBase (EDB) - In 1991, CMS resigned their Medicare Enrollment functional area. The EDB is the successor to the Health Insurance Master File, which was CMS's centralized source of beneficiary Medicare enrollment information before the EDB was created in 1991.
- B. BERT - BERT is an acronym for an on-line software tool called the Beneficiary Enrollment ReTrieval system. BERT provides authorized users with the on-line capability to search for, access, and review both current and historical Medicare enrollment and entitlement data for a specific beneficiary on EDB.

The beneficiary's information is retrieved by entering a RR claim number or a SS number (SSN) and, optionally, a Beneficiary Identification Code (BIC). The BIC is the symbol and prefix for the RR claim number or the BIC at the end of the SSN. When only a RR claim number or a SSN is entered, BERT displays limited identification information for all beneficiaries associated with the RR claim number or the SSN. When both a RR claim number or a SSN and BIC are entered, BERT retrieves the enrollment record for the individual claimant

identified by that RR claim number or SSN and BIC combination. A RR claim number or a SSN and BIC combination is also called the Medicare health insurance claim number.

The Medicare Section and field offices have access to BERT. See RCM 19.4 for additional information.

- C. ERNIE - ERNIE is an extension of BERT and an acronym for an on-line software tool called the Enrollment Retrieval New Interactive Edit. ERNIE was designed to update beneficiary Medicare enrollment information.

Changes applied to ERNIE are immediately applied to the EDB. Updates, like changes to a beneficiary's Part A effective date, are applied to the EDB by ERNIE and forwarded to other systems where applicable. ERNIE shares changed information with the Common Working File (CWF), SSA, RRB and CMS's Group Health Plan (GHP) and Third Party Systems.

When ERNIE facilitates changes to beneficiary information found on EDB, ERNIE relies on BERT to retrieve information from EDB. BERT performs the retrievals of data that ERNIE acts upon. It is BERT that decides whether an accretion of a new beneficiary record will be allowed. ERNIE is only accessible from BERT because BERT must retrieve the beneficiary record.

MS can make limited changes to the EDB through ERNIE. These limited changes are changes that could be made using CMS's forms, such as to remove a date of death, change a date of birth, etc. The majority of changes to EDB are done through the MIRTEL system.

Field offices do not have access to ERNIE.

- C. Common Working File (CWF) - RRB is not directly involved in handling Medicare claims or the payment of Medicare claims for services performed within the U.S. The CWF is a Medicare Part A/Part B benefit coordination and pre-payment claims validation system which uses localized databases maintained by designated contractors (Host sites). The Host site provides Medicare intermediaries and MAC (also known as satellites) with beneficiary entitlement and utilization data.

Under the CWF, the country is divided into nine processing sectors. A Host site runs the system for each sector and maintains a database with information on all Medicare beneficiaries assigned to the sector. Each Medicare intermediary and carrier is a satellite in an assigned sector. Generally, the sectors were made on a geographic basis. However, there are some exceptions to this geographic alignment for processing considerations. All QRRB's are housed in the south sector.

When a beneficiary receives Part A/Part B services, the provider of services (e.g., hospital, skilled nursing facility, hospice, home health agency, doctor or various suppliers of services) starts the claim process by submitting a bill/claim to, for Part A claims, to its intermediary and for Part B claims, to the Part B carrier. The intermediary or the Part B carrier reviews the bill/claim and enters it into their system. The intermediary or the Part B carriers' history is updated and the bill/claim is also transmitted to the CWF Host site. This is usually done overnight. The CWF Host site edits the bill/claim for validity, entitlement, remaining benefits and deductible status.

The CWF Host site compares the data on the bill/claim to the beneficiary's utilization shown on the CWF Master File. The CWF Host site transmits a reply back to the intermediary or the Part B carrier within 24 hours of receipt of the bill/claim. If the bill/claim is correct, the Host site will advise the intermediary or the Part B carrier to make payment. If the bill/claim is incorrect, the Host site notifies the intermediary or the Part B carrier by correcting the bill (automatic adjustment) or reject (utilization reject).

The intermediary or the Part B carrier, upon notice from the CWF Host site, takes the indicated action to either pay the bill/claim as entered, pay the bill/claim but make an adjustment, deny the claim or wait because the CWF does not currently have the information needed to determine if the bill/claim can be paid.

The intermediary or the Part B carrier will also send the notification of payment, denial, etc. to the beneficiary.

The Host site is also in daily communication with CMS. It sends updated information to be added to CMS's EDB. It also receives updated beneficiary information from CMS which it uses to update its database.

The entitlement information on the CWF is established or updated when RRB establishes or changes a EDB record for a beneficiary.

Field offices do not have access to the CWF.

- D. Medicare Beneficiary Database (MBD) - The Medicare Beneficiary Database (MBD) is CMS's centralized database of beneficiary information. The MBD data is divided into four categories: Beneficiary Profile, Entitlement, Coverage and Medicaid. Once fully populated and integrated with other systems, the MBD will be the authoritative source of all beneficiary-level Medicare information; and other information systems, such as BERT, will be phased-out. See RCM 19.5 for additional information.

The Medicare Section and field offices have inquiry access to the MBD.

Exhibits

Exhibit 1 - Legislative History Provisions

7-1-66	<p>Established health insurance program (Medicare) for people age 65 or older and insured under the SS Act or the RR Act.</p> <p>Eligible insured individuals may enroll for Part A three months before age 65 and any time thereafter. No premium for Part A.</p> <p>Eligible individuals may enroll for Part B during their IEP or in a GEP within three years of their IEP. Part B is voluntary with a monthly premium.</p> <p>After Part A is terminated twice, an individual cannot re-enroll.</p> <p>Eligibility determinations and enrollment under both parts is the responsibility of both SSA and RRB.</p>
1-1-73	Three year limitation for enrollment in Part B following the individual's IEP eliminated.
2-1-73	RRB received legislative authority to enroll and collect medical insurance premiums for all QRRB's entitled to annuities.
7-1-73	<p>Coverage extended to disabled beneficiaries under age 65. Eligibility determinations and enrollment the responsibility of SSA and of RRB for all QRRB's.</p> <p>Coverage extended to individuals with chronic renal disease. Eligibility determinations and enrollment of all applicants the responsibility of SSA. EXCEPTION: When RRB is paying a social security benefit, RRB will enroll the individual for chronic renal disease (this is after SSA made eligibility, entitlement, etc. determinations) even though the individual may not be eligible based on the regular disability or aged provisions.</p> <p>Coverage extended to uninsured individuals on a voluntary basis. Eligibility determinations and enrollment of all applicants the responsibility of SSA. In addition to the premium for Part B, enrollees would pay a premium for Part A. Applicants for premium Part A must file in their IEP or GEP.</p> <p>Established automatic enrollment for Part B for U.S. residents receiving an SS benefit and RR annuity.</p>
1-1-81	A survivor may be reimbursed for unpaid physician's bill.

4-1-81	The GEP (January through March) eliminated. An individual may enroll for Part B in his IEP and any time thereafter.
10-1-81	The GEP from January through March of each year was re-established. Only expenses in the current calendar year may be considered in meeting the Part B deductible.
1-1-83	Federal service after 12-31-82 can be used to qualify a person for Part A and Part B. Passage of the Working Aged Provision requiring employer to provide the same group health insurance coverage to both age 65 working individuals and those younger, if the employer consists of 20 or more employees. Also, Medicare became secondary payer of benefits in these instances. The Deficit Reduction Act of 1984 provided premium surcharge relief, retroactive to 1-1-83, to those affected by the Working Aged Provision.
5-1-86	Changes affecting the SEP eliminated the requirement that the individual previously enroll for Part A to be eligible for a SEP. A retroactive adjustment was made to remove those months which could not previously be excluded from the premium penalty calculation because of non-enrollment for Part A. Also, the EGHP could be based on being the worker or the spouse of a worker any age, not under age 70.
1-1-87	Working Aged Provision extends coverage to disabled individuals, if certain requirements are met. This coverage is limited to the period between 1-1-87 and 12-31-91 as set by law. This period of coverage is commonly referred to as the "sunset provision."
1-1-89	First year of implementation of the Medicare Catastrophic Coverage Act of 1988 provided the following: <ul style="list-style-type: none"> • Annual Part A deductible imposes one time each year. Benefit periods eliminated. • Protection against back-to-back payment of the Part A deductible for December/January of any year beginning December 1988. • Part A provides expanded skilled nursing care and home health care. • Establishment of a supplemental catastrophic premium to be based on an individual's income tax liability and collected by the IRS. • Establishment of a Part B catastrophic component based on residency to be collected with the Part B Medicare premium. There

	<p>were 3 categories of enrollees: residents of Puerto Rico (\$1.30), residents of other U.S. Commonwealth/Territories (\$2.10) and all others (\$4.00).</p> <ul style="list-style-type: none"> • Out-of-pocket medical expenses covered under Part B limited to \$1370.00. The annual Part B deductible, 20% coinsurance of reasonable charges and the Part B blood deductible applied to this limit. Any amount that exceeded reasonable charges was excluded and had to be paid by the beneficiary. • Home health care coverage increased to allow up to seven days a week for 38 days under Part B. • Mammography screening provided for elderly and disabled beneficiary under Part B. • Coverage provided for home IV drugs (\$550.00 deductible and 20% coinsurance) and immunosuppressive drugs used in the second year after transplant (\$550.00 deductible and 50% coinsurance for immunosuppressives). • Part B covers drugs other than IV drugs and immunosuppressives (\$600.00 deductible and 50% coinsurance applied to these other drugs). <p>Coinsurance for drug coverage under Part B was reduced to 40%, and the deductible was \$652.00.</p> <p>Coinsurance for drug coverage under Part B was reduced to 20% and the deductible was later to be determined.</p>
1-1-90	Implementation of the Medicare Catastrophic Repeal Act of 1989, restored Medicare benefits to levels prior to January 1, 1989.
7-1-90	Starting 7-1-90, disabled employees and their spouses can qualify for an SEP based on coverage under either an EGHP or LGHP as an active individual. Disabled children are still required to be covered under a LGHP.
9-1-90	Doctors or the companies that furnish medical supplies and equipment are required to prepare and submit Part B claims for beneficiaries.
11-26-91	Sunset provision for SEP for the disabled was extended to 9-30-95.

Exhibit 2 - Medicare Premium Freeze

1973 MEDICARE PREMIUM FREEZE

- A. Premium Freeze - Premiums were increased for the period starting July 1, 1973, even though they were covered by the price freeze in effect at that time. It was later announced that the 7-1-73 rates would remain in effect through 8-12-73. It was also announced that rates that were erroneously put into effect on 7-1-73 would actually be the rates for the period beginning 8-13-73. From an operational standpoint, it was necessary to arrive at a single rate for August 1973 for computational purposes. This rate was \$6.10 and was referred to as a "simulated" rate. Effective 9-1-73, the monthly premium rates increased to \$6.30 and the comparable increases for late filing.
- B. Freeze Adjustment - The overcharge of premiums for July and August was refunded by increasing the December 1, 1973 annuity checks or by reducing bills for direct payees and third party payers. The following tables show the refunds for each month:

REFUNDS FOR JULY 1973

	CORRECT RATE	RATE CHARGED	REFUND
Basic	\$5.80	\$6.30	.50
10%	6.40	6.90	.50
20%	7.00	7.60	.60
30%	7.50	8.20	.70
40%	8.10	8.80	.70
50%	8.70	9.50	.80
60%	9.30	10.10	.80

REFUNDS FOR AUGUST 1973

	CORRECT RATE	RATE CHARGED	REFUND
Basic	\$6.10	\$6.30	.20
10%	6.70	6.90	.20
20%	7.30	7.60	.30
30%	7.90	8.20	.30

40%	8.50	8.80	.30
50%	9.20	9.50	.30
60%	9.80	10.10	.30

The cases that were not mechanically adjusted in the mass premium rollback adjustment of December 1973, were identified in the claim folder by a pink 805 form, headed "Possible Rollback - Possible Refund."

Manual handling was taken if a refund was to be made. A refund was not made unless an annuity payment (recurring or lump sum) was being made to an eligible individual. In such cases, the pink 805 was noted "Refund Amt" was added to the award computation and the adjustment was explained in the award letter.

The folder was routed to the Medicare section for a transfer of the funds.

A manual refund of the "Refund Amt" was not made if an annuity payment was not being adjusted unless a specific claim for the refund was made. Then, a Form G-804 was prepared.

Exhibit 3 - Part B Premium Rates Prior To 1-1-89

TABLE USED FOR ALL ENROLLEES FROM 7/66 THROUGH 12/88

EFF DATE	7-66	4-68	7-68	7-69	7-70	7-71	7-72	7-73
BASIC	3.00	4.00	4.00	4.00	5.30	5.60	5.80	5.80
10%			4.40	4.40	5.80	6.20	6.40	6.40
20%				4.80	6.40	6.70	7.00	7.00
30%					6.90	7.30	7.50	7.50
40%						7.80	8.10	8.10
50%							8.70	8.70
60%								9.30

EFF DATE	8-73	9-73	7-74	7-75	7-76	7-77	7-78
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BASIC	6.10	6.30	6.70	6.70	7.20	7.70	8.20
10%	6.70	6.90	7.40	7.40	7.90	8.50	9.00
20%	7.30	7.60	8.00	8.00	8.60	9.20	9.80
30%	7.90	8.20	8.70	8.70	9.40	10.00	10.70
40%	8.50	8.80	9.40	9.40	10.10	10.80	11.50
50%	9.20	9.50	10.10	10.10	10.80	11.60	12.30
60%	9.80	10.10	10.70	10.70	11.50	12.30	13.10
70%			11.40	11.40	12.20	13.10	13.90
80%				12.10	13.00	13.90	14.80
90%					13.70	14.60	15.60
100%						15.40	16.40
110%							17.20

EFF DATE	7-79	7-80	7-81	7-82	7-83	1-84	7-84
BASIC	8.70	9.60	11.00	12.20	12.20	14.60	14.60
10%	9.60	10.60	12.10	13.40	13.40	16.10	16.10
20%	10.40	11.50	13.20	14.60	14.60	17.50	17.50
30%	11.30	12.50	14.50	15.90	15.90	19.00	19.00
40%	12.20	13.40	15.40	17.10	17.10	20.40	20.40
50%	13.10	14.40	16.50	18.30	18.30	21.90	21.90
60%	13.90	15.40	17.60	19.50	19.50	23.40	23.40
70%	14.80	16.30	18.70	20.70	20.70	24.80	24.80
80%	15.70	17.30	19.80	22.00	22.00	26.30	26.30
90%	16.50	18.20	20.90	23.20	23.20	27.20	27.20

100%	17.40	19.20	22.00	24.20	24.40	29.20	29.20
110%	18.30	20.20	23.10	25.60	25.60	30.70	30.70
120%	19.10	21.10	24.20	26.80	26.80	32.10	32.10
130%		22.10	25.30	28.10	28.10	36.60	36.60
140%			26.40	29.30	29.30	35.00	35.00
150%				30.50	30.50	36.50	36.50
160%					31.70	38.00	38.00
170%						41.90	41.90
180%							
190%							

EFF DATE	1-85	7-85	7-86	1-87	7-87	1-88	7-88
BASIC	15.50	15.50	15.50	17.90	17.90	24.80	24.80
10%	17.10	17.10	17.10	19.70	19.70	27.30	27.30
20%	18.60	18.60	18.60	21.50	21.50	29.80	29.80
30%	20.20	20.20	20.20	23.30	23.30	32.20	32.20
40%	21.70	21.70	21.70	25.10	25.10	34.70	34.70
50%	23.30	23.30	23.30	26.90	26.90	37.20	37.20
60%	24.80	24.80	24.80	28.60	28.60	39.70	39.70
70%	26.40	26.40	26.40	30.40	30.40	42.20	42.20
80%	27.90	27.90	27.90	32.20	32.20	44.60	44.60
90%	29.50	29.50	29.50	34.00	34.00	47.10	47.10
100%	31.00	31.00	31.00	35.80	35.80	49.60	49.60
110%	32.60	32.60	32.60	37.60	37.60	52.10	52.10

120%	34.10	34.10	34.10	39.40	39.40	54.60	54.60
130%	35.70	35.70	35.70	41.20	41.20	57.00	57.00
140%	37.20	37.20	37.20	43.00	43.00	59.50	59.50
150%	38.80	38.80	38.80	44.80	44.80	62.00	62.00
160%	40.30	40.30	40.30	46.50	46.50	64.50	64.50
170%	41.90	41.90	41.90	48.30	48.30	67.00	67.00
180%		43.40	43.40	50.10	50.10	69.40	69.40
190%			45.00	51.90	51.90	71.90	71.90
200%					53.70	74.40	74.40
210%							76.90

Exhibit 4 - Part B Premium Rates For 1989

PREMIUM RATES FOR THE THREE RESIDENCY TABLES FOR 1989

	See 1 below	See 2 below	See 3 below
Basic Rate	\$31.90	\$29.20	\$30.00
10%	35.10	32.10	33.00
20%	38.30	35.00	36.00
30%	41.50	38.00	39.00
40%	44.70	40.90	42.00
50%	47.90	43.80	45.00
60%	51.00	46.70	48.00
70%	54.20	49.60	51.00
80%	57.40	52.60	54.00
90%	60.60	55.50	57.00

100%	63.80	58.40	60.00
110%	67.00	61.30	63.00
120%	70.20	64.20	66.00
130%	73.40	67.20	69.00
140%	76.60	70.10	72.00
150%	79.80	73.00	75.00
160%	82.90	75.90	78.00
170%	86.10	78.80	81.00
180%	89.30	81.80	84.00
190%	92.50	84.70	87.00
200%	95.70	87.60	90.00
210%	98.90	90.50	93.00
220%	102.10	93.40	96.00

- 1) Rates used for all enrollees except residents of Puerto Rico and U.S. Commonwealth/Territories, the basic premium without penalty consisted of a \$27.90 age/disabled component and a \$4.00 catastrophic component.
- 2) Rates used for all enrollees who are residents of Puerto Rico, the basic premium without penalty consisted of a \$27.90 age/disabled component and a \$1.30 catastrophic component.
- 3) Rates used for all enrollees who are residents of American Samoa, Virgin Islands and Northern Mariana Islands, the basic premium without penalty consisted of a \$27.90 age/disabled component and a \$2.10 catastrophic component.

Exhibit 5 - Part B Premium Rates For 1-90 Thru Current

FOM, PART I, ARTICLE 8 - APPENDIX E RCM 3.1

RATES FOR ALL ENROLLEES

Eff Date	01-2017	01-2016	01-2015	01-2014	1-2013
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Basic	134.00	121.80	104.90	104.90	104.90
10%	147.50	134.00	115.40	115.40	115.40
20%	160.80	146.20	125.90	125.90	125.90
30%	174.20	158.30	136.40	136.40	136.40
40%	187.60	170.50	146.90	146.90	146.90
50%	201.00	182.70	157.40	157.40	157.40
60%	214.40	194.90	167.80	167.80	167.80
70%	227.80	207.10	178.30	178.30	178.30
80%	241.20	219.20	188.80	188.80	188.80
90%	254.60	231.40	199.30	199.30	199.30
100%	268.00	243.60	209.80	209.80	209.80
110%	281.40	255.80	220.30	220.30	220.30
120%	294.80	268.00	230.80	230.80	230.80
130%	308.20	280.10	241.30	241.30	241.30
140%	321.60	292.30	251.80	251.80	251.80
150%	335.00	304.50	262.30	262.30	262.30
160%	348.40	316.70	272.70	272.70	272.70
170%	361.80	328.90	283.20	283.20	283.20
180%	375.20	341.00	293.70	293.70	293.70
190%	388.60	353.20	304.20	304.20	304.20
200%	402.00	365.40	314.70	314.70	314.70
210%	415.40	377.60	325.20	325.20	325.20
220%	428.80	389.80	335.70	335.70	335.70
230%	442.20	401.90	346.20	346.20	346.20

240%	455.60	414.10	356.70	356.70	356.70
250%	469.00	426.30	367.20	367.20	367.20
260%	482.40	438.50	377.60	377.60	377.60
270%	495.80	450.70	388.10	388.10	388.10
280%	509.20	462.80	398.60	398.60	398.60
290%	522.60	475.00	409.10	409.10	409.10
300%	536.00	487.20	419.60	419.60	419.60
310%	549.40	499.40	430.10	430.10	430.10
320%	562.80	511.60	440.60	440.60	440.60
330%	576.20	523.70	451.10	451.10	451.10
340%	589.60	535.90	461.60	461.60	461.60
350%	603.00	548.10	472.10	472.10	472.10
360%	616.40	560.30	482.50	482.50	482.50
370%	629.80	572.50	493.00	493.00	493.00
380%	643.20	584.60	503.50	503.50	503.50
390%	656.60	596.80	514.00	514.00	514.00
400%	670.00	609.00	524.50	524.50	524.50
410%	683.40	621.20	535.00	535.00	535.00
420%	696.80	633.40	545.50	545.50	545.50
430%	710.20	645.50	556.00	556.00	556.00
440%	723.60	657.70	566.50	566.50	566.50
450%	737.00	669.90	577.00	577.00	577.00
460%	750.40	682.10	587.40	587.40	587.40
470%	763.80	694.30	597.90	597.90	

480%	777.20	706.40	608.40		
490%	790.60	718.60			
500%	804.00				

Eff Date	1-2012	1-2011	1-2010	1-2009
Basic	99.90	115.40	110.50	96.40
10%	109.90	126.90	121.60	106.00
20%	119.90	138.50	132.60	115.70
30%	129.90	150.00	143.70	125.30
40%	139.90	161.60	154.70	135.00
50%	149.90	173.10	165.80	144.60
60%	159.80	184.60	176.80	154.20
70%	169.80	196.20	187.90	163.90
80%	179.80	207.70	198.90	173.50
90%	189.80	219.30	210.00	183.20
100%	199.80	230.80	221.00	192.80
110%	209.80	242.30	232.10	202.40
120%	219.80	253.90	243.10	212.10
130%	229.80	265.40	254.20	221.70
140%	239.80	277.00	265.20	231.40
150%	249.80	288.50	276.30	241.00
160%	259.70	300.00	287.30	250.60
170%	269.70	311.60	298.40	260.30
180%	279.70	323.10	309.40	269.90

190%	289.70	334.70	320.50	279.60
200%	299.70	346.20	331.50	289.20
210%	309.70	357.70	342.60	298.80
220%	319.70	369.30	353.60	308.50
230%	329.70	380.80	364.70	318.10
240%	339.70	392.40	375.70	327.80
250%	349.70	403.90	386.80	337.40
260%	359.60	415.40	397.80	347.00
270%	369.60	427.00	408.90	356.70
280%	379.60	438.50	419.90	366.30
290%	389.60	450.10	431.00	376.00
300%	399.60	461.60	442.00	385.60
310%	409.60	473.10	453.10	395.20
320%	419.60	484.70	464.10	404.90
330%	429.60	496.20	475.20	414.50
340%	439.60	507.80	486.20	424.20
350%	449.60	519.30	497.30	433.80
360%	459.50	530.80	508.30	443.40
370%	469.50	542.40	519.40	453.10
380%	479.50	553.90	530.40	462.70
390%	489.50	565.50	541.50	472.40
400%	499.50	577.00	552.50	482.00
410%	509.50	588.50	563.60	491.60
420%	519.50	600.10	574.60	501.30

430%	529.50	611.60	585.70	
440%	539.50	623.20		
450%	549.50			

Eff. Date	1-2008	1-2007	1-2006	1-2005	1-2004	1-2003	1-2002
Basic	96.40	93.50	\$ 88.50	\$ 78.20	\$ 66.60	\$ 58.70	\$54.00
10%	106.00	102.90	97.40	86.00	73.30	\$ 64.60	\$59.40
20%	115.70	112.20	106.20	93.80	79.90	\$ 70.40	\$64.80
30%	125.30	121.60	115.10	101.70	86.60	\$ 76.30	\$70.20
40%	135.00	130.90	123.90	109.50	93.20	\$ 82.20	\$75.60
50%	144.60	140.30	132.80	117.30	99.90	\$ 88.10	\$81.00
60%	154.20	149.60	141.60	125.10	106.60	\$ 93.90	\$86.40
70%	163.90	159.00	150.50	132.90	113.20	\$ 99.80	\$91.80
80%	173.50	168.30	159.30	140.80	119.90	\$105.70	\$97.20
90%	183.20	177.70	168.20	148.60	126.50	\$111.50	\$102.60
100%	192.80	187.00	177.00	156.40	133.20	\$117.40	\$108.00
110%	202.40	196.40	185.90	164.20	139.90	\$123.30	\$113.40
120%	212.10	205.70	194.70	172.00	146.50	\$129.10	\$118.80
130%	221.70	215.10	203.60	179.90	153.20	\$135.00	\$124.20
140%	231.40	224.40	212.40	187.70	159.80	\$140.90	\$129.60
150%	241.00	233.80	221.30	195.50	166.50	\$146.80	\$135.00
160%	250.60	243.10	230.10	203.30	173.20	\$152.60	\$140.40
170%	260.30	252.50	239.00	211.10	179.80	\$158.50	\$145.80
180%	269.90	261.80	247.80	219.00	186.50	\$164.40	\$151.20

190%	279.60	271.20	256.70	226.80	193.10	\$170.20	\$156.60
200%	289.20	280.50	265.50	234.60	199.80	\$176.10	\$162.00
210%	298.80	289.90	274.40	242.40	206.50	\$182.00	\$167.40
220%	308.50	299.20	283.20	250.20	213.10	\$187.80	\$172.80
230%	318.10	308.60	292.10	258.10	219.80	\$193.70	\$178.20
240%	327.80	317.90	300.90	265.90	226.40	\$199.60	\$183.60
250%	337.40	327.30	309.80	273.70	233.10	\$205.50	\$189.00
260%	347.00	336.60	318.60	281.50	239.80	\$211.30	\$194.40
270%	356.70	346.00	327.50	289.30	246.40	\$217.20	\$199.80
280%	366.30	355.30	336.30	297.20	253.10	\$223.10	\$205.20
290%	376.00	364.70	345.20	305.00	259.70	\$228.90	\$210.60
300%	385.60	374.00	354.00	312.80	266.40	\$234.80	\$216.00
310%	395.20	383.40	362.90	320.60	273.10	\$240.70	\$221.40
320%	404.90	392.70	371.70	328.40	279.70	\$246.50	\$226.80
330%	414.50	402.10	380.60	336.30	286.40	\$252.40	\$232.20
340%	424.20	411.40	389.40	344.10	293.00	\$258.30	\$237.60
350%	433.80	420.80	398.30	351.90	299.70	\$264.20	\$243.00
360%	443.40	430.10	407.10	359.70	306.40	\$270.00	
370%	453.10	439.50	416.00	367.50	313.00		
380%	462.70	448.80	424.80	375.40			
390%	472.40	458.20	433.70				
400%	482.00	467.50					
410%	491.60						

Eff. Date	1-2001	1-2000	1-99	1-98	1-97	1-96
Basic	\$ 50.00	\$ 45.50	\$ 45.50	\$ 43.80	\$ 43.80	\$ 42.50
10%	\$ 55.00	\$ 50.10	\$ 50.10	\$ 48.20	\$ 48.20	\$ 46.80
20%	\$ 60.00	\$ 54.60	\$ 54.60	\$ 52.60	\$ 52.60	\$ 51.00
30%	\$ 65.00	\$ 59.20	\$ 59.20	\$ 56.90	\$ 56.90	\$ 55.30
40%	\$ 70.00	\$ 63.70	\$ 63.70	\$ 61.30	\$ 61.30	\$ 59.50
50%	\$ 75.00	\$ 68.30	\$ 68.30	\$ 65.70	\$ 65.70	\$ 63.80
60%	\$ 80.00	\$ 72.80	\$ 72.80	\$ 70.10	\$ 70.10	\$ 68.00
70%	\$ 85.00	\$ 77.40	\$ 77.40	\$ 74.50	\$ 74.50	\$ 72.30
80%	\$ 90.00	\$ 81.90	\$ 81.90	\$ 78.80	\$ 78.80	\$ 76.50
90%	\$ 95.00	\$ 86.50	\$ 86.50	\$ 83.20	\$ 83.20	\$ 80.80
100%	\$100.00	\$ 91.00	\$ 91.00	\$ 87.60	\$ 87.60	\$ 85.00
110%	\$105.00	\$ 95.60	\$ 95.60	\$ 92.00	\$ 92.00	\$ 89.30
120%	\$110.00	\$100.10	\$100.10	\$ 96.40	\$ 96.40	\$ 93.50
130%	\$115.00	\$104.70	\$104.70	\$100.70	\$100.70	\$ 97.80
140%	\$120.00	\$109.20	\$109.20	\$105.10	\$105.10	\$102.00
150%	\$125.00	\$113.80	\$113.80	\$109.50	\$109.50	\$106.30
160%	\$130.00	\$118.30	\$118.30	\$113.90	\$113.90	\$110.50
170%	\$135.00	\$122.90	\$122.90	\$118.30	\$118.30	\$114.80
180%	\$140.00	\$127.40	\$127.40	\$122.60	\$122.60	\$119.00
190%	\$145.00	\$132.00	\$132.00	\$127.00	\$127.00	\$123.30
200%	\$150.00	\$136.50	\$136.50	\$131.40	\$131.40	\$127.50
210%	\$155.00	\$141.10	\$141.10	\$135.80	\$135.80	\$131.80
220%	\$160.00	\$145.60	\$145.60	\$140.20	\$140.20	\$136.00

230%	\$165.00	\$150.20	\$150.20	\$144.50	\$144.50	\$140.30
240%	\$170.00	\$154.70	\$154.70	\$148.90	\$148.90	\$144.50
250%	\$175.00	\$159.30	\$159.30	\$153.30	\$153.30	\$148.80
260%	\$180.00	\$163.80	\$163.80	\$157.70	\$157.70	\$153.00
270%	\$185.00	\$168.40	\$168.40	\$162.10	\$162.10	\$157.30
280%	\$190.00	\$172.90	\$172.90	\$166.40	\$166.40	\$161.50
290%	\$195.00	\$177.50	\$177.5	\$170.80	\$170.80	\$165.80
300%	\$200.00	\$182.00	\$182.00	\$175.20	\$175.20	
310%	\$205.00	\$186.60	\$186.60	\$179.60		
320%	\$210.00	\$191.10	\$191.10			
330%	\$215.00	\$195.70				
340%	\$220.00					

Eff. Date	1-95	1-94	1-93	1-92	1-91	1-90
Basic	46.10	41.10	36.60	31.80	29.90	28.60
10%	50.70	45.20	40.30	35.00	32.90	31.50
20%	55.30	49.30	43.90	38.20	35.90	34.30
30%	59.90	53.40	47.60	41.30	38.90	37.20
40%	64.50	57.50	51.20	44.50	41.90	40.00
50%	69.20	61.70	54.90	47.70	44.90	42.90
60%	73.80	65.80	58.60	50.90	47.80	45.80
70%	78.40	69.90	62.20	54.10	50.80	48.60
80%	83.00	74.00	65.90	57.20	53.80	51.50
90%	87.60	78.10	69.50	60.40	56.80	54.30

100%	92.20	82.20	73.20	63.60	59.80	57.20
110%	96.80	86.30	76.90	66.80	62.80	60.10
120%	101.40	90.40	80.50	70.00	65.80	62.90
130%	106.00	94.50	84.20	73.10	68.80	65.80
140%	110.60	98.60	87.80	76.30	71.80	68.60
150%	115.30	102.80	91.50	79.50	74.80	71.50
160%	119.90	106.90	95.20	82.70	77.70	74.40
170%	124.50	111.00	98.80	85.90	80.70	77.20
180%	129.10	115.10	102.50	89.00	83.70	80.10
190%	133.70	119.20	106.10	92.20	86.70	82.90
200%	138.30	123.30	109.80	95.40	89.70	85.80
210%	142.90	127.40	113.50	98.60	92.70	88.70
220%	147.50	131.50	117.10	101.80	95.70	91.50
230%	152.10	135.60	120.80	104.90	98.70	94.40
240%	156.70	139.70	124.40	108.10	101.70	
250%	161.40	143.90	128.10	111.30		
260%	166.00	148.00	131.80			
270%	170.60	152.10				
280%	175.20					

Effective 1-90, the basic premium without penalty was \$28.60. There is no catastrophic component due to the repeal of the Medicare Catastrophic Coverage Act of 1988. Repeal does not affect premium amounts for 1989. Rates for all three residency tables are the same effective 1-90.

Exhibit 5a – IRMAA (Income Related Monthly Adjustment Amount)

2017 Part B IRMAA Tables

Listed below are the 2017 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow (er) with dependent child, or married filing separately who lived apart from their spouse for entire taxable year) or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$134.00
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$53.50	\$187.50
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$133.90	\$267.90
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$214.30	\$348.30
Greater than \$214,000	Greater than \$428,000	\$294.60	\$428.60

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$134.00
Greater than \$85,000 and less than or equal to \$129,000	\$214.30	\$348.30

Greater than \$129,000	\$294.60	\$428.60
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- Part D - Supplementary Medical Insurance (SMI) Prescription Drug Account

Part D Base Beneficiary Premium for 2017 is \$35.63.

Listed below are the 2017 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$13.30
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$34.20
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$55.20
Greater than \$214,000	Greater than \$428,000	\$76.20

In addition, the monthly income-related premium adjustment amounts to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from	Income-related monthly adjustment amount
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their spouse:	
Less than or equal to \$85,000	\$0.00
Greater than \$85,000 and less than or equal to \$129,00	\$55.20
Greater than \$129,000	\$76.20

2016 Part B IRMAA Tables

Listed below are the 2016 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow (er) with dependent child, or married filing separately who lived apart from their spouse for entire taxable year) or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$121.80
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$48.70	\$170.50
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$121.80	\$243.60
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$194.90	\$316.70
Greater than \$214,000	Greater than \$428,000	\$268.00	\$389.80

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$121.80
Greater than \$85,000 and less than or equal to \$129,000	\$194.90	\$316.70
Greater than \$129,000	\$268.00	\$389.80

- Part D - Supplementary Medical Insurance (SMI) Prescription Drug Account

Part D Base Beneficiary Premium for 2016 is \$34.10.

Listed below are the 2016 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$12.70
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$32.80
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$52.80

Greater than \$214,000	Greater than \$428,000	\$72.90
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In addition, the monthly income-related premium adjustment amounts to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount
Less than or equal to \$85,000	\$0.00
Greater than \$85,000 and less than or equal to \$129,00	\$52.80
Greater than \$129,000	\$72.90

2015 Part B IRMAA Tables

Listed below are the 2015 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow (er) with dependent child, or married filing separately who lived apart from their spouse for entire taxable year) or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$104.90
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to	\$42.00	\$146.90

	\$214,000		
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$104.90	\$209.80
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$167.80	\$272.70
Greater than \$214,000	Greater than \$428,000	\$230.80	\$335.70

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$104.90
Greater than \$85,000 and less than or equal to \$129,000	\$167.80	\$272.70
Greater than \$129,000	\$230.80	\$335.70

- Part D - Supplementary Medical Insurance (SMI) Prescription Drug Account

Part D Base Beneficiary Premium for 2015 is \$33.13.

Listed below are the 2015 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00

Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$12.30
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$31.80
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$51.30
Greater than \$214,000	Greater than \$428,000	\$70.80

2014 Part B IRMAA Tables

Listed below are the 2014 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year) or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$104.90
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$42.00	\$146.90
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$104.90	\$209.80
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$167.80	\$272.70

Greater than \$214,000	Greater than \$428,000	\$230.80	\$335.70
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In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$104.90
Greater than \$85,000 and less than or equal to \$129,000	\$167.80	\$272.70
Greater than \$129,000	\$230.80	\$335.70

- Part D - Supplementary Medical Insurance (SMI) Prescription Drug Account

Part D base beneficiary premium for 2014 is \$32.42.

Listed below are the 2014 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$12.10
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$31.10

Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$50.20
Greater than \$214,000	Greater than \$428,000	\$69.30

In addition, the monthly income-related premium adjustment amounts to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

2013 Part B IRMAA Tables

Listed below are the 2013 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year) or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$104.90
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$42.00	\$146.90
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$104.90	\$209.80
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$167.80	\$272.70
Greater than \$214,000	Greater than \$428,000	\$230.80	\$335.70

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$104.90
Greater than \$85,000 and less than or equal to \$129,000	\$167.80	\$272.70
Greater than \$129,000	\$230.80	\$335.70

-2013 - Part D - Supplementary Medical Insurance (SMI) Prescription Drug Account

Part D base beneficiary premium for 2013 is \$31.17.

Listed below are the 2013 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$11.60
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$29.90
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$48.30
Greater than \$214,000	Greater than \$428,000	\$66.60

In addition, the monthly income-related premium adjustment amounts to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount
Less than or equal to \$85,000	\$0.00
Greater than \$85,000 and less than or equal to \$129,000	\$48.30
Greater than \$129,000	\$66.60

2012 Part B IRMAA Tables

Listed below are the 2012 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year) or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$ 0.00	\$ 99.90
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$ 40.00	\$139.90
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$ 99.90	\$199.80

Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$159.80	\$259.70
Greater than \$214,000	Greater than \$428,000	\$219.80	\$319.70

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$ 0.00	\$ 99.90
Greater than \$85,000 and less than or equal to \$129,000	\$159.80	\$259.70
Greater than \$129,000	\$219.80	\$319.70

2012 Part D – Supplementary Medicare Insurance (SMI) Prescription Drug Account - IRMAA Tables

The Part D base beneficiary premium for 2012 is \$31.08.

Listed below are the 2012 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$ 0.00

Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$11.60
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$29.90
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$48.10
Greater than \$214,000	Greater than \$428,000	\$66.40

In addition, the monthly income-related premium adjustment amounts to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount
Less than or equal to \$85,000	\$ 0.00
Greater than \$85,000 and less than or equal to \$129,000	\$48.10
Greater than \$129,000	\$66.40

2011 Part B IRMAA Tables

Listed below are the 2011 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year) or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$115.40
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$46.10	\$161.50
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$115.30	\$230.70

\$320,000			
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$184.50	\$299.90
Greater than \$214,000	Greater than \$428,000	\$253.70	\$369.10

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$115.40
Greater than \$85,000 and less than or equal to \$129,000	\$184.50	\$299.90
Greater than \$129,000	\$253.70	\$369.10

2011 - Part D - Supplementary Medical Insurance (SMI) Prescription Drug Account - IRMAA

Starting January 2011, the Patient Protection and Affordable Care Act requires beneficiaries in Medicare Part D prescription drug coverage plans whose incomes exceed the same thresholds that apply to higher-income Part B beneficiaries to pay a monthly adjustment amount in addition to their regular Part D plan premiums.

Part D Base Beneficiary Premium for 2011 - \$32.34

Listed below are the 2011 Part D monthly income-related premium adjustment amounts to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00
Greater than \$85,000 and less than or	Greater than \$170,000 and	\$12.00

equal to \$107,000	less than or equal to \$214,000	
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$31.10
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$50.10
Greater than \$214,000	Greater than \$428,000	\$69.10

In addition, the monthly income-related premium adjustment amounts to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount
Less than or equal to \$85,000	\$0.00
Greater than \$85,000 and less than or equal to \$129,000	\$50.10
Greater than \$129,000	\$69.10

2010 Part B IRMAA Tables

Listed below are the 2010 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$110.50
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$44.20	\$154.70
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to	\$110.50	\$221.00

\$320,000			
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$176.80	\$287.30
Greater than \$214,000	Greater than \$428,000	\$243.10	\$353.60

In addition, the 2010 monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$110.50
Greater than \$85,000 and less than or equal to \$129,000	\$176.80	\$287.30
Greater than \$129,000	\$243.10	\$353.60

2009 Part B IRMAA Tables

The 2009 income-related monthly adjustment amounts that are included in the Part B monthly premium rates paid by beneficiaries with modified adjusted gross incomes over prescribed thresholds are shown in the following tables. Calendar year 2009 is the third and final year of the phase-in of IRMAAs and, therefore, the first year in which affected Part B enrollees will pay the full amount of the income-related premiums. The monthly premium rates paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return are as follows.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$96.40
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$38.50	\$134.90
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$96.30	\$192.70

Greater than \$160,000 and less than or equal to \$213,000	Greater than \$320,000 and less than or equal to \$426,000	\$154.10	\$250.50
Greater than \$213,000	Greater than \$426,000	\$211.90	\$308.30

In addition, the 2009 monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$85,000	\$0.00	\$96.40
Greater than \$85,000 and less than or equal to \$128,000	\$154.10	\$250.50
Greater than \$128,000	\$211.90	\$308.30

2008 Part B IRMAA Tables

The 2008 income-related monthly adjustment amounts that are included in the Part B monthly premium rates paid by beneficiaries with modified adjusted gross incomes over prescribed thresholds are shown in the following tables. The monthly premium rates paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return are as follows:

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$82,000	Less than or equal to \$164,000	\$0.00	\$96.40
Greater than \$82,000 and less than or equal to \$102,000	Greater than \$164,000 and less than or equal to \$204,000	\$25.80	\$122.20
Greater than \$102,000 and less than or equal to \$153,000	Greater than \$204,000 and less than or equal to \$306,000	\$64.50	\$160.90
Greater than \$153,000 and less than or equal to \$205,000	Greater than \$306,000 and less than or equal to \$410,000	\$103.30	\$199.70
Greater than \$205,000	Greater than \$410,000	\$142.00	\$238.40

The 2008 monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are shown below:

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$82,000	\$0.00	\$96.40
Greater than \$82,000 and less than or equal to \$123,000	\$103.30	\$199.70
Greater than \$123,000	\$142.00	\$238.40

2007 Part B IRMAA Tables

The 2007 income-related monthly adjustment amounts that are included in the Part B monthly premium rates paid by beneficiaries with modified adjusted gross incomes over prescribed thresholds are shown in the following tables. The monthly premium rates paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return are as follows:

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$80,000	Less than or equal to \$160,000	\$0.00	\$93.50
Greater than \$80,000 and less than or equal to \$100,000	Greater than \$160,000 and less than or equal to \$200,000	\$12.30	\$105.80
Greater than \$100,000 and less than or equal to \$150,000	Greater than \$200,000 and less than or equal to \$300,000	\$30.90	\$124.40
Greater than \$150,000 and less than or equal to \$200,000	Greater than \$300,000 and less than or equal to \$400,000	\$49.40	\$142.90
Greater than \$200,000	Greater than \$400,000	\$67.90	\$161.40

The 2007 monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are shown below:

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$80,000	\$0.00	\$93.50
Greater than \$80,000 and less than or equal to \$120,000	\$49.40	\$142.90
Greater than \$120,000	\$67.90	\$161.40

Note: The premium rates shown in these tables do not reflect any penalty surcharges that a beneficiary may be required to pay, or any premium reductions that may be made because the beneficiary is enrolled in a Medicare Advantage plan that offers enrollees reduced Part B premiums.

Exhibit 6 - Part A Base Premium Rate

2017	\$413.00
2016	\$411.00
2015	\$407.00
2014	\$426.00
2013	\$441.00
2012	\$451.00
2011	\$450.00
2010	\$461.00
2009	\$443.00
2008	\$423.00
2007	\$410.00
2006	\$393.00
2005	\$375.00
2004	\$343.00
2003	\$316.00

2002	\$319.00
2001	\$300.00
2000	\$301.00
1999	\$309.00
1998	\$309.00
1997	\$311.00
1996	\$289.00
1995	\$261.00
1994	\$245.00
1993	\$221.00

Exhibit 7 - Deductible & Coinsurance Amounts – Part A and Part B

PART A – HOSPITAL INSURANCE

Note: SNF = Skilled Nursing Facility

	2017	2016
Inpatient hospital deductible	\$1,316.00	\$1,288.00
Daily Coinsurance 61 st through 90 th day	329.00	322.00
Daily Coinsurance for each reserve day used	658.00	644.00
Daily Coinsurance 21 st through 100 th day in SNF	164.50	161.00

	2015	2014	2013	2012
Inpatient hospital deductible	\$1,260.00	\$1,216.00	\$1,184.00	\$1,156.00

Daily Coinsurance 61 st through 90 th day	315.00	\$304.00	\$296.00	\$289.00
Daily Coinsurance for each reserve day used	630.00	\$608.00	\$592.00	\$578.00
Daily Coinsurance 21 st through 100 th day in SNF	157.50	\$152.00	\$148.00	\$144.50

	2011	2010	2009	2008
Inpatient hospital deductible	\$1,132.00	\$1,100.00	\$1,068.00	\$1,024.00
Daily Coinsurance 61 st through 90 th day	283.00	275.00	267.00	256.00
Daily Coinsurance for each reserve day used	566.00	550.00	534.00	512.00
Daily Coinsurance 21 st through 100 th day in SNF	141.50	137.50	133.50	128.00

	2007	2006	2005	2004
Inpatient hospital deductible	\$992.00	\$952.00	\$912.00	\$876.00
Daily Coinsurance 61 st through 90 th day	248.00	238.00	228.00	219.00
Daily Coinsurance for each reserve day used	496.00	476.00	456.00	438.00
Daily Coinsurance 21 st through 100 th day in SNF	124.00	119.00	114.00	109.50

	2003	2002	2001	2000
Inpatient hospital deductible	\$840.00	\$812.00	\$792.00	\$776.00
Daily Coinsurance 61 st through 90 th day	210.00	203.00	198.00	194.00
Daily Coinsurance for each reserve day used	420.00	406.00	396.00	388.00
Daily Coinsurance 21 st through 100 th day in SNF	105.00	101.50	99.00	97.00

	1999	1998	1997	1996
Inpatient hospital deductible	\$768.00	\$764.00	\$760.00	\$736.00
Daily Coinsurance 61st through 90th day	192.00	191.00	190.00	184.00
Daily Coinsurance for each reserve day used	384.00	382.00	380.00	368.00
Daily Coinsurance 21st through 100th day in SNF	96.00	95.50	95.00	92.00

	1995	1994	1993	1992
Inpatient hospital deductible	\$716.00	\$696.00	\$676.00	\$652.00
Daily Coinsurance 61st through 90th day	179.00	174.00	169.00	163.00
Daily Coinsurance for each reserve day used	358.00	348.00	338.00	326.00
Daily Coinsurance 1st through 100th day in SNF	89.50	87.00	84.50	81.50

	1991	1990	1989	1988
Inpatient hospital deductible	\$628.00	\$592.00	\$560.00	\$540.00
Daily Coinsurance 61st through 90th day	157.00	148.00	N/A	135.00
Daily Coinsurance for each reserve day used	314.00	296.00	N/A	270.00
Daily Coinsurance 21st through 100th day in SNF	78.50	74.00	N/A	67.50
Daily Coinsurance 1st through 8th day in SNF (1989 ONLY)			25.50	

	1987	1986	1985	1984
Inpatient hospital deductible	\$520.00	\$492.00	\$400.00	\$356.00
Daily Coinsurance 61st through 90th day	130.00	123.00	100.00	89.00

Daily Coinsurance for each reserve day used	260.00	246.00	200.00	178.00
Daily Coinsurance 21st through 100th day in SNF	65.00	61.50	50.00	44.50

	1983	1982	1981	1980
Inpatient hospital deductible	\$304.00	\$260.00	\$204.00	\$180.00
Daily Coinsurance 61st through 90th day	76.00	65.00	51.00	45.00
Daily Coinsurance for each reserve day used	152.00	130.00	102.00	90.00
Daily Coinsurance 21st through 100th day in SNF	38.00	32.50	25.50	22.50

	1979	1978	1977	1976
Inpatient hospital deductible	\$160.00	\$144.00	\$124.00	\$104.00
Daily Coinsurance 61st through 90th day	40.00	36.00	31.00	26.00
Daily Coinsurance for each reserve day used	80.00	72.00	62.00	52.00
Daily Coinsurance 21st through 100th day in SNF	20.00	18.00	15.50	13.00

	1975	1974	1973	1972
Inpatient hospital deductible	\$92.00	\$84.00	\$72.00	\$68.00
Daily Coinsurance 61st through 90th day	23.00	21.00	18.00	17.00
Daily Coinsurance for each reserve day used	46.00	24.00	36.00	34.00
Daily Coinsurance 21st through 100th day in SNF	11.50	10.50	9.00	8.50

	1971	1970	1969	7-66
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				thru 1968
Inpatient hospital deductible	\$60.00	\$52.00	\$44.00	\$40.00
Daily Coinsurance 61st through 90th day	15.00	13.00	11.00	10.00
Daily Coinsurance for each reserve day used	30.00	26.00	22.00	20.00
Daily Coinsurance 21st through 100th day in SNF	7.50	6.50	5.50	5.00

PART B DEDUCTIBLE

2017	\$183.00
2016	\$166.00
2015	\$147.00
2014	\$147.00
2013	\$147.00
2012	\$140.00
2011	\$162.00
2010	\$155.00
2009	\$135.00
2008	\$135.00
2007	\$131.00
2006	\$124.00
2005	\$110.00
1991 thru 2004	\$100.00
1982 thru 1990	\$ 75.00
1973 thru 1981	\$ 60.00

1966 thru 1972	\$ 50.00
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Exhibit 10 - Hospital Benefits In 1989

Hospital Benefits - January 1, 1989 - December 31, 1989

- A. Inpatient Hospital Services - Under the provisions of the Medicare Catastrophic Coverage Act of 1988, the "benefit period" was eliminated as a way of measuring the use of services under Part B. Effective January 1, 1989, the "benefit period" was replaced with a single annual deductible. Medicare paid for unlimited medically necessary inpatient hospital care after the annual deductible was paid.

A "carry-over" rule prevented the payment of back-to-back deductible amounts in December and January. If an individual paid a hospital deductible in December 1988, no additional deductible was required if he was still a patient in or was readmitted to a hospital in January 1989.

Because of the Repeal of the Medicare Catastrophic Coverage Act of 1988, the following exceptions apply:

For hospital services provided in 1990 and later, no day before January 1, 1990 can be used in determining the beginning of a benefit period. For example, if an individual was hospitalized for 6 days in December of 1989 and still was in the hospital or was readmitted to a hospital in January of 1990, a new "benefit period" began the first day in 1990 that the person was in the hospital. A new 90 days of coverage was granted.

"Lifetime reserve days" used before January 1, 1989, are counted with "lifetime reserve days" used after December 31, 1989, in determining if the 60 day limit was used. No "lifetime reserve days" were charged for 1989.

The hospital deductible did not apply for services provided January 1, 1990 or later, if:

- an individual was receiving inpatient hospital services during a continuous period beginning before and including January 1, 1990, and a deductible was imposed in 1989; or
- a "benefit period" began in January 1990 and a deductible was imposed for a period of hospitalization that began in December 1989; or
- a "benefit period" began before January 1, 1989, and did not end on January 1, 1990.

- B. Skilled Nursing Facility (SNF) Services - Under the provisions of the Medicare Catastrophic Coverage Act of 1988, the post hospitalization requirements were

eliminated. Effective January 1, 1989, Part A helped pay for inpatient care in a Medicare certified SNF if both of the following conditions were met:

- a doctor certified that the care was needed and the patient actually received skilled nursing or skilled rehabilitation services on a daily basis; and
- the Medicare intermediary or the facility's Utilization Review Committee did not disapprove the stay.

Part A helped pay for up to 150 days in a calendar year. For the first eight days of care during the year, Part A paid for all allowable expenses except the daily coinsurance amount. (See Exhibit 7 for a list of SNF coinsurance amounts.) Part A paid all other allowable charges for up to 150 days even if the patient is discharged and readmitted to a SNF more than once during the year.

NOTE: The requirements for post-hospitalization did not apply to an individual receiving extended care services from a SNF during a continuous period beginning before (and including) January 1, 1990, until the end of the 30 consecutive day period in which the individual is not provided inpatient hospital or extended care services.

Exhibit 11 - An Important Message From Medicare

YOUR RIGHTS WHILE YOU ARE A MEDICARE HOSPITAL PATIENT

You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs, not by "DRGs" or Medicare payments.

You have the right to be fully informed about decisions affecting your Medicare coverage and payment for your hospital stay and for post-hospital services.

You have the right to request a review by a Peer Review Organization of any written Notice of Noncoverage that you receive from the hospital stating the Medicare will no longer pay for your hospital care. Peer Review Organizations (PRO's) are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients. The phone number and address of the PRO for your area are:

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post-hospital care,

don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "Notice of Noncoverage". You must have this Notice of Noncoverage if you wish to exercise your right to request a review by the PRO.

The Notice of Noncoverage will state either that your doctor or the PRO agrees with the hospital's decision that Medicare will no longer pay for your hospital care.

If the hospital and your doctor agree, the PRO does not review your case before a Notice of Noncoverage is issued. But the PRO will respond to your request for a review of your Notice of Noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the PRO makes its decision, if you request the review by noon of the first work day after you receive the Notice of Noncoverage.

If the hospital and your doctor disagree, the hospital may request the PRO to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation the PRO must agree with the hospital or the hospital cannot issue a Notice of Noncoverage. You may request that the PRO reconsider your case after you receive a Notice of Noncoverage but since the PRO has already reviewed your case once, you may have to pay for at least one day of hospital care before the PRO completes this reconsideration.

IF YOU DO NOT REQUEST A REVIEW, THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDED YOU WITH A NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

If the Notice of Noncoverage states that your physician agrees with the hospital's decision:

You must make your request for review to the PRO by noon of the first work day after you receive the Notice of Noncoverage by contacting the PRO by phone or in writing.

The PRO must ask for your views about your case before making its decision. The PRO will inform you by phone or in writing of its decision on the review.

If the PRO agrees with the Notice of Noncoverage, you may be billed for all costs of your stay beginning at noon of the day after you receive the PRO's decision.

Thus, you will not be responsible for the cost of hospital care before you receive the PRO's decision.

If the Notice of Noncoverage states that the PRO agrees with the hospital's decision:

You should make your request for reconsideration to the PRO immediately upon receipt of the Notice of Noncoverage by contacting the PRO by phone or in writing.

The PRO can take up to three working days for receipt of your request to complete the review. The PRO will inform you in writing of its decision on the review.

Since the PRO has already reviewed your case once, prior to the issuance of the Notice of Noncoverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your Notice of Noncoverage even if the PRO has not completed its review.

Thus, if the PRO continues to agree with the Notice of Noncoverage, you may have to pay for at least one day of hospital care.

NOTE: The process described above is called immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of Medicare's decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The Notice of Noncoverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Medicare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, patient representative and your family in making preparations for care after you leave the hospital. Don't hesitate to ask questions.

ACKNOWLEDGEMENT OF RECEIPT

My signature only acknowledges my receipt of this Message from (name of hospital) on (date) and does not waive any of my rights to request a review or make me liable for any payment.

Signature of beneficiary or person
acting on behalf of beneficiary

(Date of receipt)

Exhibit 14 - CMS Forms

FOM PART I/ARTICLE 17/1730

CMS-I500, SUPPLIER'S REQUEST FOR MEDICARE PAYMENT

Doctors, hospitals, and other suppliers use Form HCFA-I500 to claim reimbursement under Medicare Part B. The Railroad Retirement Board does not stock Form HCFA-I500; a provider must request it directly from the Centers for Medicare & Medicaid Services. The form is also numbered RRB-I500.

Forward requests for reimbursement to the appropriate Part B carrier. For regular claims, that is Palmetto GBA. For durable medical equipment or supplies, this is the regional DEMERC. Current addresses are shown in the Medicare Handbook (Form RB-23).

Exhibit 16 - Letter To Enrollee - Referral of MA Plan Problem to CMS

Beneficiary's Name

Address

Dear :

The Centers for Medicare & Medicaid Services has overall responsibility for the Medicare program, including Medicare Advantage plans..

The responsibility for resolving problems that beneficiaries may have with Medicare Advantage plans rests with the Centers for Medicare & Medicaid Services' Regional Offices. Therefore, we have referred your recent inquiry to the Centers for Medicare & Medicaid Services, Regional Office, (enter the address of the regional office).

They will evaluate the situation and respond directly to you. If you have any further questions or additional material, you should write to the Centers for Medicare & Medicaid Services' Regional Office.

Very truly yours,

Director of Operations

cc: CMS R/O

Exhibit 17 - CMS's Region/Addresses, Various Contacts And States Within CMS Regional Offices

Exhibit_17:

I. Boston

Connecticut

Maine

Massachusetts

New Hampshire

Rhode Island

Vermont

CMS

Associate Regional Administrator

Division of Medicare

John F. Kennedy Federal Building

Room 2375

Boston, Massachusetts 02203

MAHP Manager

Martha Stuker

1-617-565-1266 FAX 1-617-565-3856

e-mail: martha.stuker@cms.hhs.gov

II. New York

New Jersey

New York

Puerto Rico

Virgin Islands

CMS

Associate Regional Administrator

Division of Medicare

26 Federal Plaza

Room 3811

New York, New York 10278

Associate Regional Administrator

Jose Mirabal

1-212-616-2333 FAX 1-212-264-2665

e-mail: jose.mirabal@cms.hhs.gov

III. Philadelphia

Delaware

District of Columbia

Maryland

Pennsylvania

Virginia

West Virginia

CMS

Associate Regional Administrator

Division of Medicare

The Public Ledger Building

150 S. Independence Mall, Suite 216

Philadelphia, PA 19106-3499

Medicare Advantage Coordinator

Annmarie Anderson

1-215-861-4184

e-mail: annmarie.anderson@cms.hhs.gov

FAX 1-215-861-4334

IV. Atlanta

Alabama
Florida
Georgia
Kentucky
Mississippi
North Carolina
South Carolina
Tennessee

CMS
Associate Regional Administrator
Division of Medicare
Atlanta Federal Center
61 Forsyth St., SW
Suite 4T20
Atlanta, Georgia 30303

MAB Manager
Teresa Kries
1-404-562-7362

e-mail: teresa.kries@cms.hhs.gov
FAX 1-404-562-7386

V. Chicago

Illinois
Indiana
Michigan
Minnesota
Ohio
Wisconsin

CMS
Associate Regional Administrator
Division of Medicare
233 N. Michigan Ave, Suite 600
Chicago, Illinois 60601

MAB Branch Director
Raymond 1-312-353-3620
Swisher
e-mail:
raymond.swisher@cms.hhs.gov
FAX 1-312-353-8703

HPB Branch Director
Dolores Perteet 1-312-353-9864

e-mail: Dolores.perteet@cms.hhs.gov

VI. Dallas

Arkansas
Louisiana
Oklahoma
New Mexico
Texas

CMS
Associate Regional Administrator
Division of Medicare
1301 Young St., Room 833
Dallas, Texas 75202

Branch Chief
Art Pegan 1-214-767-4471

e-mail: art.pagan@cms.hhs.gov
FAX 1-214-767-6439

VII. Kansas City

Iowa
Kansas
Missouri
Nebraska

CMS
Associate Regional Administrator
Division of Medicare
Richard Bolling Federal Office Building
601 East 12th Street - Room 235
Kansas City, Missouri 64106

Acting Branch Chief
Sandy Neal
1-816-426-6543
e-mail: sandra.neal@cms.hhs.gov
FAX 8-816-426-7604

VIII. Denver

Colorado
Montana
North Dakota
South Dakota
Utah
Wyoming

CMS
Associate Regional Administrator
Division of Medicare
Federal Office Building
1600 Broadway, Ste. 700
Denver, Colorado 80202

Associate Regional Administrator
Tod Anderson
1-303-844-2126
e-mail: tod.anderson@cms.hhs.gov
FAX 1-303-844-3753

IX. San Francisco

Arizona
California
Hawaii
Nevada
Samoa

CMS
Associate Regional Administrator
Division of Medicare
90 7th Street, Suite 5-300 (5W)
San Francisco, California 94103-6708

Associate Regional Administrator
David Sayen
1-415-744-3621
e-mail: david.sayen@cms.hhs.gov

FAX 1-415-744-3761

X. Seattle

Alaska
Idaho
Oregon
Washington

CMS
Associate Regional Administrator
Division of Medicare
2201 Sixth Avenue
Mail Stop: TX-47
Seattle, Washington 98121

Associate Regional Administrator
Linda Barley
1-206-615-2371
FAX 8-206-553-8390
e-mail: linda.barely@cms.hhs.gov

3.2.1 Scope Of Chapter

This chapter describes the basic entitlement and eligibility criteria for Medicare hospital insurance (Part A) and Medicare supplementary medical insurance (Part B). It discusses how eligible individuals establish entitlement for both parts of Medicare and how the Railroad Retirement Board (RRB) establishes effective dates of coverage. Also, this chapter explains the events that can terminate coverage. We have also included the procedures applicable when an individual's enrollment or coverage rights are prejudiced due to government error or inaction and reconsideration rights.

3.2.5 Part A – Entitlement Provisions

To qualify for Part A, an individual can meet either the aged or disabled requirements.

- A. Qualification Based on Age - An individual is entitled to Part A for the first month after June 1966 that he or she:
 - 1. attained age 65; and
 - 2. is entitled to a monthly benefit; or
 - 3. has attained status as a qualified railroad retirement beneficiary (QRRB).
- B. Qualification Based on Disability - An individual under age 65 is entitled to Part A for the first month after June 1973 that he or she:
 - 1. has been entitled to social security disability benefits for 25 consecutive months prior to 12-1-80; effective 12-1-80, the months do not have to be consecutive; or
 - 2. could have been entitled to a social security disability benefit had he or she not already established entitlement to monthly benefits; or
 - 3. has attained status as a disabled qualified railroad retirement beneficiary (DQRRB).

3.2.6 Transitionally Insured Provision

An individual who does not meet the requirements under the regular insured provision, can become entitled to Part A coverage. Coverage begins with the first month after June 1966 in which the individual meets ALL of the following requirements:

- A. Files an application with SSA for deemed insured Part A coverage; and
- B. Is not, or, upon filing application, would not be, entitled to a monthly benefit; and does not meet the requirements for certification as a QRRB; and

- C. Has attained age 65; and
- D. Has, if he or she attains age 65 after 1967, not less than 3 quarter of coverage (QC's) for each calendar year elapsing after 1966 and before the year he or she attains age 65; and
- E. Is a resident of the U.S.; and
- F. Is a U.S. citizen or an alien lawfully admitted for permanent resident who has resided in the U.S. continuously for the 5-year period immediately preceding the month all other requirements are met; and
- G. Is not precluded from entitlement because he or she is covered, or would have been covered currently had he or she enrolled under the Federal Employee Health Benefits Act of 1959; and
- H. Is not precluded from entitlement because he or she has been convicted of certain crimes against the U.S.

The Social Security Administration (SSA) has jurisdiction of all transitionally insured individuals. For men who attain age 65 in 1975 or later, and women who attain age 65 in 1974 or later, the same fully insured status is required for Part A.

3.2.7 Voluntary Hospital Insurance

Effective July 1, 1973, Part A became available on a voluntary basis to uninsured persons excluded under the transitionally insured provision because they do not have sufficient QCs, or because they are, or could have been covered under the Federal Employees Health Benefits Act program. This coverage is commonly called "Premium-HI." This plan is administered by the Centers for Medicare & Medicaid Services (CMS). To be eligible for Premium-HI, an individual must be:

- 1. Age 65 or older; and
- 2. A resident of the U.S.; and
- 3. Either a U.S. citizen or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously for at least the past 5 years; and
- 4. Simultaneously enrolled for Part B or currently entitled to Part B; and
- 5. Ineligible for Part A coverage under both the regular and transitionally insured provisions.

3.2.8 End Stage Renal Disease Cases

The 1972 Social Security (SS) Act amendments extended Medicare health insurance coverage to certain persons who have chronic renal disease (CRD) requiring

hemodialysis (including peritoneal dialysis) or kidney transplantation. Only insured SS Act workers and their spouses and dependent children were eligible for coverage. Medicare health insurance coverage based on CRD is termed R-HI and R-SMI. Entitlement to R-HI and R-SMI coverage extends only to the individual afflicted with End Stage Renal Disease (ESRD), not to other members of the family. The insured status requirement could be met by career railroad employees (and their spouses and dependent children) only if they also had sufficient work and earnings to be covered under the SS Act. However, the 1973 Railroad Retirement (RR) Act technical amendments extended protection of R-HI and R-SMI to career railroad employees and their spouses and dependent children based on entitlement to an annuity under the RR Act or on a fully or currently insured status counting RR Act compensation as though it were SS Act earning. The 1978 amendments further liberalized the qualifications for entitlement to R-HI and R-SMI.

For a railroad employee to qualify for R-HI coverage, he or she must:

1. Be medically determined to have a chronic kidney disease that required kidney dialysis or transplant to maintain life, and
2. Be insured under the SS Act on the basis of combined railroad and SS earnings, or be entitled to an RR Act annuity or monthly SS benefit.

For a family member to be eligible, he or she must meet the requirements of 1 above and also:

1. Be the spouse or dependent child of a railroad employee who is either insured under the SS Act on the basis of combined earnings or entitled to a monthly SS benefit, or
2. Be entitled to a RR annuity or a monthly SS benefit.

SSA has jurisdiction of Medicare coverage for ESRD only cases, even for railroad workers and their families. However, when an R-HI enrollee attains age 65 or becomes eligible for Medicare for the disabled, Medicare jurisdiction will be transferred mechanically to RRB from SSA. Persons inquiring about Medicare for ESRD should be directed to the SSA field office nearest them.

EXCEPTION: If RRB is paying a SS benefit (LAF E) and SSA determines that an individual is eligible for ESRD, RRB will establish the Medicare record with the information provided from SSA. If no information was provided, contact the SS program center to secure the information necessary to enroll the individual. This is true even if the individual is not yet eligible for Medicare based on the regular disability or aged provisions. For these cases, because of the MEDCOR edits, it is necessary to establish the MIRTEL record by creating a MEDCOR Activity 13L and then submit a MEDCOR Activity 21S. The screening request will reject. Await the Screening Reject Referral and force clearance with a MEDCOR Activity 32S. When action is completed, delete the referrals on MEDREF.

If a disabled child's Medicare effective date based on CRD is prior to the attainment of age 20, the HI date of birth has to be changed to prevent rejects at CMS. If the date of birth is not changed, Referral Code 5052 – PART A EFF DATE FOR DIB BENE INCORRECT will be produced. The RR date of birth should be the correct date of the birth. The HI date of birth should make the disabled child age 20 in the month of the Part A effective date. This should be done when the Medicare record is initially set up.

3.2.9 Qualified Railroad Retirement Beneficiary

A "qualified railroad retirement beneficiary" (QRRB) is a person who has been certified by RRB to SSA under Section 7 of the RR Act of 1974. Certification refers to the screening process which is the notification RRB transmits to SSA that an individual is a QRRB entitled to Medicare, Part A and Part B or Part A only. A QRRB can be certified on the basis of age or disability.

3.2.10 Aged QRRB

An individual who has attained age 65 may be certified as a QRRB if he or she meets any one of the following qualifications:

1. Is entitled to an RR annuity or pension, even if the annuity amount is zero, or
2. Has filed an application for Part A with RRB and would be entitled to an RR annuity if he or she ceased compensated service and filed an application for such annuity, or
3. Has filed an application for Part A with RRB and would be entitled as the spouse of a RRB employee if the employee ceased compensated service and filed an application for an annuity, or
4. Is so related to an RR employee that he or she can be considered under the special SS guarantee provision in computing the amount of the employee's annuity. It is sufficient to merely establish the relationship necessary for O/M consideration; whether the O/M would apply is irrelevant. It is unnecessary to determine if earnings would preclude inclusion in the O/M.

Effective January 1, 2002, if there are 10 years of RR service or less, but at least 5 years of RR service after 1995, an individual is considered a QRRB, and could be enrolled for Medicare.

If the employee has 5 years of service prior to January 1, 2002, use January 2002 as the QRRB status date. If the employee has 5 years of service on or after January 1, 2002, use the date the 5 years of service is obtained as the QRRB status date.

In some cases, the QRRB status date is used to determine the Part A effective date, see RCM 3.1.12 and RCM 3.2.20.

A spouse age 65 or older can qualify as a QRRB under item 4 even though the employee is less than 65 and not eligible for Part A if she or he has filed an application for Part A purposes and:

1. The employee is 62-64 and is receiving a reduced age and service annuity.
2. The employee is receiving a full annuity at age 60 based on 30 years of service.
3. The employee annuitant is under age 62 and is under a DF.
4. The employee is not on the rolls but is
 - at least 62 and has 10 years of service, or less than 10 years but at least 5 years of service after 1995, or
 - at least 60 and has 30 years of service

If the residual lump sum has been paid to any type of widow(er) because that person's annuity rate is zero, the widow(er) is considered entitled to an annuity and to be QRRB.

3.2.11 Disabled Qualified Railroad Retirement Beneficiary

An individual who is under age 65 may be certified as a disabled qualified railroad retirement beneficiary (DQRRB) if he or she meets the following qualifications:

1. Has been entitled to an RR annuity, even if the annuity amount is zero, or could have been considered in the computation of an annuity under the special SS guaranty provision, for at least 24 consecutive months prior to 12-1-80; effective 12-1-80, the months do not have to be consecutive, and
2. Has met the criteria for a disability benefit under the SS Act for at least 24 consecutive months prior to 12-1-80; effective 12-1-80, the months do not have to be consecutive.

See RCM 3.2.22.

RR Act annuitants who are receiving non-disability annuities can be deemed entitled to a disability benefit in order to establish entitlement to Medicare.

In addition, an employee annuitant must -

1. Satisfy SSA disability medical criteria,
2. Have a freeze-insured status, and
3. Satisfy the waiting period requirement.

A widow must -

1. Be at least 52 years of age,
2. Satisfy SSA disability medical criteria, and
3. Satisfy the waiting period requirement.

A child annuitant must -

1. Be at least 20 years of age, and
2. Satisfy SSA medical criteria for a child's disability benefit.

3.2.12 Deemed QRRB

An individual is considered to be a "deemed qualified railroad retirement beneficiary" (deemed QRRB) if he or she:

1. Is entitled to SS benefits based on his or her own wages and self employment income and is the spouse of an individual who has 120 months of creditable railroad service, or if less than 120 months, has at least 60 months of creditable railroad service after 1995; or
2. Is entitled to SS benefits based on the wages and/or self employment income of an individual who has 120 months of railroad service, or if less than 120 creditable railroad service, has at least 60 months of railroad service after 1995 (except a survivor of such an individual if the individual did not have a current connection with the railroad industry at the time of death).

The fact that an SSA award is certified to RRB for payment does not in itself make the beneficiary a QRRB. However, these individuals are deemed QRRBs for the purpose of convenience and consistency in handling claims. See 3.2.8 for information on ESRD cases.

3.2.13 Government Employment Quarters Of Coverage

- A. General - Federal, State, and local government employment may be used in some cases to establish Medicare entitlement. QCs received for this type of employment are called Government Employment Quarters of Coverage (GEQCs). They cannot be used to establish entitlement to an annuity or a disability freeze. GEQCs should not be developed in all cases. First, every attempt should be made to establish Medicare based on railroad retirement earnings or social security wages. If this fails and if the application indicates government employment, an attempt should be made to establish Medicare based on government employment. General information about social security insured status can be found in RCM 5.6.5. Information about disability insured status can be found in DCM 6.3.2 and RCM 5.6.11.

- B. Federal Employment -- All wages paid to Federal employees after December 1982 are taxed for Medicare purposes. Federal quarters of coverage awarded January 1983 or later may be used to establish Medicare coverage.

In addition, a Federal employee may be granted deemed QCs for Federal employment before January 1983 to establish Medicare coverage if:

- the employee was in an employer - employee relationship with the Federal government at anytime during January, 1983, and;
- the employee was employed by the Federal government prior to January 1983.

Proof of Federal Employment - The employee must provide proof of Federal employment during the quarter(s) that he or she claimed to be entitled to GEQCs. In addition, if GEQCs are claimed for any quarter through December 1982, the employee must provide proof of employment by the Federal government during January 1983. In most cases, a DEQY will provide sufficient proof.

The term "employee" includes individuals in pay status (including those on approved annual leave or sick leave), those on approved "leave without pay", and certain other categories of individuals who are in non-pay status. If the individual was not in pay status or approved leave status, a statement from the employing agency that the individual was an employee at any time during January 1983 will suffice.

Form OPM 1528 is also acceptable proof of pre-1983 earnings as well as proof of Federal employment during January 1983. This form is given to employees when they leave Federal service. Other acceptable forms of proof may be W-2 forms, pay slips, or a signed statement from the employing agency certifying to the amount of wages paid each year as shown on the agency's records.

In cases in which the DEQY is not sufficient to determine GECQs in the pertinent time period, the employee should attempt to secure the necessary proof. Do not contact OPM. If the employee does not have the necessary documentation, advise him or her to write to the National Personnel Records Center to obtain a copy of his or her official personnel folder. The address is:

National Personnel Records Center
111 Winnebago Street
St. Louis, MO 63118-4126

The fax number is:
(314) 801-9270

It will be necessary to provide the railroad employee's name, social security number, date of birth, and the name of the agency where the employee worked.

- C. State or Local Government Employment - State or local government QCs awarded April 1986 or later may be used to establish Medicare coverage only. No quarters may be granted for employment before April 1986.

Proof of State or Local Government Employment - The employee must provide proof of employment during the quarter(s) that he or she claimed to be entitled to a GEQC. GEQCs cannot be awarded for government employment prior to April 1986.

In most cases, a DEQY will provide sufficient proof. Other acceptable forms of proof may be W-2 forms, pay slips, or a signed statement from the employing agency certifying to the amount of wages paid each year as shown on the agency's records.

- D. Disability Examiner Action - If Medicare entitlement cannot be established in a disability cases based on railroad retirement earnings or social security wages, further development may be required. The disability examiner will check the application for an indication of Federal, State, or local government employment. If such employment is indicated, a DEQY must be requested. Upon receipt of the DEQY (or other acceptable proof), the disability examiner will determine whether the GEQCs will provide Medicare coverage.

1. Federal Employment Claimed - Under Public Law 97-248, Federal employment may be used in some cases to establish Medicare entitlement.

GEQCs are defined in item A above. An explanation of the Federal QCs that may be considered GEQCs is given in item B.

2. State or Local Government Employment Claimed - State or local government employment may be used in some cases to establish Medicare entitlement.

GEQCs are defined in item 'A' above. An explanation of the state or local government QCs that may be considered GEQCs is given in item B.

3. Crediting GEQCs - QCs for January 1978 or later may be determined as explained in RCM 5.6.18. Prior to January 1978, 1 quarter of coverage may be awarded for each \$250 in wages in a calendar year up to the maximum of 4 deemed QCs if \$1000 or more was earned in any 1 year. However, if using this deeming method results in the individual having insufficient QCs for Medicare, advise the employee that he or she can submit evidence, (e.g. paystubs, earnings and leave statements) of actual earnings in each quarter for the year in question. One QC may be awarded for each quarter in which there are wages of \$50 or more.

3.2.14 ALS (Lou Gehrig's Disease) and Medicare Coverage

Normally, to qualify for disability Medicare, RR Act annuitants and IPIs must meet SSA disability requirements for a period of 24 months of entitlement to an annuity. Medicare

coverage begins with the 25th month of annuity entitlement. The 24 months of actual or deemed annuity entitlement cannot begin until after completion of a 5-month waiting period. An applicant other than a child must be disabled for 5 full calendar months before he or she becomes entitled to a period of disability under the SS Act.

Public Law 106-554, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, waives the 24-month waiting period for Medicare coverage for disabled individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS).

Effective July 1, 2001, persons who are determined to be disabled with Amyotrophic Lateral Sclerosis, also known as Lou Gehrig's disease, are entitled to Medicare (with the right to refuse Part B) the month after the completion of the 5-month waiting period. They do not have to meet the additional 24-month waiting period.

Starting July 1, 2001, this provision affects both new and current disability beneficiaries with ALS. The earliest Medicare effective date for these individual is July 1, 2001. Once an individual is determined to be disabled with ALS, the disability examiner will forward the case to MS for enrollment.

These cases are not part of the attainment process. The enrollment will be manual. Take the following action when enrolling an individual because of ALS:

1. Establish the MIRTEL Record by creating a MEDCOR Activity 13L. A MEDCOR Activity 12L will reject because the ABD and DF dates are required to verify the effective date.
2. Once the MIRTEL Record is established, create a MEDCOR Activity 21S for the screening process.

Example 1:

The employee diagnosed with ALS has a DF date of 2-4-2001. His Medicare effective date is 8-2001.

Example 2:

The employee's DF is 11-16-1999. He is disabled because of ALS. His Medicare effective date is 7-2001. This is the earliest date based on the law.

Example 3:

The employee's DF is 10-23-2001, and he is disabled because of ALS. His Medicare effective date is April 2002.

3.2.20 Effective Date Of Part A Coverage Based On Age

Part A coverage begins with the latest of the following:

- 7-1-66; or
- The month in which age 65 is attained; or
- The month in which the applicant attains status as a QRRB or insured status at SSA; or
- Effective September 1, 1983, 6 months before the month of filing an application which establishes entitlement for Part A. However, the effective date for the divorced spouse of a disabled employee may be 12 months before the filing date.
- Note: Prior to September 1, 1983, application filed at the RRB could have 12 months of retroactivity; and prior to March 1, 1981, applications filed at SSA could have 12 months of retroactivity.
- The Railroad Retirement and Survivors Improvement Act of 2001 (RRSIA) lowered the number of years of RR service required for RR benefits and RR Medicare. Prior to January 1, 2002, an employee had to have 10 years of RR service in order to be a QRRB. Effective January 1, 2002, if a RR employee has less than 10 years of RR service but has at least 5 years of RR service after 1995, they are considered a QRRB and could be enrolled for Medicare.

If the employee has the 5 years of service prior to January 1, 2002, use January 2002 as the QRRB status date. If the employee has 5 years of service on or after January 1, 2002, use the date the 5 years of service is obtained as the QRRB status date. In some cases, the QRRB status date is used to determine the Part A effective date.

RRSIA EXAMPLES:

Example 1:

If an individual is 65 in 11-2000; has 5 years of RR service in 9-2001 – QRRB status date is 1-02; and files in 1-2002 -
Part A effective date is 1-2002 and if yes to Part B, the Part B effective date is 7-2002.

Example 2:

If an individual is 65 in 11-2001; has 5 years of RR service in 2-2002 – QRRB status date is 2-02; and files in 3-2002 –
Part A effective date is 2-2002 and if yes to Part B, the Part B effective date is 7-2002.

3.2.21 Effective Date Of Part A Coverage Based On Disability

A. Introduction.

To qualify for Medicare, RRA annuitants and IPIs must meet SSA disability requirements for a period of 24 months all occurring after 6-71. Medicare

coverage begins with the 25th month. 7-73 is the earliest date on which Medicare entitlement can begin. The 24 months of actual or deemed entitlement cannot begin until after completion of a waiting period, when it is required (see B below). If there is an interruption in disability annuity entitlement after the 24-month period is started or completed, and the beneficiary subsequently becomes reentitled, only the balance of months needed to total 24 months of entitlement need to be completed. See RCM 3.2.22.

Partial months will be considered as full months when determining the Medicare beginning date. For example, an employee's disability freeze (DF) is effective 1-1-73. He chooses an annuity beginning date (ABD) of 8-7-73. The month of 8-73 counts as the first of the 24 months and Medicare coverage can begin 8-1-75.

Once it has been determined that the medical and insured status requirements have been met, the Medicare eligibility date will be established as follows:

1. In most cases, those awarded disability annuities and rated disabled under the SS Act will automatically be called up for establishment of the Medicare record and release of the enrollment package.

However, MS will manually establish an eligibility date and a call-up date in certain cases in which a disabled survivor child could have been included in the O/M prior to the effective date of the survivor annuity.

2. Non-disability annuitants and IPIs are not automatically called up. A manual tickler call-up must be entered to insure establishment of the Medicare record. This will be accomplished by completing Form G-65b for the 5th month before the Medicare beginning date.

A call-up established for a disabled retirement child or a disabled widowed mother remains open and effective even if, during the 24-month period, the child's status changes to a survivor child annuitant or the widowed mother's annuity changes to a DWIA or a WIA. The MS call-up should be closed out before the expiration date only if the disabled person recovers.

- B. SSA Disability Waiting Period - Effective with benefits payable after 12-72 based on an application filed in or after 10-72, or an application filed before 10-72 on which a final determination was made in or after 10-72, an applicant other than a child must be disabled for 5 full calendar months before he becomes entitled to a period of disability under the SS Act.

There is no waiting period for children.

The 5-month waiting period applies to cases in which the disability onset date is 8-72 or later and the period of disability begins 1-73 or later, with Medicare coverage effective 1-75 or later. See RCM 1.2.120 for further information.

A 6-month disability waiting period must be served before entitlement to a period of disability in a case in which benefits would be payable under the SS Act before 1-73 or in which a final determination was made before 10-72.

The 6-month waiting period applies to cases in which the disability onset date is before 8-72 and the period of disability would begin before 1-73, with Medicare coverage effective before 1-75.

- C. Employee Cases - The Medicare eligibility date for employee disability annuitants is automatically determined from the information supplied on Form G-325. Shortly before the initial enrollment period (IEP) begins, a Medicare record will be established and clearance will be secured. Then, prior to the first month of the IEP, an enrollment package will be released.

The program does not provide for automatic selection of A&S annuitants who establish disability for Medicare only. Those cases in which a non-disability annuitant has been rate disabled under the SS Act are sent, after rating, to MS where manual call ups are set. Enter the call-up date on Form G-65b as the later of the following:

1. 24 months after the onset date shown in Item 26 of the G-325 (25 months if the waiting period is 6 months) (see B above), or
2. 19 months after the annuity beginning date shown on the award form.

This will be the 5th month before the Medicare beginning date.

EXAMPLE: Mr. Henry, born in 5-11 has been receiving an A&S annuity since 5-73. In 6-74, he files an AA-1d for Medicare purposes and is rated disabled effective 6-73.

MS will check to see if there has been entitlement to the A&S annuity from 6-73. If so, the Medicare eligibility date will be 11-1-75, 29 months from the onset date. Therefore, the tickler call-up will be entered for 6-1-75, the 5th calendar month before the Medicare beginning date.

- D. Retirement Child Case - MS will enter a tickler call-up on Form G-65b for the 5th month before the Medicare beginning date. To determine the call-up date, add 19 months to the latest of the following dates:
1. The date the child attained age 18, or
 2. The disability onset date entered in Item 28 of the G-325, or
 3. The earliest date the child could have been included under the O/M, as shown in the remarks section of Form G-325 for a child who is not an IPI, or

4. The date the employee attained age 62, or
5. The date the employee became entitled to a DIB-O/M (5 or 6 months after his or her entitlement to a DF; see B above to determine the length of the disability waiting period).

If necessary, refer the case to the RBD to determine the O/M date to establish the correct Medicare effective date.

The case of each retirement child must be reviewed before the child is enrolled in Medicare. When the case is called up 5 months before the child is eligible for enrollment, MS will take the following actions:

1. Review the claim folder for any reports regarding the child. If the child has recovered, died, or married, do not take any action to enroll him or her.

If the child has been employed since he or she was rated disabled and DPS has not reviewed the case since the employment was reported, refer the case to DSUBD for review.

If he or she has been employed and the employment has been reconciled with the disability, enroll the child.
2. If there is no recent report on the child's employment and he or she has an SS number, send the case DSUBD for review.

- E. Widow Cases - A disabled widow annuitant who also meets SSA's disability requirements will be automatically enrolled for Medicare when she becomes eligible.

MS must set a manual call-up on Form G-65b for a disabled mother annuitant or an age 60-64 widow annuitant who establishes disability for Medicare only. Manual call-ups are established for the 5th month before the Medicare beginning date. Select as the tickler call-up date the later of the following:

1. 24 months after the onset date entered in Item 28 of the G-325 (25 months if the waiting period is 6 months) (see B above), or
2. 19 months after the annuity beginning date (as shown on the award form).

When a mother entitled to WCIA files for Medicare prior to 7-1-74, the application may be deemed to have been filed timely in the earliest month for which she met all eligibility requirements under the SS Act. Applications filed on or after 7-1-74 will have 12 months retroactivity.

EXAMPLE: Mrs. Curtis, born in 1922, has been receiving WCIA payments since 6-72. In 9-73 she submits a Medicare application and proofs establishing that her

disability began in 8-65 (Item 28 of the G-325). The call-up date will be 1-74, the 19th month after the 6-72 DOE.

If Mrs. Curtis had filed her Medicare application in 8-74, her application would have only 1 year retroactivity. The call-up date in that event would be 3-75, since her Medicare could begin no earlier than 8-75.

In some cases where the Part B effective date is retroactive, MS will immediately take action to establish a Medicare record.

EXAMPLE: Mrs. Scott, born in 1919 began receiving a WCIA in 5-71. In 3-74, she filed proof establishing that she met the SS Act requirements for a disabled widow's benefit on 5-1-71.

Since she could have been eligible for a DWIA at least beginning 5-71 and since she established this fact before 7-1-74, the 24-month period will begin at the earliest possible date, 7-1-71, with Medicare beginning 7-1-73. MS will take action to establish a Medicare record.

If she had filed the same evidence in 9-74, her Medicare application would have only 1 year retroactivity (9-73), with Medicare beginning 24 months later, on 9-1-75.

When a widowed mother (father) established disability during her WCIA entitlement, her 24-month period will not be disturbed as long as she is converted to a DWIA or WIA. If the widowed parent first files to establish disability when converted to a DWIA or WIA, MS can use WCIA entitlement to determine the Medicare beginning date.

EXAMPLE: Mrs. Conroy, born in 6-23, has received a WCIA since 9-72. In 4-74, the annuity is to be terminated because her only child will attain age 18. In 3-74, she files to establish disability when her WCIA is converted to a DWIA. She is rated disabled under both Acts back to 6-69, and her DWIA is effective 4-74. Her 24-month period begins 6-74, the date she attained age 50. (A widow is not entitled to Medicare until she attains age 52.) 10 months of WCIA entitlement (from 6-73 through 3-74) are used to satisfy the waiting period. MS will enter a 1-75 call-up on Form G-65b (19 months after 6-73).

- F. Survivor Child Cases - A disabled child receiving a CIA, who meets the disability criteria of the SS Act, will be automatically selected for Medicare enrollment when he becomes eligible. However, MS must determine the Medicare effective date and take action to establish the Medicare record or set a manual call-up on Form G-65b for 4 months before the effective date in any case in which a disabled survivor child was or could have been included under the O/M before the employee's death. To determine the call-up date, add 19 months to the latest of the following dates:

1. The date the child attained age 18, or
2. The disability onset date entered in Item 28 of the G-325, or
3. The date the child was eligible for inclusion under the O/M; the latest of: the ABD of the employee's annuity, the date the employee attained age 62 or became entitled to a DIB-O/M (5 or 6 months after his or her entitlement to DF; see B above to determine the length of the disability waiting period), or 1 year before the existence of the child was mentioned in file.

3.2.22 Reentitled To Medicare After Termination Of Disability

Public Law 96-265, the Social Security Disability Amendments of 1980, made a number of changes in the law designed to remove disincentives for disability annuitants to attempt to return to work.

Prior to the enactment of these amendments, an individual was required to be entitled to a disability annuity for 24 consecutive months before he or she was entitled to Medicare. Any interruption in the 24-month waiting period necessitated that a new 24-month waiting period be met before Medicare could begin. The 1980 amendments provided that the 24-months of the qualifying period need no longer be consecutive.

In addition, beginning December 1, 1980, months from previous periods of disability benefit entitlement can be counted in determining when the 24-month waiting period is met if:

- the current disability onset date is no later than 5 years (60 months) after the end of a prior period of disability entitlement for an **employee; or**
- the current disability onset date is no later than 7 years (84 months) after the end of a prior period of disability entitlement for a **widow(er) or child disability annuitant; or**
- the current disabling impairment is the same as, or directly related to, the impairment which served as the basis for disability during a previous period of disability benefit entitlement (applies to individuals whose prior period of entitlement ended after February 29, 1988); **or**
- an individual whose previous disability entitlement ended for non-disability reasons prior to March 1, 1988 is reentitled to disability benefits with the same disability onset date. (If the individual's previous period of entitlement ended after February 29, 1988, prior months of entitlement may be counted under the preceding rule.)

The 60 or 84 month period begins with the month following the last month of disability benefit entitlement (whether or not the individual actually receives a benefit payment for that month). It ends with the month before the first month through all of which he or she

is again under a disability. To determine if the current onset is within the 5 or 7-year period specified above, count back 60 or 84 months beginning with the month prior to the month of current onset.

- If the employee was entitled to disability benefits during the 60-month period (or the widow(er) or child during the 84-month period), count all months all disability benefit entitlement in the prior period to determine when Medicare coverage begins.
- If the prior period ended more than 60 (or 84) months before the current month of onset, do not count the months in the prior period since the individual must begin a new 24-month qualifying period.

EXAMPLES:

1. Mary Jones was receiving a disabled widow's annuity with Medicare deductions. She recovered and her annuity was terminated effective January 1999. In June 2001, she is again entitled to a disabled widow's annuity with Medicare deductions. Medicare can begin immediately because a 24-month waiting period has already been met.
2. John's disability entitlement (based on an onset date of August 15, 2000 and an annuity beginning date of February 1, 2001) ended September 2002 because he was working. If he becomes disabled again at any time within 60 months of the September 2002 termination, the months in the prior period can be counted in determining when Medicare coverage may begin, regardless of the relationship between the two impairments. For example, if he becomes disabled again in December 2003, the 20 months from February 2001 through September 2002 will count in satisfying the 24-month waiting period. However, if John becomes disabled again after the 60-month period, i.e. after August 2007, the previous months of entitlement may only be counted if the current impairment is the same as, or directly related to, the previous impairment. If the two impairments are not directly related, John would have to begin a new 24-month waiting period.
3. Jane, who has been disabled since birth, was entitled to Medicare as an IPI on her disabled father's record beginning November 1985, the month she attained age 20. Since Jane's father recovered from his disability, his entitlement to disability benefits ended May 1986. Both Jane and her father were entitled to Medicare at the time of termination. In September 1993, Jane's father again became disabled, and he was reentitled to disability benefits beginning March 1, 1994. Since his prior period of entitlement ended before March 1, 1988 and more than 60 months elapsed between the prior termination and current onset, he must serve a new 24-month waiting period and his Medicare will begin March 1, 1996. Jane, however, can be immediately reentitled to Medicare beginning March 1, 1994, because her previous entitlement ended for non-disability reasons.

These provisions were effective for all those on the disability rolls as of December 1, 1980 and later. Any months of disability entitlement prior to December 1, 1980 were counted toward meeting the 24-month waiting period requirement as long as all months included occurred within the 60 (or 84) month period outlined above. Therefore, cases involving annuitants who were on the rolls as of December 1, 1980 but not yet entitled to Medicare would become entitled to Medicare earlier than the date that was in the record for processing their attainments. Because there was no mechanical means of identifying these individuals, they were enrolled as they were discovered. Individuals not enrolled timely were eligible for equitable relief.

Handling of These Cases

Disability Examiner Action—

Send Form G-405 to MS to enroll the individual. Disabled beneficiaries especially are likely to need Medicare to help them financially handle their medical expenses. When possible, send Form G-405 to MS to enroll the individual for Medicare while waiting for field development or other actions. Normally, enrollment by MS requires less than 5 work days. MS will establish the Medicare record and if necessary, apply equitable relief. Refer to DCM 6.4.4 for additional information.

If the Medicare effective date is not provided in item 9 of Form G-405, enter it in Summary/Comments section of the form. In addition, always show the basis for establishing the Medicare effective date. For example, show:

- Current onset date is within 60 months of prior period of disability entitlement. 24-month waiting period requirement already met.
- Current onset date is within 84 months of prior period of disability entitlement. 18 months of 24-month waiting period requirement already met.
- Current disabling condition is same as condition during previous period of disability entitlement. 24-month waiting period requirement already met.

MS Action

If the Part A and Part B entitlement date is in the past, or 4 or less months in the future, prepare a MEDCOR activity code 12L if the individual has never been enrolled for Medicare before. If the individual was enrolled for Medicare before and there is still a MOLI record, prepare a MEDCOR activity code 22. If the individual was previously enrolled but the record has been dropped, prepare a MEDCOR code 22. Follow current instructions for preparing the MEDCOR activity except for the following changes.:

- Ann Beg Date - always blank

- Dis Freeze Date - always blank

If the Part A and Part B entitlement date is 5 or more months in the future, set a call-up date to take the action prescribed above. See RCM 3.4.2.

3.2.23 Crediting Of Supplemental Security Income Entitlement Months Towards Disability And Medicare Waiting Periods

Under the Railroad Retirement Act (RR Act), a disabled widow(er)'s annuity or a disabled surviving divorced spouses annuity cannot begin until 5 full months have elapsed from the onset date of disability, and Medicare eligibility cannot begin until after 24 months of annuity entitlement have elapsed.

The Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, provides that prior entitlement months to Supplemental Security Income (SSI) under Title XVI of the Social Security Act or federally administered State Supplementary Payments (SSP) can be used to satisfy the 5-month waiting period for annuity entitlement and the 24-month qualifying period for Medicare for disabled widow(er)'s and disabled surviving divorced spouses.

Our General Counsel has ruled that this provision applies to widow(er)s and surviving divorced spouses filing for an annuity under the RRA.

The same months of SSI/SSP which are credited toward the 5-month waiting period for widow(er)'s disability benefits may also be credited toward the 24-month qualifying period for Medicare.

Medicare coverage can begin the later of:

- * the 25th month of entitlement to Railroad Retirement benefits while under a disability.
- * the 30th month after the disability began.

However, the earliest possible original beginning date or Medicare entitlement date for a widow(er) based on this provision is January 1, 1991.

EXAMPLE: A widow files a disability application in January 1991. Her disability onset is established as June 1, 1989, based on medical/vocational criteria. She received SSI/SSP from June 1989 through December 1990 (19 months). Considering her entitlement to SSI/SSP, her original beginning date would be January 1, 1991, since the 5-month waiting period based on the SSI/SSP entitlement ended before January 1, 1991. Her Medicare effective Date would be June 1, 1991, which is the regular Medicare effective date of January 1, 1993 (the 25th month of annuity entitlement), minus the 19 months of SSI/SSP.

3.2.30 Supplementary Medicare Insurance – Part B

Part B is voluntary insurance, provided under Title XVIII of the SS Act. Part B pays a substantial part of enrollees' expenses for physicians' services, home health services, hospital outpatient services and medical and other health services not covered by Medicare's Part A.

Anyone who meets the eligibility requirements becomes entitled to Part B if he or she enrolls during a specified enrollment period. It is possible to be entitled to Part B without being entitled to monthly benefits or Part A (for SS beneficiaries only), but only for those aged 65 or over. Under the automatic provision, an individual is deemed to have enrolled in Part B upon becoming entitled to Part A.

Part B is financed through premiums paid by enrollees and money appropriated from general revenues. The general revenue contribution is about 3 times greater than the amount of premiums paid by enrollees. Premiums are deducted from RR annuities, RSDI benefits or Civil Service annuities, whenever possible. Otherwise, they are paid by direct remittance by or for the enrollee.

3.2.31 Definition Of Terms

Because of the distinctive meanings attached to the words below in the part of the SS Act relating to Part B, they are defined here as they are used throughout this chapter.

- **ELIGIBLE** - "Eligible" and its derivatives refer to the requirements the person must meet to be able to enroll during an appropriate enrollment period and thus qualify for Part B.

This word is also used in referring to individuals enrolled by a State to indicate that they meet the State's requirements for buy-in under Medicaid. It will be clear from the context when this meaning is intended.

- **ENROLL** - "Enroll" and its derivatives refer to the process by which an eligible individual establishes entitlement to Part B. There are three different enrollment processes.
- **ENTITLED** - "Entitled" describes an eligible person who has enrolled and is covered under Part B as of a legally-specified month, depending on when the enrollment occurred. Part B benefits are payable for covered services received while entitled.
- **ENROLLMENT PERIOD** - "Enrollment period" refers to the time established by law during which a valid request for enrollment may be filed.

3.2.32 Kinds Of Enrollment Periods

There are two types of enrollment periods for all enrollees: the initial enrollment period (IEP) and the general enrollment period (GEP). There is also a special enrollment period (SEP) for aged and disabled beneficiaries who are covered under group health plans based on employment.

3.2.35 Eligibility For Part B

- A. Requirements for Eligibility - The eligibility requirements for Part B are separate and distinct from the requirements for Part A. Unless excluded from eligibility by 1 of the factors listed in 3.2.36, an individual is eligible to enroll for Part B if he meets either of the following requirements:
1. Entitlement to Part A - Entitled to premium-free Part A based on age, disability or ESRD, he or she is eligible for Part B.
 2. Alternate Requirement - Not entitled to Part A, but he or she has attained age 65 and is a resident of the U.S. (including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, or American Samoa); and is either:
 - a U.S. citizen, or
 - an alien lawfully admitted for permanent residence who has resided in the U.S. continuously for the 5-year period immediately preceding the month in which he or she effectively files for enrollment, i.e., the month when the alien will be entitled to Part B based on the enrollment request.

The 5 years' continuous residence may begin prior to the date that the lawful admission for permanent residence is granted e.g., where the original admission was illegal, or under color of law.

- B. First Month of Eligibility for Part B - An individual's first month of eligibility for Part B is the month in which he or she meets the requirements in A above. Where eligibility is based solely on entitlement to premium-free Part A, the first month for which the individual is eligible for premium-free Part A is the first month of eligibility for Part B.

The month of first eligibility for Part B is the fourth month of the IEP. The first month of eligibility is not necessarily the first month of entitlement. The filing date controls the entitlement date.

- C. Additional Considerations

1. Prescribed Enrollment Period - A person may enroll only during a prescribed enrollment period.

2. No Limit on Number of Enrollments - Effective 4-1-81, there is no limit on the number of times an individual may enroll and disenroll as long as the individual continues to meet the eligibility requirements for enrollment.
3. Earliest Entitlement - For the earliest possible entitlement (coverage), an individual should enroll during the first 3 months of their IEP, i.e., during the 3 months before the first month of eligibility, as defined in B above.
4. Prior Enrollment - Eligibility need not be developed for a person previously enrolled who seeks to reenroll. unless, there is a basis for believing that the person is no longer eligible, e.g., he/she is a non-beneficiary who has recently lived outside the U.S.
5. Premium Indebtedness - A person may reenroll even though he/she owes premiums for prior Part B coverage.
6. Monthly Benefits Are Suspended - Do not confuse non-coverage situations with non-entitlement situations. For example, incarcerated felons whose monthly benefits are suspended retain entitlement to monthly benefits and Part A, as well as eligibility for Part B. However, health care services received while incarcerated may not be covered under Medicare due to the governmental entity exclusion.

3.2.36 Limitations On Eligibility

No person can enroll for Part B if he or she:

1. Has been convicted of a crime against the U.S. referred to in section 202(u) of the Act, (such as espionage, sabotage, treason or sedition); or
2. Loses entitlement to Part A for any reason, and cannot qualify for Part B according to the requirements in 3.2.35.

Prior to the 1972 Amendments, the SS Act provided that an individual could not enroll for Part B for the first time unless he did so in his IEP or in a GEP that began no later than 3 years after the close of his IEP. An individual whose Part B coverage was previously terminated could reenroll only if he did so in a GEP that began no later than 3 years after the last day of his previous coverage. If a person who was denied Part B coverage in accordance with this regulation enrolls for Part B in a subsequent GEP, his coverage cannot be made retroactive by virtue of the 1972 Amendments.

In addition, prior to 4-1-81, any individual who had been enrolled twice and terminated twice could not enroll again for Part B, except if an individual was covered under a State buy-in agreement. This individual could terminate his Part B coverage after the State buy-in coverage terminated and reenroll in a GEP regardless of the number of prior enrollments in Part B.

3.2.37 References

Sections 1836 and 1837 of the SS Act and SSA's Regulations 42 CFR 407.1 - 407.32 are references for the above procedure.

3.2.40 Rules On Enrollment Periods

A. The First Enrollment Period For the Aged

1. Filing and Effective Dates - For persons who attained age 65 before 3-1-66, the enrollment period began 9-1-65 and ended 5-31-66. Their Part B coverage was effective 7-1-66.
2. "Good Cause" Provision - Those individuals who were age 65 and otherwise eligible to enroll before 3-1-66, but who did not file for Part B before 5-31-66, were eligible to file between 6-1-66 and 9-30-66, if they could show "good cause" for their failure to file during the IEP. The effective date for Part B coverage under this provisions was 6 months after the application was filed.

B. Specific Times for Enrollment - The law provides specific times for an individual to enroll or to be deemed enrolled in Part B.

The IEP is explained in 3.2.41. If the individual does not enroll in the IEP, or if the Part B is terminated, he/she can only enroll in a GEP, see 3.2.42. However, individuals with employer group health plan coverage may be eligible for a SEP, if they meet the requirements of 3.2.113, 3.2.114 and 3.2.115.

If coverage under a State buy-in agreement terminates, Part B coverage period continues on an individual basis as though the individual had enrolled in the IEP, i.e., with no penalty.

C. Filing Occurs Outside Enrollment Period - Unless automatic enrollment applies (see 3.2.50), an enrollment request filed outside an applicable enrollment period is not valid and must be denied.

If an individual files an enrollment request shortly before an enrollment period and the request has not been denied by the beginning of the enrollment period, ask the individual to file again as soon as the enrollment period begins. The premature request need not be formally denied if he/she files in the enrollment period.

If an individual's request for enrollment will be denied because it is not filed in an IEP or GEP, advise the individual that he/she may enroll during a subsequent GEP. See 3.2.105 where there is failure to advise the individual to file a valid enrollment request during a prescribed enrollment period.

- D. Part B Rights For Those with Part A Who Develop ESRD.--A beneficiary on Medicare when he/she contracts ESRD has a second IEP, beginning three months before and three months after the first month of R-HI eligibility.

3.2.41 Initial Enrollment Period (IEP)

- A. First Opportunity To Enroll -The IEP is the first opportunity an individual has to enroll in Part B. The IEP is based on the month of eligibility for Part A for those who are eligible for Part B based only on Part A entitlement.
- B. Seven-Month Period - For those persons who attain age 65 on or after 3-1-66 and disabled individuals, the IEP is a 7-month period. The IEP begins on the first day of the third month before the first month of eligibility and ends on the last day of the third month following the first month of eligibility. If the last day of the IEP falls on a non-work day for Federal employees, by the statute or Executive Order, the enrollment period will be extended through the first regular work day after the end of the period.

EXAMPLE: An individual's first month of eligibility is 7-92. The IEP begins 4-1-92 and ends 10-31-92.

- C. When Part B Will Begin - For an individual who first meets the eligibility requirements for Part A on or after 3-1-66 and the disabled and enrolls in the IEP, the Part B effective date is related to the month of enrollment, as follows:
- If a person enrolls during first three months of IEP (in the 3 months prior to the first month of eligibility for Part B), Part B effective date is the first day of the month of eligibility.
 - If a person enrolls during fourth month of IEP (month of eligibility), Part B effective date is first day of the month after the month of eligibility.
 - If a person enrolls in fifth month of IEP (month after the month of eligibility), Part B effective date is the first day of the second month after he files. Thus, if a person first meets the requirements in June and enrolls in July, Part B begins the first day of September.
 - If a person enrolls in sixth or seventh month of IEP (2nd or 3rd month after the month of eligibility), Part B effective date is the first day of the third month after he files. Thus, if a person first meets the requirements in June and enrolls in August, Part B begins the first day of November. If enrollment is in September, Part B begins the first day of December.

This chart illustrates the situations described above:

Month Application Filed	Month Age 65											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
October	Jan											
November	Jan	Feb										
December	Jan	Feb	Mar									
January	Feb	Feb	Mar	Apr								
February	Apr	Mar	Mar	Apr	May							
March	Jun	May	Apr	Apr	May	Jun						
April	Jul	Jul	Jun	May	May	Jun	Jul					
May		Aug	Aug	Jul	Jun	Jun	Jul	Aug				
June			Sep	Sep	Aug	Jul	Jul	Aug	Sep			
July				Oct	Oct	Sep	Aug	Aug	Sep	Oct		
August					Nov	Nov	Oct	Sep	Sep	Oct	Nov	
September						Dec	Dec	Nov	Oct	Oct	Nov	Dec
October							Jan	Jan	Dec	Nov	Nov	Dec
November								Feb	Feb	Jan	Dec	Dec
December									Mar	Mar	Feb	Jan
January										Apr	Apr	Mar
February											May	May
March												Jun

- D. More than one IEP - An individual under age 65 may have more than 1 IEP if he/she establishes entitlement to Part A based on disability or ESRD more than once.

EXAMPLE: When a disabled person's disability entitlement is terminated, Part A and Part B are also terminated. Part A is reestablished based on a second period of disability entitlement, or based on ESRD. The beneficiary has a new IEP beginning three months before the new date of entitlement to Part A.

No matter how often, or under what circumstances, entitlement occurred prior to age 65, every eligible beneficiary has a new IEP at age 65. An individual age 65 or over has only 1 IEP, except where the aged individual develops ESRD after age 65 and may have a second IEP based on ESRD.

No months prior to a new IEP are countable for premium surcharge purposes. If the beneficiary had paid a surcharge during the earlier period of Part B entitlement, that has no effect on the premiums due for the new enrollment. If the beneficiary is paying a penalty rate, the premium rate is reduced to the basic rate when he/she attains age 65.

3.2.42 General Enrollment Period (GEP)

- A. Definition of GEP - The first GEP began 10-1-67 and ended 4-1-68, with Part B effective 7-1-68.

Beginning in 1969, for enrollments in a GEP prior to 4-1-81 and after 9-30-81, a GEP is the first calendar quarter of each year (January through March).

For enrollments in a GEP during the period 4-1-81 through 9-30-81, a person could enroll for Part B after his IEP at any time during the year.

- B. GEP Enrollment - A person who fails to enroll during his IEP, or refuses automatic enrollment, may enroll only during the GEP. The person whose Part B has ended because of non-payment of premiums or voluntary withdrawal from Part B, may reenroll only during the GEP.

However, for a person who becomes eligible for Part B and does not lose that eligibility, the only time enrollment after the IEP need not occur in a GEP is where the individual meets the requirements for a SEP, as described in 3.2.113, 3.2.114 and 3.2.115.

Consult 3.7 to compute the applicable Part B premium rate in effect at the time of enrollment.

- C. Extension of GEP - When the GEP ends on a day which is a non-workday, e.g., Saturday, Sunday, legal holiday, etc., an eligible individual may enroll on the first regular workday after the end of the GEP.
- D. When Part B Will Begin - Part B entitlement based on a GEP enrollment always begins July 1 of the year during which the GEP enrollment takes place, unless the enrollment was during 4-1-81 through 9-30-81. Then, the Part B was effective the first day of the third month after enrollment (i.e., an individual who enrolled on 9-23-83 had Part B coverage beginning 12-1-81).
- E. Inquiry Late in GEP - Individuals who inquire by telephone about enrollment shortly before a GEP expires should be told to make their request for Part B enrollment on a letter or postcard and immediately mail it to RRB, if they are unable to visit the FO before the end of the GEP.
- F. GEP Enrollment Handling by MS Examiners – MS examiners will normally process a GEP enrollment using a MEDCOR 11-27 activity if this is the applicant's first enrollment into Medicare Part B.

If the GEP enrollment occurs after the following scenarios, do not use a MEDCOR 11-27 activity to process the enrollment:

- If the beneficiary was previously offered an option for Medicare Part B.

- If this is the beneficiary's second enrollment and a penalty rate was applied to the first enrollment.
- If this is the beneficiary's third or subsequent enrollment in Medicare Part B.

For the instances listed above, the enrollment will need to be processed with a MEDCOR 32 long activity (clear jurisdiction and cross-reference from SSA at CMS). Examiners can use information found on the imaging system, PAR, MOLI, and BERT to verify previous periods of Part B entitlement.

3.2.43 Relationship Between Initial And General Enrollment Periods

An individual's IEP may overlap a GEP in whole or in part. In such a case, the following considerations apply.

- A. GEP Ends With or Before End of IEP - When the GEP ends with or before the end of an individual's IEP, the GEP has no effect on either the individual's enrollment or date of coverage. That is, the enrollment is based on the IEP.
- B. IEP Ends Prior to End of GEP - If the IEP extends into, but ends prior to, the end of the GEP, the individual has the benefit of the additional time remaining in the current GEP in which to enroll, with a July 1 effective date for Part B.

Months elapsing between the end of the IEP and the end of the GEP may count against the individual for premium penalty purposes if the period of Part B coverage terminates and the individual subsequently re-enrolls.

EXAMPLE: Mrs. Benton was born 11-4-22. Her IEP is 8-1-87 through 2-29-88. If she enrolls in Part B during 1-88 or 2-88, it is considered an IEP enrollment. If she enrolls during 3-88, it is a GEP enrollment and coverage begins with 7-1-88.

3.2.44 Reference

The following references were used for the above procedure: Section 1837 of the SS Act, SS Amendments of 1965 - Section 103(b), P.L. 89-732, P.L. 90-97, P.L. 90-248, P.L. 92-603 and P.L. 96-499.

3.2.50 Nature And Purpose Of Automatic Enrollment

Under the provisions of Title XVIII as originally enacted, an individual eligible for Part B had to take the positive action of filing a written request for enrollment. While most individuals did enroll, some persons who wanted Part B failed to enroll at their first opportunity because of senility, misunderstanding, or other reasons. Since the enrollment provisions are so strict, many incurred medical expenses before they had the opportunity to enroll again.

To avoid loss of coverage, the law as amended effective 7-1-73, to provide that eligible persons are "automatically" enrolled for Part B when they first became entitled to Part A. As part of the notice of automatic enrollment, individuals are informed of their right to decline Part B and given a reasonable period to notify RRB that they do not want Part B. By giving timely notice, they will not be deemed to have enrolled, and will not incur any premium liability.

A person who first becomes entitled to Part A after 6-73, is deemed to have enrolled or is "automatically" enrolled for Part B in accordance with the following rules. Automatic enrollment does not occur if the individual files with RRB a timely refusal of Part B.

- A. During First 3 Months of IEP - An individual is deemed enrolled for Part B in the first 3 months of the IEP if he/she either:
- qualifies for Part A without an application by attaining age 65 while on the benefit rolls; or
 - qualifies for Part A without an application by being rated disabled under the SS Act and entitled to monthly benefits for the prescribed period of time.
 - files during or before the first 3 months of the IEP, an application with RRB or SSA which establishes entitlement to Part A.

The individual becomes entitled to Part B beginning with the first month in which he or she is entitled to Part A.

EXAMPLE: Mr. Bennett established entitlement to disability beginning 7-89 and is entitled to Part A based on disability beginning 7-91, his 25th month of disability entitlement. He is deemed enrolled in disability Part B during the first 3 months of his IEP which began 4-1-91, and will be entitled to disability Part B beginning 7-91, the first month of disability Part A entitlement.

- B. After First 3 Months of IEP - If a person files the application establishing entitlement to Part A in the last 4 months of the IEP or during a GEP, he or she is deemed to have enrolled for Part B at the time the Part A application is filed.

EXAMPLE: Mary Hanover did not file for monthly benefits and Medicare when she attained age 65 in 9-90. In 11-91, she filed and was awarded monthly benefits and Part A. She did not refuse Part B. Because filing occurred after her IEP, but not during a GEP, she is deemed to have enrolled in Part B during the next GEP (1-92 - 3-92) with coverage beginning 7-1-92.

3.2.51 When Deemed Enrollment Does Not Apply

- A. Persons Living Outside the U.S - The law excludes from automatic enrollment persons who reside in PR or outside the U.S.

A high proportion of eligible individuals in PR receive medical care without payment on the basis of actual or presumed need. For them, as for persons living outside the U.S., automatic enrollment generally would not be advantageous.

Such individuals are told about Part B and advised that, if they wish to have such protection, they must file an enrollment request.

- B. Persons Who Are Not Entitled To Part A - Automatic enrollment applies only to individuals eligible to enroll by reason of entitlement to Part A. Beneficiaries not receiving an annuity who want Part B must file a request during an enrollment period open to them.

If a person files an application for Part A (or for an annuity and Part A), which is disallowed, he or she does not qualify for automatic enrollment. Therefore, that individual must file an enrollment request during an enrollment period.

Because of the possibility of disallowance, an individual who is age 64 or older should be asked whether or not he or she wants Part B when filing for monthly benefits. If the disallowed individual elects "no," he or she will not be enrolled for Part B under any circumstances. If he or she elects "yes," the individual will be enrolled if eligible for Part B and the application was filed during a prescribed enrollment period.

- C. Refusal of Part B Before IEP - A "no" election filed by an individual who is awarded monthly benefits precludes automatic enrollment if the benefit award notice is mailed no earlier than 3 months before IEP begins.
- D. New Opportunity At Age 65 - An individual attaining age 65 who refused deemed enrollment when eligible for Medicare based on disability or allowed Part B entitlement and it terminated, is deemed to have enrolled in the 3 months prior to attainment of age 65.

3.2.52 Notice Of Right To Refuse Deemed Enrollment

Notices of deemed enrollment in Part B are sent to persons on the benefit rolls prior to the beginning of their IEP. Generally, the G-41 and package are sent 6 months before the month of eligibility for aged cases and 5 months before the month of eligibility for disabled cases.

3.2.53 Refusal Of Part B

When a beneficiary states that he or she wishes to refuse Part B, make all reasonable efforts to assure that the individual understands the nature and effect of refusing or terminating Part B.

Every person who is "deemed" to have requested enrollment is notified that he or she has until a specified date (at least 2 calendar months after the month in which notice of Part B coverage is mailed) to notify RRB in writing that he or she does not wish Part B. If a timely notice to this effect is filed, the person is deemed not to have enrolled, and does not incur any premium liability.

- A. Timely Filed Refusal - Notice of refusal is timely if filed before Part B coverage starts. In those cases where the notice of entitlement is sent less than 2 months before the Part B coverage is supposed to begin or if it is sent after Part B coverage would begin, the notice of refusal is timely filed if it is filed within 2 months after the month the notice of Part B coverage is mailed to the person.
- B. Refusal Not Timely Filed - Any refusal received after the time indicated in A above is treated as a request for voluntary termination of Part B. Part B coverage ends with the last day of the calendar month after the calendar month in which the refusal is filed.

There are some cases in which a notice of Part B coverage may not have been mailed timely or was not received by the enrollee. In such circumstances, the first indication to the enrollee of coverage may be a premium billing notice, a reduced benefit check, or some type of post adjudicative notice.

If a signed refusal of Part B is received or post marked no later than 2 months after the earlier of the following, it is acceptable as a timely-filed refusal of Part B:

- the month in which the beneficiary states the notice was received; or
- the month in which the beneficiary received the first premium billing, reduced check, etc.

If filed later, the refusal of Part B is treated as a voluntary request for termination.

EXAMPLE: Mr. Roy filed for an annuity in 4-91, shortly before his 64th birthday. However, in developing proof of age, it was found in 9-91, that Mr. Roy was born in 5-26, rather than 5-27 as he had alleged. Since he did not say "no" to the Part B enrollment question on his application, he was notified in 9-91 that he was entitled to have Part A and Part B effective 5-91, subject to his right to refuse Part B by filing an appropriate notice no later than 11-30-91. If such notice is received by that date, Mr. Roy will be deemed not to have enrolled. If the notice is received after 11-30-91, it will be treated as a request for voluntary termination, effective with the end of the calendar month after the month in which it was filed.

- C. Refusal Rescinded During IEP - If an individual refuses automatic enrollment but, during the balance of the IEP, changes his or her mind and files a Part B enrollment request, the request is a valid IEP enrollment, despite the prior refusal. Coverage begins as noted in 3.2.41, depending on which month the enrollment request is filed.

- D. Current Application is Pending - Applications include enrollment information and an explanation that an eligible individual who establishes entitlement to monthly benefits and/or Part A is deemed to have enrolled in Part B unless he or she answers "no" to the enrollment question.

In some cases, an individual not yet eligible to enroll in Part B may become eligible before all issues are fully developed and resolved. Thus, there will be cases in which an individual's first notice of Part B entitlement is received long after the first month of Part B coverage. Any such person has at least 2 months in which to file a refusal of Part B without incurring liability.

Any individual who has not affirmatively stated that he or she wants Part B is sent a notice. The notice is not essential if the individual has requested Part B coverage.

- E. Refusal by Incompetent Person - Neither the IEP nor a GEP can be extended for an individual because he or she is mentally incompetent during all or part of the period.

However, where a Part A beneficiary enrolled for Part A and refused enrollment

- could otherwise have been automatically enrolled in Part B, and
- is shown to have been mentally incompetent at the time of the refusal, he or she may be deemed not to have refused Part B. This is true even if the beneficiary currently has Part B based on an enrollment filed after the refusal.

An individual will be considered incompetent for purposes of this subsection on the basis of the following documents:

- signed statement from a physician indicating that the individual was incapable of managing his or her own affairs at the time the refusal was filed, or
- certified copy of a court order showing that, at the time the refusal was filed, the individual had been adjudged legally incompetent.

If the potential enrollee is the party making the request, evidence must show that the individual is now competent.

To set aside a refusal, the beneficiary's responsible representative (or the beneficiary, if now competent) must submit proof

- within 12 months of the first month of potential entitlement or,
- if later, within 12 months of the month of the refusal, that the beneficiary was mentally incompetent at the time the refusal was filed.

All premiums owed for the retroactive period must be paid or RRB authorized to withhold them from monthly benefits payable.

Begin Part B entitlement with the month coverage would have begun had the individual never filed the refusal.

EXAMPLE: Della K. Tessen, DOB 6-15-25, had been entitled to an annuity since she was age 63. In response to a notice of automatic enrollment, she refused Part B in 5-90. Although she subsequently enrolled in 8-90, the 6th month of her IEP, and was awarded Part B coverage as of 11-90, her sister contacted the FO in 12-90 to advise that Della was mentally incompetent and had been at the time she had refused Part B in 5-90.

If evidence shows that Ms. Tessen was mentally incompetent at the time she refused Part B and if premium withholding from her monthly benefit check for the retroactive premiums due is authorized, her Part B entitlement date may be adjusted to 6-90. Even if Della had not enrolled later during her IEP, she could nevertheless be awarded Part B as of 6-90.

3.2.54 References

Sections 1837 and 1838 of the SS Act and the 1972 Amendments, Section 206 are references for the above procedure.

3.2.60 Voluntary Request For Enrollment

- A. Who Must Enroll - While most persons are deemed to have enrolled for Part B, many individuals are excepted from automatic enrollment and must enroll.

To be entitled, or reentitled to Part B, individuals or their representatives must file either a properly executed enrollment form or any signed statement that unequivocally shows intent to enroll.

The form or statement requesting Part B can only be filed with RRB or SSA during a prescribed enrollment period.

The date of receipt (or mailing, if material) of an equivocal signed statement or improperly executed enrollment form may serve as the enrollment date. However, it must be followed by an unequivocal request for enrollment within 60 days of the date the individual is notified of the need to submit such a request.

- B. Enrollment Form Completed Improperly - Any form which is unclear as to whether the person wishes to enroll is an improperly completed enrollment form.

Any office receiving an improperly completed enrollment form should notify the potential enrollee that, to enroll, he or she must file, within 60 days of the date of the notice, a written statement clearly expressing this intention and bearing his or

her signature or properly witnessed mark (or that of a responsible representative). This may be done on an enrollment form (enclosed with the notice) or on a supplemental statement. If the individual fails to respond within 60 days, the incorrectly completed form is not effective.

Among the improperly completed enrollment forms which may establish the application date are those in which the individual:

- Signed but failed to answer "yes" or "no."
- Answered "yes" but failed to sign.
- Signed with an unwitnessed mark, with or without answering "yes" or "no."

If a person writes on an enrollment form "I am already enrolled" or a similar phrase, check for dual deductions. If the person is not enrolled, have the FO contact the person to clarify if he or she wants Part B coverage.

If the person writes "I am a welfare recipient" or any statement constituting an allegation of State buy-in coverage, the office receiving the qualified or restricted enrollment application should initiate action to resolve the issue.

Enrollment forms returned by mail which have been checked "no" but are unsigned are treated and acknowledged as declinations. No further development is required merely to obtain a signature.

3.2.61 Enrollment Form Not In File

The fact that an enrollment request cannot be located in RRB or SSA's files does not necessarily mean that one was not filed. An individual may insist that the enrollment request was mailed timely even though RRB or SSA has no record of the request. Generally, the sooner the individual inquires about disposition of the enrollment request after the alleged filing, the more weight can be given to the person's allegation.

Thus, despite the absence of an enrollment request in RRB or SSA's records, a finding that the individual is effectively enrolled may be made where supported by adequate evidence. If SSA is involved, contact SSA first to see if they have any information in their file. If not, secure from the individual a signed statement which documents as fully as possible the circumstances surrounding the filing of the enrollment request (i.e., when, how, and where filed, etc.), along with any corroborating evidence available.

EXAMPLES:

- Enrollment Was Probably Filed - It would be appropriate to find that an enrollment was filed as alleged where an individual:
 - says he or she enrolled during a prescribed period and furnishes specific information as to the time and manner of filing;

- has followed up with RRB or SSA promptly to question why the enrollment has not been processed (i.e., no later than 3 months after premiums should have been deducted from monthly benefits or premium billing notices sent); and
- submits corroboration, if available, of filing at the time alleged (e.g., a statement from another person who of his or her own knowledge can give information as to the time and manner of filing).

There must be no basis in file for doubting the credibility of the allegation.

- Enrollment Probably Not Filed - A finding of enrollment would usually not be appropriate where:
- RRB or SSA's records show that the individual refused Part B at, or shortly after, the time he or she allegedly mailed the enrollment request, or
- the individual first inquires about his or her enrollment status 4 or more months after coverage would have started, or after incurring substantial medical expenses.

A decision on this matter is strictly judgmental. No decision made by RRB personnel on enrollment or non-enrollment under the circumstances given in this section should be challenged, unless there is evidence that the judgement is incorrect.

3.2.62 Who May Execute A Valid Request For Part B Enrollment

An individual who is competent and physically able to transact business must file his or her own request for enrollment. The enrollment request must be filed during a prescribed enrollment period.

An individual who is incompetent, or is competent but physically unable to apply for enrollment, may be enrolled by the legal guardian or representative payee, if he or she has one. If there is no representative payee (e.g., the individual is a nonbeneficiary), the person providing care and/or support may enroll the individual. If such person is unwilling or uninterested, some other relative or friend willing to assume responsibility for premium payments may file an enrollment request on behalf of the individual.

The Part B premium notices are sent to the person who filed on behalf of the incompetent individual as long as he or she has such individual in care or assumes responsibility for premium payment. When he or she no longer has the Part B enrollee in his or her care, the notices will be sent directly to the enrollee, unless another person applies to receive them.

3.2.63 Prescribed Enrollment Forms

Most people are eligible for automatic enrollment. For those who are not eligible for automatic enrollment or wish to reenroll after a termination of Part B, the following forms are used:

- AA-6, AA-7 or AA-8 - Application for Medicare Enrollment for employee, spouse/divorced spouse and widow/widower - Application form used by individuals who are not eligible for monthly benefits. See 3.2.162.
- G-44 - Application for Medical Insurance - Mechanically produced during the GEP solicitation.
- G-44b - Application for Supplementary Medicare Insurance - used
 - to enroll individuals (not subject to automatic enrollment) who applied for monthly benefits and/or Part A but did not indicate on the application whether they wished to enroll in Part B;
 - to enroll during the GEP;
 - to enroll during the IEP if Part B was refused earlier in that IEP; or
 - to enroll during a SEP if only Part B is being requested.
- G-44f - Application for Supplementary Medical Insurance for People Outside the U.S. - Form used by persons living outside the U.S.

Enrollment Item on Other Applications:

An individual may enroll for Part B by answering "yes" to the enrollment item appearing on an application for monthly benefits, AA-1, AA-3 or AA-17.

RBD or SBD is responsible for assuring that a Medicare record is established when the above applications are filed.

3.2.64 Withdrawal Of Enrollment Before It Goes Into Effect

An individual, or proper party on his or her behalf, can withdraw the enrollment application by requesting withdrawal any time before Part B coverage is effective. They should be processed as a refusal of Part B coverage.

To serve as a withdrawal or termination, there must be an appropriately signed and unequivocal statement that the individual no longer wishes Part B coverage, or that he or she wishes to withdraw or cancel the enrollment request, etc.

An individual may withdraw an enrollment request any time before Part B coverage becomes effective. A withdrawal of the enrollment request is also honored if filed after

the effective month of Part B coverage but within 2 months after the month the enrollment request was filed.

An individual who enrolls during a GEP may withdraw the enrollment request at any time up to the following July, when Part B becomes effective.

When withdrawal of an enrollment request is not filed in time to prevent enrollment, it serves as a request for voluntary termination of Part B coverage, effective (as of July 1987) with the end of the month after the month in which the request is filed.

EXAMPLE: Millie enrolls in 7-92, the third month of his or her IEP, She may file an effective withdrawal at any time prior to 10-92 (2 months later). On the other hand, if the withdrawal request is not filed until 10-92, it is treated as a voluntary termination. This means that the Part B coverage (which begins 8-1-92) is terminated 11-30-92, (the end of the month following the month the withdrawal request was filed).

Whenever an individual indicates that he or she wants to withdraw or terminate Part B enrollment, you should ensure that he or she realizes the effect of such action.

If an enrollment form is received which is merely answered "no" and signed by a person who has enrolled for Part B, it should not be treated as a withdrawal or termination of Part B enrollment without further development. The individual should be promptly contacted for an unequivocal signed statement clarifying his or her intent. If a withdrawal or termination was intended, it can be considered filed as of the date of receipt of the "no" option form only if the unequivocal statement is submitted within 60 days of such receipt.

3.2.65 References

Section 1837 of the SS Act and SSA's Regulations 42 CFR 407.10ff are references for the above procedure.

3.2.70 Effect Of Reentitlement To Part A After Termination

- A. New IEP if Reentitled to Disability Part A - During each separate period of Part A entitlement, Part B enrollment rights and premium rates are determined independently of enrollments during any previous periods of Part A entitlement. Where a person's disability Part A terminates and he or she later becomes reentitled to disability Part A, for purposes of Part B enrollment and premium amounts, he or she is deemed to have never had previous eligibility.

This means the individual has a new IEP, beginning 3 months before the first month of the new period of Part A entitlement. Note that disability beneficiaries do not always have a 24-month waiting period if they become reentitled to disability benefits.

- B. New IEP for Age 65 Part A - Even if previously entitled to Part A as a disability beneficiary or ESRD patient, a person who becomes entitled to Part A under the regular or deemed insured provisions at age 65, has a new IEP. Part B enrollment rights (and premium amounts) are not affected by any events which occurred during previous periods of Part A entitlement.

If a person previously refused Part B, he or she has a new IEP based on the new period of Part A eligibility and may enroll for Part B.

If an increased premium was payable for late enrollment prior to age 65, the premium is reduced to the standard rate for the month of attainment of age 65 and following months of continuous coverage.

These provisions assure that all persons upon becoming entitled to Part A (at age 65 or otherwise) will be treated identically. Those who had one or more earlier periods of Part A entitlement are not penalized for events which took place during such earlier periods.

EXAMPLE: Mrs. Dibb, born in 9-30, established entitlement to Part A based on disability beginning 5-84 but refused Part B enrollment at the time.

Upon attaining age 65 in 9-95, she becomes eligible for Part A under the regular insured provision. Part B and Part A based on entitlement to disability benefits technically terminates with the month before the month of attainment of age 65.

Mrs. Dibb has a new IEP based on her new period of Part A eligibility and will be automatically enrolled for Part B as of 9-95.

If Mrs. Dibb had enrolled for Part B in a GEP and was paying in increased premium for late enrollment in the month prior to attaining age 65, her premium rate is reduced to the standard (unincreased) rate beginning at age 65.

These provisions ensure that all persons upon becoming entitled to Medicare at age 65 will be treated identically.

3.2.71 Part B Enrollment Of Reentitled Disability Beneficiaries

Section 103 of P.L. 96-265 modified section 226 of the Social Security Act effective 12-1-80, to provide that the 24 months in the disability Part A qualifying period no longer need to be consecutive.

- A. 24 Months in Prior Period of Entitlement - An individual may establish immediate entitlement to both Part A and Part B if he or she:
- becomes reentitled to disability benefits within the time limits specified 3.2.22, and

- received disability benefits for at least 24 months during the earlier period of entitlement.
- B. Less Than 24 Months in Prior Entitlement - An individual who becomes reentitled within the time limits specified in 3.2.17 (with less than 24 months prior disability benefit entitlement) may have such prior months counted toward the 24-month qualifying period during a subsequent period of entitlement to disability benefits.
- C. Retroactive Part B Award - Medicare eligibility in reentitlement cases may begin before the month the award notice is sent to the individual. If limited to a choice of paying for retroactive coverage they did not know they had, or refusing Part B altogether, many individuals may refuse Part B.

Automatic enrollment should apply when an individual files an application for disability benefit reentitlement, and is eligible without a waiting period (or has a shortened waiting period) for Part A, and is deemed to have enrolled for Part B in the third month of the IEP. Therefore, he or she is awarded coverage beginning with the first month of disability Part A entitlement.

At the time of final processing, if more than 5 months' retroactive premiums must be withheld from the monthly benefit check, the individual is awarded Part B effective with the month in which final action is taken to process the Medicare record, (equitable relief applies).

They are advised of the option to have Part B begin with the first month of disability Part A entitlement provided that, within 30 days, the enrollee requests such earlier date and authorizes the deduction of the accrued premiums from monthly benefits.

The individual is also has the right to refuse Part B. If he or she refuses Part B by the end of the second month following the month the notice is mailed, he or she is deemed not to have enrolled and does not incur any premium liability. Any refusal received later than that is treated as a voluntary termination request.

EXAMPLE: Mr. Davis was previously entitled to disability for the period 6-84 - 12-87 and was entitled to disability Part A and Part B on the basis of 24 months if disability entitlement. He files on 4-12-91 alleging he became disabled on 11-15-90. When the claim is adjudicated in 8-91, Mr. Davis is found eligible for Disability and Part A beginning 12-90.

Because more than 5 months' Part B premiums have accrued, he is awarded Part B effective 8-91. He is advised he may have coverage beginning 12-1990, provided he notifies us in 30 days and authorizes deduction of all retroactive premiums.

If he decides instead to refuse enrollment, and does so by 10-31-91, he will be deemed never to have enrolled. The Part B effective 8-91 will be deleted and any Part B premiums that were withheld will be refunded to him.

Automatic enrollment does not apply for individuals residing in Puerto Rico or outside the U.S. because they are not subject to automatic enrollment. If such individuals desire Part B coverage, they must specifically request enrollment.

Refer to 3.2.17 for further information.

3.2.75 What Constitutes An Effective Enrollment

There are 3 ways for an eligible person to be effectively enrolled in Part B:

- Be deemed to have enrolled under the automatic enrollment provision.
- Personally enroll (or be enrolled by a proper person acting on his or her behalf).
- Be enrolled by a State under a buy-in agreement for the coverage of eligible individuals.

3.2.76 Individual Incapacitated During IEP, GEP, or SEP

No enrollment period can be extended because the individual is mentally incompetent during part or all of the period, or because he or she may have been physically incapacitated.

3.2.77 Enrollee Needs Help In Paying Premiums Or Claiming Reimbursement

A person, though competent and able to enroll for Part B, may need help in the mechanics of paying premiums or in claiming reimbursement for medical expenses. The difficulty may be temporary or indefinite and may come to light during the enrollment process or later.

The arrangements for assisting an individual to overcome the problem, will vary with the nature and duration of the impairment. The procedure described below is intended to guide FO's in procuring the necessary assistance for such enrollees.

The fact that RRB or SSA provides help, does not relieve the enrollee of the responsibility to pay premiums promptly, or to claim reimbursement timely in an acceptable manner.

- A. Locating a Person to Help Enrollee - Ask the enrollee whether there is some relative or friend who might be willing to help him or her mail premiums, or claim reimbursement. Try to have the enrollee nominate a relative or friend who:

- is likely to be reliable,
- lives near the enrollee,
- has the enrollee's confidence,
- is interested in the enrollee's welfare, and
- sees the enrollee frequently.

If there is such a person, have the FO contact him or her. In the meantime, take care to avoid termination of coverage or a loss of reimbursement. It may be necessary, pending the selection of someone to assist the enrollee, for the FO to give the help the enrollee needs.

- B. Representative Payee - If the enrollee is an beneficiary for whom a representative payee has been or should be appointed, explain to the representative payee that he or she is expected to give the necessary assistance.
- C. Interviewing Relative or Friend - The FO should interview the relative or friend as soon as possible after you see the need for someone to assist the enrollee. If another FO is the servicing FO, ask that office to conduct the interview. Be sure to give the servicing FO full particulars about the situation. Wherever possible, select a relative or friend who lives near the enrollee. Explain the situation to the relative or friend. Instruct him or her in detail how to assist the beneficiary in paying premiums and claiming reimbursement.

Stress the importance of prompt payment of premiums (where premiums must be paid by remittance) and give the enrollee's relative or friend a copy of Form RB-23, Your Medicare Handbook.

The FO should tell the friend or relative who agrees to act for the person that, if he or she wishes to withdraw from the arrangement at any time, RRB would like 30 days advance notice. This should allow sufficient time to select another representative to assure that the enrollee will have necessary assistance continuously.

Explain, if appropriate, that any reimbursement checks due the enrollee from the carrier will be sent directly to the enrollee as long as he or she is capable of managing financial affairs. Also, if the enrollee receives monthly checks, ask the relative or friend to notify RRB promptly if the enrollee's condition deteriorates so that he or she might need help in managing benefits.

Stress that, although beneficiaries are encouraged to get help if they need it, this does not relieve the beneficiary of the responsibility for paying premiums promptly, and for claiming reimbursement promptly and properly.

3.2.78 Enrollment Process

- A. Voluntary Enrollment - This section does not give information on special enrollment period (SEP) cases. That material is in 3.2.110

When an individual is not subject to automatic enrollment because he/she is not receiving an annuity or already entitled to Part A, they must file an enrollment request during a prescribed enrollment period. The eligibility must be developed, the Medicare record must be established or disallowed as appropriate.

When the request for enrollment is processed, send the individual a notice indicating whether it has been approved or denied (including a reconsideration paragraph).

- B. Automatic Enrollment

- Attainment Cases - Prior to the first month of Part B eligibility (approximately, the 20th month of consecutive entitlement to disability benefits or at age 64 and 5 months), a beneficiary is mailed a Medicare health insurance card, G-41, showing the effective dates of Part A and Part B entitlement.

Accompanying the G-41, are instructions that, if the individual does not want Part B coverage, he or she should check the appropriate box, sign, and return the G-41 to RRB before the effective date shown on it. Upon receipt of a refusal of Part B, a new Medicare card, G-43, is issued, showing the Part A entitlement date only.

- New Entitlement Cases - Eligible individuals filing applications establishing Part A entitlement can expect to receive their health insurance cards, G-41, approximately 6 weeks after adjudication. The card shows the effective dates of entitlement to Part A and Part B unless the claimant refused Part B; in which case the card shows Part A coverage only. Of course, each person who is automatically enrolled is notified that he or she has until a specified date (at least 2 calendar months after the month in which notice of the Part B coverage is mailed) in which to decline Part B.

3.2.79 Enrolling Beneficiaries Who Reside In Puerto Rico

When beneficiaries are identified from RRB records for automatic enrollment, beneficiaries residing in Puerto Rico are identified and sent an enrollment message. If the beneficiary wishes to enroll, they must notify RRB.

3.2.80 Enrolling Beneficiaries Who Reside In A Foreign Country

Beneficiaries who reside in foreign countries are also identified and if they wish to enroll or obtain additional information, they must contact RRB.

3.2.81 When An Enrollment Is Considered Filed

Enrollments made through the mail are considered filed when deposited in the U.S. mail, if this is advantageous to the enrollee, i.e., when this allows the individual to be enrolled during a certain month but the actual date of receipt would not.

The date of deposit will ordinarily be the postmark date. However, a filing date may be established up to 2 days earlier than the postmark where there is an identifiable delay in handling of mail in the U.S. Postal Service. Verification of such delay from postal authorities is not normally needed.

A filing date earlier than 2 days prior to postmark may be established based on a credible statement from the enrollee which is not contradicted by other evidence (e.g., a date shown on the enrollment request agrees with or precedes the alleged date of deposit).

When enrollments are received through the mails early in the month following the end of the IEP or GEP, retain the envelope containing the postmark until the enrollment is finally processed.

Enrollments mailed to RRB may have a 7-day tolerance applied to them if the date of filing is material, the postmark is illegible or missing (or the envelope is missing or destroyed), and it originated in the continental U.S. (other than Alaska).

That is, if an enrollment is received during the first 7 days of the month following the end of an enrollment period (or month - where the month of enrollment is significant), it will be presumed in the absence of any evidence to the contrary, that the writing was mailed before the end of the enrollment period (or month).

Where the postmark is illegible or missing, and the writing originated in Alaska, Hawaii, Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, the mailing date is determined on a case-by-case basis.

Despite the above provisions, if the writing from the enrollee is itself dated after the end of the enrollment period (or month, where the month of enrollment is significant), the writing would not be considered filed in the enrollment period (or month). This is because it appears that the individual did not attempt to enroll during such enrollment period (or month).

3.2.82 Extending The Enrollment Period

Sometimes the last day of an IEP or a GEP falls on a Saturday, Sunday, legal holiday, or any other day all or part of which is declared to be non-workday for Federal employees by statute or Executive Order. In such a case, an eligible individual may enroll in the first regular workday after the end of the enrollment period.

This non-workday rule does not apply to months before the end of the IEP. Thus, for example, if the third month of an individual's IEP ends on a non-workday and the individual enrolls on the next regular workday, he or she is considered to have enrolled in the fourth month of the IEP.

3.2.83 Enrollment Action - Claim For Entitlement Pending When IEP Or GEP Begins

Although most individuals who file applications which establish Part A entitlement will be automatically enrolled for Part B, there will continue to be cases in which the individual is not subject to deemed enrollment (e.g., those whose applications are denied and do not establish Part A entitlement).

Thus, in any case where:

- an individual expresses a desire for Part B during or shortly before an enrollment period, and
- there is any doubt about his or her Part A entitlement, the individual should be advised to file, as soon as possible, a Medicare application.

3.2.85 Deemed IEP Based On Alleged Date Of Attainment Of Age 65

The deemed IEP provision was instituted for individuals who missed their IEP (as established by RRB or SSA based on best evidence of age) because they relied on a document that led them to believe that they were not yet age 65.

Whenever a person believes, and there is documentary evidence indicating, that he or she was under age 65 during the IEP, a deemed IEP will be established.

For Part B (and Premium-Part A) enrollment purposes, the individual is treated as though he or she attained age 65 at the time shown on the erroneous evidence. The premium surcharge for late enrollment (if any) is figured by counting the months beginning after the end of the deemed IEP.

- A. The Date of Birth Allegation - Usually, an individual alleges a DOB based on a document in the individual's possession. Some individuals, however, may not know when they were born or have only the vaguest idea of how old they are.

Where possible, obtain from the individual an allegation as to probable DOB, even if it must be qualified as "uncertain." The allegation is important because having a document agree with an allegation relieves RRB of the burden of "assigning" a DOB for deemed IEP purposes. Never insists on an allegation for this purpose.

It may be possible to help an individual recall family or historical references which will enable that person to remember his or her birth date. Under no

circumstances should you suggest a DOB to the individual, even if it seems the most likely DOB based on the evidence at hand.

B. Evaluating Evidence

1. Document Not in Individual's Possession - If an individual alleges a DOB based on evidence not in his or her possession, the document must be retrievable and must either agree with the alleged DOB or at least show that the person was under the age 65 during his or her IEP.

Note, however, that it is more likely that a person relied on a document in his or her possession rather than on a record that has not been seen in years.

2. Weight to Be Accorded Documents - Where the individual does not know the correct DOB (which would include the case where a DOB is alleged but no evidence of that date is ever located), it is probable that various documents will show different dates of birth. No particular weight is assigned to a document based on its formality or having been recorded early in life.
3. Usual Situation - Rule A in 3.2.86 deals with the usual situation - an individual thinks he or she was born on a specified date in reliance on a document that is believed to be accurate. The reason for the person's belief that the document is accurate is not material to the determination of the deemed IEP. Even if the individual submits conflicting documents as to DOB, the fact that he or she possesses a document and gives as his or her DOB shown on it is sufficient proof that there was reliance on that particular evidence, thus missing the IEP.
4. No Real Allegation of DOB - Rules B, C and D in 3.2.86 cover the rare but perplexing situations where an individual with various documents does not believe in the correctness of any of them; or alleges a DOB for which there is no corroborating evidence; or is unable to allege a DOB.

- C. Filing After Deemed IEP Ends - Where an individual's deemed IEP ended before the month of current filing, the person will be deemed enrolled in the current GEP or, if filing in April-December and automatic enrollment is applicable, during the next GEP. Where automatic enrollment is not applicable and the individual files in April-December, he or she must enroll for Part B during the next GEP.

Only months after the end of the deemed IEP are charged against the enrollee in computing a premium increase based on enrollment during a GEP. If an erroneous surcharge comes to your attention, adjust the enrollee's premium rate.

When an individual requests enrollment in GEP and the file shows a prior enrollment attempt was denied because the individual was older than alleged

and outside his enrollment period, action should be taken on the evidence previously submitted. Use the actual DOB established for the individual.

3.2.86 The Date Of Birth To Be Established

The primary consideration in deemed IEP cases are:

The individual

- believes he or she was born on a certain date in reliance on one or more documents containing information as to DOB, or
- is confused about the correct DOB because of erroneous or conflicting information on documentary evidence of age; and
- The individual missed the IEP because of the belief, based on erroneous or conflicting documents, that he or she was too young to enroll during the IEP.

A deemed IEP may not be established for a person merely because some of the evidence submitted indicates that he or she is younger than his or her actual age.

- A. Different Month of Birth - If the allegation and the document being used to establish the deemed IEP disagree as to month of birth, use the month indicated on the document unless the month of birth alleged is established by best evidence. If there is no allegation as to month of birth, use the month on the document that is being used to establish the deemed IEP.
- B. Rules for Establishing Date of Birth - Usually, the individual alleges a DOB and submits a document to corroborate that allegation. In rarer situations, the individual is unable to corroborate an allegation or may state that he or she does not know the correct DOB. Following are the rules for establishing the DOB in cases involving a deemed IEP.
 1. Rule A - DOB Allegation and a Document Agree - When the DOB allegation and a document agree, use the DOB alleged.

EXAMPLE: Marty Keith files in 4-85. He alleges he was born 7-17-20 and submits two documents. One shows 7-18-20, the other 6-12-18. His DOB is eventually established as 6-12-17.

For deemed IEP purposes, 7-17-20 will be used because he submitted a document that agrees with his allegation.

This is true even if the individual submits several other documents showing different dates of birth, some of which may be more advantageous. The fact that the individual alleges a date and submits even one corroborating document is sufficient to establish the alleged DOB for deemed IEP purposes.

2. Rule B - Vague DOB Allegation - The individual does not know the correct DOB, but believes he or she is about age 65 or younger. The individual submits (or obtains) various documents, some of which indicate that he or she is under age 65: Use the DOB which is closest to (but does not make the person older than) the DOB finally established.

EXAMPLES:

- Joan Martin files in 7-85. She presents 3 documents showing 8-12-19, 8-12-20 and 8-12-22. She does not know which document is correct, but believes she is between 62 and 65.

Her DOB is finally established as 8-12-18 based on "best evidence" obtained for her by RRB. For deemed IEP purposes, 8-12-19 will be used because it is closer to the correct DOB.

- Ken Overfell stated he was unsure of his DOB and refused to make an allegation when he filed in 9-84, other than to say that he was about age 65. He submitted two documents which showed his DOB as 10-17-17 and 10-17-19.

His DOB was established as 10-17-18. The DOB for deemed IEP purposes will be established as 10-17-19.

3. Rule C - Definite Allegation, But No Proof of It - The individual gives a definite allegation as to DOB and, according to the allegation, is about age 65 or younger. The person is unable to submit any evidence of the date alleged. However, some of the documents submitted (or obtained) indicate that the person was under age 65 during all or part of what is established as his or her actual IEP: Since this situation is comparable to that in Rule B. (i. e., the person does not know when he or she was born), follow Rule B.

EXAMPLE:

- Dan Arge alleged he was born in 1922 (month unknown) when he filed for an annuity in 10-84. He was unable to submit evidence of the alleged DOB but two documents were obtained which indicated that he was born 1-20 and 12-21 respectively.

His DOB was eventually established as 11-16. For deemed IEP purposes, 1-20 will be used, with the month of birth established as indicated in 3.2.86A.

Since Mr. Arge filed in 10-1984, his Part B will begin with 1-85, the month he is "deemed" to attain age 65.

- Whitney Hertz filed in 3-83, alleging that he was born in 12-16. Documents submitted or obtained showed December 1914, 1915, and 1917. 12-14 is established as his DOB based on best evidence.

Use 12-15 as the DOB for deemed IEP purposes. Since Mr. Hertz is well past his IEP, establishing deemed IEP will affect only the amount of the premium surcharge for late enrollment (see 3.2.88).

4. Rule D - All Documents Show Age 65 or Over in IEP - The same or comparable situation described in Rule B or C exists but all the documents indicate that the individual was age 65 or over during the IEP: No deemed IEP may be established. The requirement that the individual have missed the IEP in the belief (based on a document) that he or she was too young to enroll during the actual IEP is not met.

EXAMPLE: Joe Hendricks filed in 12-82, alleging that he would be age 65 in the following month. He has no documentary evidence of this, but the FO helps him obtain two documents. Both show that he is past age 67. Additional development reveals that he is actually going to attain age 68 in 1-83.

No deemed IEP will be established because there is not evidence of his allegation and none of the documents obtained show that he was under age 65 during his actual IEP.

5. Rule E - No Evidence to Support Allegation - The individual alleges he or she is over age 65 (whether that person gives a definite DOB is immaterial), but has no evidence to support that allegation. Documents submitted or obtained show various dates of birth: Establish the DOB for deemed IEP purposes as in Rule B. That is, use the DOB which is closest to (but does not make the person older than) the DOB finally established.

3.2.87 Prior Month Attainment Rule

A deemed IEP may be established for an individual born on the first day of a month who files an enrollment request in the first month after the IEP.

Since persons born on the first day of a month are ordinarily unaware that they actually attain a given age in the preceding month, apply the deemed IEP provision without further development.

If there is evidence in file that demonstrates that the enrollee knew the "prior-month" attainment rule, do not use this rule.

EXAMPLE: Mr. Allen DOB 3-1-20, enrolled on 6-22-85. Although his enrollment request was filed in the month after expiration of his actual IEP, a deemed IEP of 12-84 - 6-85 is established and Part B coverage is effective 9-1-85.

On the other hand, if Mr. Allen had enrolled in 3-85, his Part B coverage would be effective 5-1-85 (see 3.2.41). A deemed IEP could not be established since he enrolled during his actual IEP.

3.2.88 Use Of The Deemed IEP

The DOB used for the deemed IEP is the person's DOB for Part B (or Premium-Part A) entitlement purposes. All provisions in the law and instructions relating to enrollment (including automatic enrollment, premiums, and coverage periods), are applied as if the person's date of attainment of age 65 based on deemed IEP rules was the actual date of attainment.

If an individual for whom a deemed IEP may be established is not subject to automatic enrollment and has not elected Part B, he or she should be contracted about the advantages of filing for Part B and given the opportunity to enroll.

In some cases, an individual who is otherwise eligible for enrollment on the basis of the deemed IEP provision may decline Part B enrollment (e.g., because he or she prefers other insurance, etc.). If that individual seeks to enroll for coverage at a later date, the deemed IEP protection no longer applies.

Similarly, if an individual was enrolled in Part B on the basis of a deemed IEP but that person allows coverage to lapse (either through non-payment of premiums or based on a request for termination), the premium protection afforded by the deemed IEP provision is not applicable should the person reenroll for coverage at a later date.

In determining the amount of the individual's Part B premium surcharge for late enrollment, begin counting months of non-coverage with the month following the end of the person's actual IEP, keeping in mind that some months of non-coverage may not be countable because of the working aged provision (see 3.2.119).

If an individual would be eligible for an SEP and/or premium surcharge rollback because of coverage under an employer group health plan (EGHP), the deemed IEP protection continues for that person. All determinations for SEP and/or premium rollback purposes will be used based on the deemed date of birth and deemed IEP.

EXAMPLES:

- Reenrollment in Part B - In 8-91, Mr. Smith, a fully insured worker, files for an annuity and Part A. He alleges, and has documentary evidence indicating, that he attained age 65 in 8-91. FO development of proof of age shows he actually attained age 65 in 8-89, and that he could have enrolled during the 7-month period 5-89 - 11-89. Nevertheless, his deemed IEP will be 5-91 - 11-91 based on the evidence he submitted.

Mr. Smith's Part B coverage begins 9-91, although his entitlement to an annuity and Part A may be effective as early as 2-91. There is no increase

in premiums since he is considered to have enrolled in his deemed IEP for both enrollment and premium purposes.

Mr. Smith's Part B coverage is terminated effective 12-31-92 based on a request for termination filed in 11-92. He reenrolls for Part B during the 1994 GEP. In computing the premium Mr. Smith must pay beginning 7-94, all months of non-coverage in Part B following expiration of his actual IEP (5-89 - 11-89) through the end of the 1994 GEP must be counted, a total of 28 months. Thus, a 20% premium increase is applicable beginning 7-94.

- Premium Penalty - On 1-10-85, Mr. Jones enrolled in Part B and presented documentary evidence supporting his allegation that he attained age 65 in 8-83. The FO's development established that Mr. Jones actually attained age 65 as of 8-10-80. Since the claimant was mistaken as to his true age and his request for enrollment on 1-10-85 was filed during a GEP, his request is accepted and coverage begins 7-1-85. Of course, Mr. Jones's premium is increased by 10 percent because there are 16 elapsed months in the period 12-1-83 - 3-31-85.
- Late Evidence - In 3-91, Mrs. Jones (who had no EGHP coverage) telephoned a FO concerning her right to Part A and Part B, and stated that she would attain age 65 in 8-91. Since she was working steadily and did not want a reduced annuity, the FO advised her to file for Part A and Part B in 5-91, and to bring proof of age at the time. Mrs. Jones then wrote for and obtained evidence which showed she was born in 1923.

She immediately filed a claim for an annuity, Part A, and Part B alleging she was born 8-15-23. Her DOB was established 8-15-23. She was advised by the FO that she would be awarded an annuity Part A effective 11-90, but that her Part B could not start until 7-92 since her Part B election had not been filed during an enrollment period open to her. She objected to the Part B delay because she thought for many years she would attain age 65 in 8-91 and had not known of the earlier DOB until shortly before filing. Upon being asked to do so, she submitted documentary evidence indicating an 8-26 DOB, and that she had been using this date of birth. On the basis of this evidence and her 5-91 enrollment request, a deemed IEP is established and Part B allowed with entitlement effective 8-91.

- Automatic Enrollment - In 7-85, Mr. Green, a fully insured worker, came to the FO and applied for an annuity and Part A. He presented documentary evidence supporting his allegation that he would attain age 65 in 8-85. However, FO development of age showed that he had attained age 65 in 8-84, and could have enrolled in Part B during the 7-month period 5-84 - 11-84.

Because the documentary evidence shows that the claimant was mistaken as to his true age, his deemed IEP is 5-85 - 11-85 and, since automatic enrollment applies, the claimant will be deemed to have enrolled for Part B during the first 3 months of his deemed IEP, with entitlement effective 8-85.

If Mr. Green's application establishing Part A entitlement had been filed in 12-85, he would be deemed to have enrolled for Part B during the 1986 GEP and his Part B coverage would begin 7-86. His premium, because of the deemed IEP, would be at the standard (unincreased) rate.

3.2.89 Enrollment Request Filed After Age 65 But Before Deemed Date Of Attainment

A person may file for Part B (or be subject to automatic enrollment) after his or her actual IEP ended and before the beginning of the deemed IEP (based on the documentary evidence on which the person relied.).

- Deemed IEP Begins After GEP - If enrollment occurs during a GEP and the deemed IEP begins after the end of the GEP, award coverage beginning the following July.

EXAMPLE: In 2-91, Mr. Brown files for a reduced annuity, alleging he was born 2-28, and submitting corroborating evidence. Based on evidence of higher probative value, a 2-4-24 DOB is established. An unreduced annuity and Part A are awarded effective 8-90.

Since Mr. Brown filed an application establishing Part A entitlement during a GEP and while eligible to enroll (being age 65 and entitled to Part A), he is deemed to have requested Part B enrollment. Unless he refuses such deemed enrollment timely, he have coverage beginning 7-91. If Mr. Brown had filed his application in 7-91, (i.e., not during a GEP), he would be deemed enrolled during the 1992 GEP, because this would permit coverage to begin earlier than enrollment in his deemed IEP (11-92 - 5-93).

- Deemed IEP Begins During GEP - If the deemed IEP begins during a GEP but after the enrollment request was filed, deem the person to have enrolled during the deemed IEP to permit coverage earlier than the following July. The individual does not have a choice of accepting the later coverage based on a GEP enrollment.

EXAMPLE: Mrs. Adams files a Part B enrollment request on 2-15-92. She submits her original birth certificate showing that she was born 6-24-25. She explains that she did not enroll for Part B when first eligible because she only recently discovered the birth certificate. She previously believed she was born on 6-24-27 in reliance upon an insurance policy issued in 1945 showing the 6-24-27 DOB.

Because Mrs. Adams relied on documentary evidence showing she was younger than her true age, a deemed IEP of 3-92 - 9-92 is established for her. This deemed IEP begins after her filing date, but during a GEP. She is effectively enrolled during her deemed IEP and is awarded coverage beginning 6-92.

- Enrollment After GEP - If the enrollment request is filed outside a GEP, the person is deemed to have enrolled during the next GEP or in the deemed IEP, whichever results in earlier coverage. This is not considered a late enrollment and there are no months which count toward a premium increase.

3.2.90 References

Sections 1837(d) of the Social Security Act and SSA's Regulations 42 CFR 407.14(b) are references for the above procedure.

3.2.95 Conditions For Providing Equitable Relief

- A. General - Amendments in 1972 authorized relief when an individual's Part B enrollment, termination, or coverage rights are prejudiced because of the error, misrepresentation or inaction of an employee or agent of the Government. In such situations, the RRB, SSA, and/or CMS may take any action necessary to prevent or correct inequity to the individual. The actions include, but are not limited to the designation of enrollment and coverage periods, and appropriate adjustment of premium liability.

The actions may be part of the initial claims, process, post-adjudicative processing, or as a result of information or decisions that arise from the appeals processes.

The effective date of the "equitable relief" amendment was July 1, 1966. There is, therefore, no time limitation on granting relief.

Where the Government clearly erred, equitable relief should be considered on its own motion without the beneficiary having to ask for it.

Equitable relief applies to Part B in disability and ESRD cases as well as to cases involving the aged. It also applies to Premium-HI for the aged and for the working disabled. Equitable relief, however, never applies to premium-free Part A.

Equitable relief is the way of undoing harm caused an individual by the Government's actions, failure to act, or misinformation. However, it is still important to ensure that only correct actions are taken and proper information is given to an individual about Medicare. There is little consolation, for example, to an individual that we can grant relief to pay for his or her surgeon's bill, but cannot pay for the hospital stay during which the surgery occurred, except in the rare case where Premium-Part A is involved.

An equitable relief decision is not subject to appeal. However, an appeal can be made concerning the correctness of, for example, the entitlement date or the termination date. Additional information relating to erroneous information can be presented during the appeal process.

B. Requirements For Equitable Relief - The elements that must be present in each case where equitable relief is granted are:

- Government error, misrepresentative, or inaction;
- Prejudice to the individual's Part A or Premium-Part A rights; and
- Evidence of the error, see 3.2.96 below.

If the individual caused or contributed materially to the Government error by fraud or similar fault, equitable relief is not granted even if the main elements are present in the case.

C. Definition of Prejudice to Part B Rights - Prejudice to the individual's rights may consist of:

- carrying private insurance he or she did not need,
- electing surgery in advance of entitlement because he or she was misinformed about the entitlement date,
- missing an enrollment period,
- inability to pay a large premium arrearage which accrued due to Government delay, or
- any other hardship with health insurance or health care needs that is traced to Government error, misrepresentation, or inaction on enrollment, premium collection, or termination of entitlement.

D. What the Evidence Must Show - There must be evidence meeting the definition in 3.2.96 which shows that:

- the individual took such appropriate and timely measures to assert his or her rights as could reasonably be expected under the circumstances, and
- because of administrative fault, delay, or erroneous action or inaction by an employee or agent of the RRB, SSA, or CMS or another Federal Government instrumentality, the enrollment or premium rights would be impaired unless relief is given.

An "agent" of the Federal Government is one who is authorized to act on behalf of the Federal Government in matters pertaining to Medicare, such as an employee of a Medicare carrier.

If the evidence shows that an individual received misinformation from someone, e.g., employer, insurance company, which received the misinformation from an employee or agent of the Federal Government, this would also qualify for equitable relief.

- E. What Does Not Justify Relief - Relief cannot be provided merely because of hardship or because of "good cause" for failure to enroll. There must be some erroneous action or inaction by the Government which is prejudicial to the rights of the individual.

Thus, for example, where an individual failed to enroll for Part B because he or she was covered under private non-employment-based health insurance, which was later terminated, the fact that he or she had "good cause" for not enrolling earlier and may now need Part B urgently does not justify relief.

- F. No Minimum Amount of Premium - When an individual complains about an error, and the requirements of this section are met, equitable relief may be granted no matter how few months of coverage are involved or how small the amount of premiums involved.

For **automatic** consideration of, and notices about, the various kinds of equitable relief in the situations described in the following sections, the number of months coverage involved must be more than 5, or the premium arrearage either because of retroactive Part B entitlement, failure to deduct Part B premiums from monthly benefits, or failure to bill a beneficiary for Part B premiums must be for 6 or more months. Note that the determining factor in such situations is the number of months for which a premium is due, not the amount of premiums due.

On the other hand, for retroactive changes in the amount of a Part B premium because of (1) the addition of or a change in an Income Related Monthly Adjustment Amount (IRMAA), (2) imposition of a premium surcharge, or (3) a change in a Medicare Advantage premium reduction (see RCM 3.2.109), the determining factor is the amount of premiums due. For automatic consideration of equitable relief in such situations, the premium arrearage must exceed 5 times the current standard Part B premium. **Exception:** When the premium arrearage is due to IRMAA, the amount must exceed 5 times the current standard Part B premium plus the amount of the individual's IRMAA (see RCM 3.2.108).

3.2.96 Evidence Of Government Error Or Delay

In most cases, the headquarters or the field office file shows that an error occurred, e.g., delay in awarding entitlement, erroneous termination, failure to bill for or collect premiums.

The individual alleges that his or her rights were prejudiced due to misinformation received. The allegations must be substantiated.

If possible, the Government employee or agent identified as having given the misinformation should report his or her recollection of the event. If the employee cannot recall the interview or discussion, he or she should nevertheless report on the probability that he or she gave the misinformation or misadvise that the individual claims receiving.

Equitable relief may not be granted unless the file contains documentary evidence. The evidence can be in the form of statements from employees, agents, or persons in authority that the alleged misinformation, misadvise, misrepresentation, inaction, or erroneous action actually occurred. In the absence of such personal knowledge, the evidence can consist of a statement that there is a strong likelihood based on personal knowledge or prior experience that an error occurred.

3.2.97 Time Limits

Ordinarily, claims for Part A benefits for covered services received during the 12-month period ending September 30 of any year must be filed on or before December 31 of the next year. Equitable relief does not apply to premium-free Part A. However, where administrative error causes the failure of a provider of Part A services to file a request for payment within the usual time limit, the time limit may be extended. The extension will end with the last day of the sixth month following the month in which the error is rectified and notice is sent.

Therefore, special language may be required for notices of awards or reinstatements of Part A entitlement involving retroactive months. This would occur where the usual claims filing time limit for services furnished in any of those months has ended (or will end within 6 months after the month of notice). The language should be similar to the following:

"If you received any services covered by Medicare during the period before October 1, (year), hospital benefits for such services can be paid only if the provider which furnished the services submits a claim for payment on or before (the last day of the 6th month after the date of the notice). You should telephone your local Railroad Retirement Board office if you have any questions regarding this matter."

This language is in addition to any language required because if the individual elects retroactive Part B entitlement. Language concerning Part B services for which the usual claims filing time limit has expired is sent only after an individual elects retroactive Part B entitlement in response to the initial award or reinstatement notice. Use Code Paragraph 921.

3.2.98 Equitable Relief And Premium Arrearage

Occasionally, the offer of equitable relief in order to award earlier or continuous coverage may result in a Part B premium arrearage. In such cases the letter to the beneficiary should explain the arrearage. The beneficiary should be advised that if he or she is not able to pay the arrearage in a cash lump sum, alternative arrangements for payment can be made.

Premium arrearage may be paid by offset from a monthly RR annuity or SS benefit, by cash refund, or if necessary, by recovery from a beneficiary's estate. Offset from monthly payments can be made by withholding the full monthly rate (after current Part B deduction) or by partial withholding of some portion of the monthly rate until the full arrearage is recovered. If there is no current annuity entitlement, the arrearage can be paid by a single cash refund or by monthly installments. Premium arrearage can not be recovered by actuarial adjustment.

3.2.99 Payment Of Part B Premium Arrearage By Partial Withholding Or Monthly Installments

If a beneficiary indicates that recovery of the arrearage in one lump sum would create a financial hardship, certain alternative methods of payment are available. For beneficiaries currently entitled to monthly RR or SS payments, recovery by partial withholding is acceptable. For non-beneficiaries, monthly installments are acceptable. Such arrangements are designed only for those whose financial circumstances make it difficult to pay the premium arrearage in a lump sum. No further development of the beneficiary's financial status need be taken if, after receiving such information, the beneficiary states that he cannot pay the arrearage in a lump sum, but accepts the installment payment or partial withholding offer.

The minimum monthly partial withholding or installment amount is the greater of:

1. \$20.00, or
2. 1/36 of the total arrearage amount.

Accordingly, monthly payments must always be for at least \$20.00, and must be rounded up to the nearest dollar amount. When the arrearage due is larger than \$720.00 (36 months x \$20), the minimum monthly payment amount must always be greater than \$20.00. In large arrearage cases, determine the minimum allowable monthly payment by dividing the amount of the arrearage by 36. (Example: If the arrearage amount due is \$815.50, the minimum monthly payment is \$815.50 divided by 36, or \$22.65. Rounded up to the nearest dollar amount, this monthly payment would be \$23.00.)

The Medicare Section (MS) will establish a record on the Program Accounts Receivable system (PARS). In most cases, PARS will generate the arrearage or option letter. Form G-363 should be prepared as a file record to document the arrearage computation.

MS will forward partial withholding cases to RBD or SBD. They will adjust the monthly payment amount in accordance with current procedures for applying partial withholding.

For installments payments for beneficiaries not in current pay status, MS will enter the arrearage amount on PARS, if this has not already been done. If a payment has been received, MS will credit the amount on PARS and set up installment billing.

If an individual defaults on installment payments, notify the individual that he or she has 30 days to remit the missing installments or the period of Part B entitlement covered by the installment agreement will be deleted. Any Part B benefit payments made for medical services received in these months will become overpayments which may not be waived. Those installment payments that were made prior to default will be refunded to the beneficiary.

Refer to RCM 3.7.52 for further information on how to collect unpaid premium.

Sometimes it is obvious that further recovery attempts are unlikely to result in collection of the amount due from any source. Especially in the case of a small arrearage, it is likely that the administrative cost of further recovery actions may actually exceed the amount due. Refer to RCM 3.7.60 for specific guidelines concerning the suspension of further recovery actions.

3.2.100 Enrollment Not Processed Timely

For a variety of reasons involving Government fault or error, an individual's Part B enrollment request may not be processed until several months or years after coverage should have started. Similarly, there may be a delay of several months or years in notifying the enrollee that coverage has been awarded.

Serious inequity is likely to result where such an individual is required to pay premiums for a long period of retroactive coverage which he or she may not have known existed, the beneficiary may have continued to carry nongovernmental health insurance, or the beneficiary may have deferred necessary treatment because he or she did not know they were insured against the cost of such treatment, and he or she may be unable to pay the premiums which accumulated over a long period of months or years.

- A. 6 or More Months Premium Owed - If retroactive premiums for 6 or more months are due when an enrollment request is processed, or the enrollee is notified about the start of Part B more than 5 months after the entitlement date, Part B is awarded with the month in which final action is taken to process the award (current operating month). Months between the end of the enrollment period in which the request was filed (or deemed to have been filed) and the Part B entitlement date are not counted in determining whether or how much the enrollee's premiums must be increased for late filing. Send the enrollee a notice of the Part B award, informing him or her of the option of having Part B coverage begin earlier (the date coverage would have started if the enrollment request were handled timely), provided that within 30 days he or she (1) requests the

earlier date of coverage, and (2) either pays all back premiums due for months of coverage prior to the month shown on the award notice, authorizes deduction of the back premiums from his or her monthly payments, or arranges for an alternate method of payment.

The following combinations should be entered on the ARTX and the ARLT screen on PARS to generate the appropriate letter: if no monthly payments are in force, H4/H4; and, if monthly payments are in force, enter one of the following combinations: H2/H2, H1/H1 or H3/H3. See RCM 3.12 for the additional PARS entries necessary.

The individual cannot choose an intermediate date to begin Part B coverage. If permitted, this would enable the individual to select the month most advantageous to him or her and most costly to the Part B Trust Fund; for example, the first month in which he or she incurred substantial covered expenses.

In the event that an enrollee has already made it clear that he or she wants only prospective coverage or that he or she wants (and is willing to pay for) earlier entitlement, award Part B accordingly without mentioning the option. If the enrollee is currently requesting the earlier entitlement date, ascertain whether he or she is willing to pay the premium arrearage before any award action is taken. If the individual pays the accrued premiums in full (or agrees to installments or agrees to benefit deduction), make an adjustment in the award to show the earlier starting date of coverage.

If the enrollee selects the earlier effective date, MS should determine whether it is necessary to alert the enrollee to the need for filing promptly Part B claims for any covered services he or she may have received during the first months of the period of Part B entitlement. Ordinarily, claims for Part B benefits for covered services received during the 12-month period ending September 30 of any year must be filed on or before December 31 of the next year. If the time limit for filing Medicare claims has expired for some services, or will expire within 6 months after the month the award is approved, the amended award notice should advise the enrollee that such claims will be honored if submitted within 6 months after the month of notice. Include code paragraph 921 in the notice.

These procedures also apply when an application for enrollment was denied initially for any reason, and as a result of reconsideration or a hearing, the original decision is reversed.

EXAMPLE: Mr. Carr, whose first month of Part B eligibility is 7-90, files an application for Part B enrollment in 5-90. Due to error, his application was not processed until 6-92.

He will be awarded Part B coverage beginning 6-92 (23 month later than Part B coverage would normally have begun), and his premiums will not be increased, since he filed the enrollment request during the IEP.

Mr. Carr will be notified that his coverage could be made retroactive to 7-1-90 if he pays the back premiums for 7-90 through 5-92 of \$689.40 (or authorizes the deduction of this amount from monthly benefits payable to him).

Assuming he elects 7-1-90 and the amended award is prepared in 8-92, the notice of award will advise him that he must file claims for any services received before 10-1-91, on or before 2-28-93.

In some cases where a person is awarded prospective Part B beginning many months after enrollment (or deemed enrollment), the individual may protest that he or she does not desire Part B enrollment, e.g., because he or she has secured other coverage which he or she now prefers to retain. In such cases (including automatic enrollment cases), if the enrollee's protest is filed within 2 months after the month in which he or she is notified of the Part B coverage:

- the Part B award is reversed,
- any premiums paid are refunded, and
- the individual is deemed not to have enrolled or, in automatic enrollment cases, is deemed to have refused enrollment.

B. Enrollment Not Processed But Premium Deductions In Force

Enrollee Not Notified Until 6 or More Months After Coverage Should Have Started - It is possible, especially in the case on an SS pure case, that premium deductions were initiated timely but the necessary enrollment activities were omitted. In such cases, the enrollee may or may not know about the deductions. Since no valid enrollment has been processed, claims for benefits could not be filed. It is possible that the individual is aware that deductions are being made, but that he or she simply has not yet had a claim to file.

In such cases, enroll the individual immediately, effective with the date deductions began. Notify the individual of the effective date of coverage, and if necessary, include paragraph 921. If the enrollee spontaneously objects within 2 months after the month in which he or she is notified of the coverage, the Part B award may be reversed. Any premiums collected should be refunded, and the individual will be deemed not to have enrolled or, in automatic enrollment cases, will be deemed to have refused enrollment. If he or she desires Part B but does not wish to accept coverage effective with the earlier date when deductions began, advise the beneficiary of the next general enrollment period. The beneficiary cannot accept an intermediate effective date of coverage.

C. Death or Part B Termination Date Occurs Before Award Is Made

Sometimes a Part B award is delayed so that the choice in A could not be made by the individual prior to the termination date of Part B (due to death, or to the termination of Part A for an individual under age 65). In such a case, the individual (or any of the survivors) should be given the option of electing Part B as of the date entitlement should have begun and paying the premiums, or refusing Part B entirely.

In other cases, an amended award, which would cause earlier Part B entitlement, is made to a person who already has been awarded Part B but the Part B termination date occurs before the individual (or survivors, if the enrollee is deceased) is able to make the choice of having earlier Part B entitlement. In these cases, the enrollee (or the survivors) should be offered the choice of accepting the new (earlier) Part B entitlement date and paying the additional premiums or refusing earlier entitlement.

For a deceased enrollee, enter H8/H8 on the ARTX and ARLT screens on PARS. See RCM 3.12 for the additional PARS entries necessary.

- D. State Buy-In - If a Part B award is delayed for an individual who would be on State buy-in for each month of the retroactive entitlement period, make the Part B award effective with the proper month since the State will pay all the retroactive premiums. If State buy-in is involved, but would not apply for the first month of retroactive coverage, or for some intervening months during the retroactive period, the individual should be awarded a closed period of Part B for the buy-in period, and Part B as of the month of processing, with a choice of coverage for the non-buy-in months, if he or she will pay the premiums due.

EXAMPLE: Mary's award is processed in 4-92. Her first month of Part B entitlement should be 1-91. She was on State buy-in from 6-91 through 10-91. She would be awarded a closed period of buy-in coverage from 6-91 through 10-91, and continuous Part B from 4-92 on. She should also be informed that she may have Part B from 1-91 or from 11-91 if she will pay the premiums due from whichever date she elects (if she elected 1-91, she would not, of course, pay premiums for the intervening buy-in months).

- E. Open Applications - If the requirements are met for an award based on an "open" application, and the beneficiary is, as a result, subject to an automatic enrollment in Part B, that is retroactive, the instructions in A above should be followed. This means that the delay in processing entitlement based on the "open" application is considered as a delay in awarding Part B.

3.2.101 Part B Awarded On Later Of Two Timely Enrollment Requests

After a person has been awarded Part B on the basis of an enrollment request, the RRB may discover an earlier timely enrollment request still unprocessed. If the RRB were, on

its own motion, to revise the existing Part B award to change the effective date of Part B coverage, the individual could be required to pay for many months of undesired retroactive coverage. Such action would likely result in complaints of hardship and inequity.

Handle cases involving an unprocessed earlier request from a person currently enrolled as follows:

- The enrollee's premium rate is reduced, if necessary, to be consistent with enrollment period in which he or she filed the earlier request.
- Any excess premium payments are refunded or credited against future premium liability.
- The enrollee is notified that the prior premium rate had been erroneously computed, and that this error has now been corrected.

No other award notice action will ordinarily be taken.

Where the file reflects a current or timely protest (one filed within 6 months of notice) against the existing Part B award, send a notice to the enrollee. The notice will advise the beneficiary that Part B coverage can begin as of (a specified date - when coverage would have begun if the original enrollment request had been properly and promptly processed) if, within 30 days,

- the enrollee elects the earlier coverage, and
- pays the retroactive premiums which have accrued since the earlier coverage date or authorizes the deduction of such amount from monthly benefits.

EXAMPLE: Mr. Blue, who attained age 65 in 4-77 was awarded Part B effective 7-79 (based on enrollment during the 1979 GEP, with a premium increase of 10 percent. In 10-80, RRB finds a request for Part B which Mr. Blue filed in 4-87. Mr. Blue's premium rate is reduced to the standard (unincreased) amount effective 7-79 and the previously collected premium increase is refunded or credited against future premium liability.

Mr. Blue is notified that the premium rate has been adjusted to correct a prior error. If RRB records show he protested timely about the effective date of Part B, he is also advised of the right to obtain earlier coverage.

3.2.102 Delayed Or Incorrect Advice Frustrates Enrollment Or Termination Rights

In some cases, an individual may be prevented from taking timely and appropriate action to enroll for or terminate Part B coverage due to administrative delay or misadvice. For example, an individual may write to the RRB shortly before, or during an

open enrollment period, but be prevented from enrolling because the RRB did not answer his inquiry until most of all of the enrollment period had elapsed. Relief in such cases will be provided to ensure that the enrollee's desires are met. Similar relief is provided in cases where an enrollee inquires about Part B termination and a reply is not given in time to permit him or her to file a voluntary termination request within the same calendar quarter in which he or she inquired about termination.

Handle all cases of this type as follows:

- A. Inquiry Shows Unequivocal Desire to Enroll - When an individual inquires about Part B during or within 9 months prior to the start of an enrollment period that is open to the beneficiary, and from the nature of the inquiry it is clear that he or she wants Part B, award coverage based on filing on the first day of that period; do not delay the award of coverage by obtaining a second enrollment request. However, if taking action to provide such relief would result in the award of 6 or more months of retroactive coverage, award Part B prospectively, beginning with the month in which the individual is notified. Inform the individual of his or her rights to obtain earlier coverage by requesting such coverage and paying the accrued premiums.
- B. Inquiry Does Not Show Unequivocal Desire to Enroll - If the inquiry does not express a clear and unequivocal desire to enroll, send the individual an enrollment card (Form G-44) and a letter informing the beneficiary that he or she may obtain coverage as of the date coverage would have started if we had promptly replied to his or her inquiry. Explain in the letter that the beneficiary may only have the earlier date of coverage if, within 30 days, he or she completes the Form G-44 and returns it with a premium payment (provide amount), if no benefits are currently payable. If the Form G-44 is returned promptly, the beneficiary will be deemed to have filed his or her enrollment request timely. Otherwise, the beneficiary must file during the next GEP.

EXAMPLES:

- On March 30, Mrs. Fortune telephoned a contact representative about enrollment for Part B. In the course of the telephone call, it became clear that Mrs. Fortune was 68 years old, had been eligible to enroll since age 65, and wished to enroll for Part B. The representative told Mrs. Fortune that she would mail her a completed enrollment application, which she should sign and return promptly. She received the application on April 10, and executed and returned it as advised. Part B was denied on the grounds that her request was not filed during the general enrollment period.

Mrs. Fortune protested and, in connection with her complaint, the facts above were established through the signed statement of the contact representative. Under these circumstances, Mrs. Fortune will be considered to have enrolled during the GEP. The contact representative should have recorded her request as an official enrollment request, taken by phone,

during an enrollment period. He should have asked her to send in, as soon as possible, her signed statement that she wished to enroll (not necessarily on an application form). The record of the phone message serves as evidence that she enrolled timely, even though the signed statement is not received until after the GEP has ended. Since the records show she acted reasonably and in a good faith to enroll in accordance with information given by an official source, she should be treated as if she had received and acted on proper advice.

- Mr. Graves phoned the district office on 3-15-82 and stated that he wanted to "cancel" his Part B coverage at the earliest possible date. He was advised to submit a signed statement clearly expressing his desire to terminate Part B. He submitted the statement in 4-82 and was notified that his coverage would end on 5-82 (the end of the month after the month in which the termination request was filed). Mr. Graves protested this delay in termination, stating that when he telephoned the district office in March to request information about termination he had not been advised of the importance of submitting his termination request before the end of the month. Although the field office had no record of Mr. Graves' call, it stated such incomplete advice could have possibly been given. Mr. Graves' Part B coverage and premium liability will, therefore, end with 4-82, the month after the month in which his termination request would have been filed if he had responded promptly to correct and complete advice.

3.2.103 Part B Awarded Erroneously

- A. General - In some cases, after an individual has been enrolled, new evidence may be discovered indicating that Part B was awarded in error or the date of entitlement is wrong. This may occur, for example, if information shows that the individual had not yet attained age 65, refused Part B enrollment, or did not file the enrollment request during an enrollment period.
- B. Timely Protest - If the individual protests timely about the erroneous enrollment (i.e., before the Part B entitlement date, or, if later, within 6 months after the month in which he or she is sent a notice of Part B entitlement), the Part B award may be set aside.

Follow the procedures below in handling timely protests of enrollment.

If a timely protest as explained above is received:

- Delete the erroneous period of Part B coverage, and
- refund any premiums paid provided that the individual repays any Part B benefits paid pursuant to the erroneous enrollment.

EXAMPLE: Mr. Thomas, age 71, files a GEP election of Part B during 3-90. His application is erroneously handled like a SEP enrollment and he is awarded Part B coverage effective 4-90. Shortly after receiving the award notice, Mr. Thomas protests the Part B award because he will continue to be covered under his employer group health plan until he retires on 6-30-90.

The Part B award is corrected to 7-90. The erroneous period of Part B coverage is deleted and Part B premiums withheld from his monthly checks are refunded to him.

On the other hand, if Mr. Thomas does not protest until more than 6 months after the month he is sent the notice of Part B coverage, his protest can only be treated as a request for voluntary termination.

- C. Wants to Keep Part B Coverage - Ordinarily, the individual will wish to retain Part B because he or she may have given up nongovernmental health insurance or incurred substantial medical expenses in reliance on the Part B award. Erroneous Part B awards will be handled as shown below:

1. Error Discovered In or After Actual IEP - If the error is discovered after the start of the individual's actual IEP, the Part B award will not be disturbed unless it was procured through fraud or similar fault of the individual.

EXAMPLE: In 4-88, Mrs. Howe enrolls for Part B with coverage beginning 5-88, based on a finding that she was born 5-17-23. Newly discovered evidence, submitted in 6-90, shows that she was born 5-17-24. There is no evidence of fault. Do not change the Part B award.

2. Fraud or Similar Fault - If there was fraud or similar fault:

- do not grant equitable relief, and
- cancel the Part B award.

Any Part B payments made during the period of erroneous entitlement will be treated as an overpayment. Offset any premium refund that may be due by the amount of the overpayments.

3. Error Discovered Before the Actual IEP - If fraud is not involved and an individual was enrolled erroneously and the error is discovered before the start of his actual IEP, Part A and Part B coverage will be canceled with the last day of the month in which the action is taken. The individual will be notified of the reason for the cancellation, and of the time when he may again enroll. Follow regular procedures for canceling Medicare coverage, rather than procedures for withdrawal from Part B coverage. Do not refund any premiums or attempt to recover any payments made due to utilization. Refer to RCM 3.3 Appendix B, G-811 instructions for activity code 06.

3.2.104 Part B Terminated Erroneously

- A. General - When an individual's Part B coverage is terminated erroneously, he is in approximately the same situation as the person whose enrollment was not processed timely. That is, he does not know whether he has Part B or not, he may enroll in a non-governmental health plan to assure some protection for his medical expenses, he may defer necessary treatment because of his uncertainty about being insured against the costs of such treatment, etc. When the error is finally corrected, it would be unfair to reinstate his entitlement retroactively and require him to pay premiums for past Part B coverage that he had been unable to use at the time. Accordingly, the options offered to the individual whose enrollment was not processed timely should also be offered to the individual whose Part B was terminated erroneously, if 6 months or more premiums are owed.
- B. Notice of Reinstatement - When 6 months or more premiums are owed, individuals should be given the same kind of option for termination as given in late enrollment cases.

The following combinations should be entered on the ALTX and the ARLT Screen on PARS to generate the appropriate letter: if no monthly payments are in force, E1/E1; and, if monthly payments are in force, enter one of the following combinations: E4/E4, E3/E3 or E2/E2. See 3.12 for the additional PARS entries necessary.

If the individual pays in full, authorizes withholding of the full amount from his monthly payments, or agrees to monthly installments, coverage should be reinstated as of the month of the erroneous termination. If necessary, alert the enrollee to the need for filing his claims promptly based on any Part B services on which the ordinary deadline for filing may have passed or be within 6 months of the month of reinstatement.

If the enrollee has already made it clear that he wants only prospective coverage or that he wants (and is willing to pay for) coverage during the retroactive period, reinstate Part B accordingly without mentioning the option. If the enrollee is currently requesting the earlier entitlement date, ascertain whether he is willing to pay the premium arrearage before any award action is taken.

In some cases where an individual's Part B is reinstated currently, the enrollee may protest that he does not desire Part B enrollment, e.g., because he had, in the interim, secured other coverage which he now prefers to retain. In such cases, if the enrollee's protest is filed within 2 months after the month in which he is notified that his coverage was reinstated, reverse the Part B reinstatement (i.e., permit the original termination to stand) and refund any premiums collected.

EXAMPLE: Mr. Clay's Part B coverage was terminated effective with 10-31-91, due to a medical cessation of disability. In 12-92, his disability was fully reinstated on appeal with no break in entitlement.

Mr. Clay will be notified that:

- his Part B was erroneously terminated but is being reinstated effective 12-92; and
 - if he wishes Part B reinstated retroactively he must submit a signed request for Part B as of 11-91 and authorize deduction of retroactive premiums amounting to \$409.60 (\$29.90 a month for 11-91 - 12-91 and \$31.80 a month for 1-92 - 11-92) from his monthly benefit check or send in the payment or request an alternative method for paying the arrearage.
- C. Error Discovered Less Than 6 Months After Month of Termination - If an erroneous termination is discovered less than 6 months after the effective month of termination, no relief from premium liability may be granted. Action should be taken to reinstate Part B coverage and collect past premiums due as soon as possible. If the enrollee spontaneously protests, advise him of the alternative methods of recovery.

3.2.105 Inadvertent Failure To Bill For Or Deduct Premiums – Non-Buy-In Cases

- A. General - In some cases, long after a person has been awarded Part B and notified of his or her Part B coverage, it is learned that premiums have inadvertently not been billed or deducted from benefit payments, or that premium billing or benefit deductions were accidentally stopped months earlier.

The coverage remained intact with only the premium billing or collection mechanism being affected. However, by the time premium collection is initiated or resumed, the enrollee may be confused as to whether he or she had coverage during the non-premium period. Also, the beneficiary may be financially unable to pay the arrearage, or have difficulty in paying the arrearage, when the problem with premium collection is finally resolved.

It is not necessary to determine whether the enrollee was also at fault (e.g. should have known premiums were due and been prepared to pay them when the billing or deduction errors were finally corrected). The type of government error involved requires relief even if there is some carelessness on the part of the beneficiary.

Equitable relief is automatically considered to avoid hardship or the necessity of terminating Part B in cases where premium arrearage of more than 5 months accumulated because of administrative error.

In addition to the right to pay the arrearage through installment, the beneficiary has the following additional options to discharge the premium indebtedness:

- waiver of the premiums in cases of severe financial hardship; or
- termination of Part B entitlement effective with the month after the last month for which a premium payment was received and reinstatement of Part B effective with the current month for which premium collection activity is being resumed. This option is available only if there have been no claims made for Part B services during the entire period for which the premiums were not collected. This will not be implemented until the PARS letters are updated with the appropriate information about the termination of Part B entitlement. You will be notified when this will be implemented.

- B. Premium Arrearage of 6 Months or More - When premiums are due for 6 months or more the enrollee should be sent a notice explaining the arrearage. Immediately reinstate premium collection with the current month and do not deduct or bill for the arrearage until at least 45 days have elapsed after the notice is sent so that the beneficiary has the opportunity to respond. The following Text Types should be entered on the ARTX screen on PARS to generate the appropriate letter: if no monthly payments are in force, enter one of the following combinations: A1/A1 or A5/A5; and, if monthly payments are in force, enter one of the following combinations: A2/A2, S5/S5 or S3/S3. See RCM 3.12 for the additional PARS entries necessary. If the enrollee is in current pay status, also establish a record for the amount of the arrearage on ASTRO (see RCM 16.5).

After establishing a PAR record send the file to "dormant" for 30 days, unless the payee is not in current pay status or the PAR record is established for a delayed Medicare Part B enrollment. If no reply is received after the call-up expires and payments are in current pay status (cps), ASTRO will automatically take action to recover the arrearage.

When there is no response to the initial notice in 30 days, and the case is not in current pay status and the PAR Dunning Flag was coded as a "Y", PAR will release a second notice. And if no response is made to the second notice in 30 days, PAR will release a final notice. When 30 days has elapsed after release of the final notice and no payment is received, no request for reconsideration or waiver is made, or method of payment is selected and the arrearage is over \$100.00, PAR will refer the receivable out on the PAR BDMO OPEN RECEIVABLES REPORT. See RCM 3.7.60 "When Collection Attempts May Be Terminated" on how to close out the open receivable. For cases where neither a payment is received, no request for reconsideration/waiver is made, or method of payment is requested and the arrearage is less than \$100.00, PAR will close out the debt and update the PAR uncollectible table 120 days after the final notice is released.

If a request for partial withholding or reconsideration is received after the call-up expires and payments have been suspended, reinstate the payments immediately. Consider partial withholding or a request for reconsideration just as if the request were received within 30 days of arrearage letter.

- C. Premium Arrearage of Less Than 6 Months - Where the premium arrearage is not substantial, payment of the amount owed within the usual grace period will not normally create undue hardship for the enrollee. Therefore, no advance offer of waiver will be given where Part B premiums are due for 5 or fewer months of coverage. The following should be entered on the ARTX screen on PARS to generate the appropriate letter: if no monthly payments are in force, enter one of the following combinations: A3/A3 or A6/A6; and, if monthly payments are in force, enter one of the following combinations: A4/A4, S4/S4 or S6/S6. See 3.12 for the additional PARS entries necessary.

After establishing a PAR record send the file to "dormant" for 30 days, unless the payee is not in current pay status (cps) or the PAR record is established for a delayed Medicare Part B enrollment. If no response has been received to the arrearage letter when the call-up expires, and the case is in cps, take action to suspend and recover the arrearage. If the monthly rate is not high enough to recover the arrearage in a lump sum, forward the file to RBD or SBD for recovery.

When there is no response to the initial notice in 30 days, for cases not in cps and the PAR Dunning Flag was coded as a "Y" PAR will release a second notice. And if no response is made to the second notice in 30 days, PAR will release a final notice. When 120 days has elapsed after release of the final notice and no payment is received, no request for reconsideration or waiver is made, or method of payment is selected and the arrearage is over \$100.00, PAR will refer the receivable out on the PAR BDMO OPEN RECEIVABLES REPORT. See RCM 3.7.60 "When Collection Attempts May Be Terminated" on how to close out the open receivable. For cases where neither a payment is received, no request for reconsideration/waiver request is made, or method of payment is requested and the arrearage is less than \$100.00 PAR will close out the debt and update the PAR uncollectible table 120 days after the final notice is released.

Although no mention of waiver should be made in the arrearage letter in these situations, if the enrollee spontaneously complains of hardship do not recover the arrearage. If payments have already been suspended, reinstate them. Develop for waiver according to section E below.

- D. Collection of Current Premiums - To prevent a premium arrearage from increasing while development is under way to establish an installment payment schedule, to determine whether payment of the arrearage can be waived or cancellation of Part B for the period of non-collection, the enrollee should pay for current coverage.

- E. Uncollected Premium Surcharges, IRMAAs, and Medicare Advantage Premium Reduction Amounts - All the types of relief described in this section - except for cancellation of Part B coverage for the months from which premiums were not collected - can also be applied in cases of individuals who should have been assessed a premium surcharge for late enrollment (or were assessed a lower surcharge than they should have paid). The surcharge total owed would have to equal 5 months' premiums at the current base rate to be considered automatically.

See RCM 3.2.108 and RCM 3.2.109 for information about the types of relief that can be applied in cases involving retroactive changes in the amount of a Part B premium because of the addition of or a change in an Income Related Monthly Adjustment Amount (IRMAA) or a change in a Medicare Advantage premium reduction.

- F. When Relief from Premium Liability Will Be Considered and Granted - Many individuals, while willing and able to pay current premiums by deduction from monthly benefits or by direct remittance, may not have the resources to pay the premium arrearage even in minimum monthly installments of \$20.00.

As explained in (B) above, if the arrearage is for 6 months or more, upon resumption of billing or premium deductions the individual will be notified about the possibility of waiver. Likewise, as explained in (C), waiver will be considered even for individuals with smaller arrearage if they request it or complain that it would be a hardship to pay the arrearage. The same criteria will be applied in determining whether waiver can be granted, regardless of whether the arrearage is 6 months or less.

Where 6 months or more of retroactive premiums are owed, only the premiums for current coverage should be deducted or billed immediately. The arrearage should not be recovered until 30 days after the enrollee has been notified of the arrearage to give him the opportunity to claim hardship.

If the beneficiary requests waiver, MS will request the FO to obtain a completed Form DR-423. Hold the file in dormant pending receipt of the completed financial statement. When the completed form is matched with the file MS will make the waiver determination.

The individual should be relieved of the obligation to pay an arrearage of premiums caused by Governmental fault if payment of the amount would deprive him of funds which are reasonably necessary for ordinary living expenses. MS will determine whether the arrearage situation meets the criteria for waiver and will so notify the enrollee. If the waiver request must be denied, advise the individual that installment payments or partial withholding are still permissible. See 3.7.

G. Cancellation of Part B/Premiums Not Collected - Cancel Part B coverage for the period during which premiums were not collected if the following requirements are met:

- the individual submits a written request to have the Part B coverage canceled during the (named) months;
- the request is filed within 30 days of the date of the notice sent to him; and
- the individual certifies that he/she has not filed, and will not file, claims for services covered by Part B during the period for which cancellation of Part B is sought.

Caution the individual who is granted Part B cancellation that if he/she erroneously states that no claims for Part B have been, or will be filed, and the opposite is true, any reimbursement received represents an overpayment that will not be waived on any grounds.

3.2.106 Delayed Deletion From State Buy-In Rolls Results In Premium Arrearage

An individual whose State buy-in coverage terminates is deemed to be individually enrolled with continuing coverage and premium liability from the month after the month in which his buy-in coverage terminates. In some cases, because of program delays, 4 or more months may elapse between the end of the buy-in coverage and initiation of premium collection.

Such individuals are not required to pay more than 3 months of premium arrearage. Most State buy-in deletions are handled mechanically, and relief is automatically given to anyone owing 4 or more months of retroactive premium (i.e., deductions or billing will be made for only three retroactive months and the current month).

When a premium arrearage of 2 or 3 months will be recovered, no special advance notice need to be sent to the beneficiary. However, if the individual spontaneously complains that he cannot afford to pay 1, 2 or 3 months retroactive premiums, it is possible to grant relief from even the 3 months' arrearage. MS will request the FO to furnish Form DR-423 to the beneficiary. "Hardship" cannot be assumed without this development, because the individual's loss of State buy-in presupposes an improvement in the beneficiary's financial status.

MS will determine whether the arrearage situation meets the criteria for waiver and will so notify the enrollee. If the waiver request must be denied, DRD will advise that installment payments and partial withholding are still permissible.

3.2.107 Delayed Deletion From State Buy-In Rolls Prejudices Termination Rights

People who wish to terminate their individual Part B coverage after State buy-in coverage ends, face the same disadvantages if delayed deletion occurs, as those beneficiaries who choose to continue coverage.

By law, the States may terminate buy-in coverage as early as 2 months prior to the month they actually report to SSA that a specific individual has been deleted from the buy-in rolls. Each month SSA furnishes RRB a tape of that month's accretion and deletion activity.

Because of administrative delays, several months may have elapsed between the date of the State's deletion and the date the individual is notified of the deletion. Such an individual would technically owe premiums for the elapsed months. The law was not intended to penalize such individuals who had no opportunity to request termination during the last month they were covered by the State. Therefore, if an individual was not advised by the State of the deletion in or before the month of deletion, equitable relief can be granted. This allows an individual's Part B coverage to end effective with the termination of buy-in coverage (thus allowing him to avoid entirely any premium liability), if all the following conditions are met:

1. The individual submits a written request to have his individual Part B coverage end effective with the end of State buy-in coverage.
2. Such request is filed within 30 days of the date of the notice informing the beneficiary that the State is no longer paying his premiums.
3. The individual certifies that he has incurred no medical services covered under Part B during the months after buy-in termination.

If an individual did receive medical service covered under Part B after the end of buy-in coverage, his individual entitlement must continue until the end of the month in which the termination request is filed (if the request is filed within 6 months of buy-in termination). No intermediate date may be selected for the termination effective date.

3.2.108 Equitable Relief for Beneficiaries Subject to IRMAA

The equitable relief provisions allow the RRB to take action to correct inequity to an individual when the beneficiary's Part B premium was calculated incorrectly. Therefore, when making retroactive adjustments to the Part B premium amount caused by the addition of or a change in an Income Related Monthly Adjustment Amount (IRMAA), equitable relief must be considered. Please note that equitable relief is based on the amount of retroactive premiums due, not the number of months for which a premium is due.

Automatic consideration of equitable relief in IRMAA cases generally means that the initial notice that premiums are due explains the options to pay by installment and to request waiver of payment of the premiums if payment would cause financial hardship. Cancellation of Part B coverage for the months from which additional premiums are due cannot be considered.

Equitable relief is applied as follows:

- Equitable relief will be automatically extended to an individual when the past due IRMAA exceeds 5 times the current standard Part B premium plus the individual's IRMAA.
- If, at the time of the IRMAA determination, the individual is no longer entitled to Part B (e.g., voluntary termination), equitable relief will be automatically extended when the past due IRMAA exceeds 5 times the current standard Part B premium.
- If IRMAA determinations are made at the same time for multiple years, equitable relief will be automatically extended when the total IRMAA (for all years) exceeds 5 times the current standard Part B premium plus the individual's IRMAA.
- If an IRMAA determination is made for a prior year and IRMAA does not apply for the current year, equitable relief will be automatically extended when the past due IRMAA exceeds 5 times the current standard Part B premium.
- If the individual loses variable SMI protection due to the imposition of IRMAA, equitable relief will be automatically extended when the total retroactive premium amount, i.e. the difference between the standard Part B premium plus the individual's IRMAA and the variable Part B premium, exceeds 5 times the current standard Part B premium plus the individual's IRMAA.

Here are examples of when equitable relief applies for beneficiaries subject to IRMAA:

Example 1 – Retroactive IRMAA Determination, No Equitable Relief: A beneficiary was entitled to Part B effective 01/2007, and paid the standard Part B premium of \$93.50 for 01/2007 through 03/2007. In April 2007, a determination is made that he is subject to an IRMAA of \$30.90. The beneficiary owes retroactive IRMAA totaling \$92.70 (3 months at \$30.90). Because the retroactive IRMAA does not exceed 5 times the standard Part B premium plus the IRMAA ($\$124.40 \times 5 = \622.00), equitable relief does not automatically apply.

Example 2 - Retroactive IRMAA Determination and Equitable Relief: A beneficiary was entitled to Part B effective 01/2008 and paid the standard Part B premium of \$98.90 for 01/2008 through 11/2008. In December 2008, a determination is made that she is subject to an IRMAA of \$84.90 beginning 01/2008. The beneficiary owes retroactive IRMAA totaling \$933.90 (\$84.90 for 01/2008 -11/2008). Since this amount exceeds 5 times the standard Part B

premium plus the IRMAA ($\$183.80 \times 5 = \919.00), equitable relief will automatically be extended.

Example 3 - Retroactive IRMAA Determination with Premium Surcharge and Equitable Relief: If the individual in Example 2 is subject to a 20 percent premium surcharge and a retroactive IRMAA determination is made in December 2008, the beneficiary would owe retroactive IRMAA totaling \$933.90 (\$84.90 per month for 01/2008 - 11/2008). Since this amount exceeds 5 times the standard SMI premium plus IRMAA ($\$183.80 \times 5 = \919), equitable relief will automatically be extended. Note that the premium surcharge is not considered in determining whether equitable relief will automatically be extended.

Example 4 - Retroactive IRMAA Determination, Variable SMI Premium and Equitable Relief: A beneficiary paid a variable SMI premium of \$64.50 for 01/2008 through 11/2008. In December 2008, a determination is made that he is subject to an IRMAA of \$84.90 beginning 01/2008. Beneficiaries who are subject to IRMAA lose variable SMI protection; therefore the beneficiary owes retroactive premiums totaling \$1312.30. This is the difference between the variable SMI premium and the standard Part B premium of \$98.90 plus the IRMAA of \$84.90 ($\$183.80 - \$64.50 = \119.30×11 months). Since this amount exceeds 5 times the standard SMI premium + IRMAA ($\$183.80 \times 5 = \919), equitable relief will automatically be extended.

Example 5 - Retroactive IRMAA Determination and Equitable Relief; Individual Not Currently Entitled to SMI: A beneficiary was entitled to Part B effective 01/2008 and voluntarily terminated coverage effective 07/2008. The standard Part B premium of \$98.90 was paid for 01/2008 through 06/2008. In August 2008, a determination is made that she is subject to an IRMAA of \$84.90 beginning 01/08. The beneficiary owes retroactive IRMAA totaling \$509.40 (\$84.90 for 01/2008 - 06/2008). Since this amount exceeds 5 times the standard Part B premium ($\$98.90 \times 5 = \494.50), equitable relief will automatically be extended.

3.2.109 Equitable Relief and Medicare Advantage Premium Reductions

The equitable relief provisions allow the RRB to take action to prevent or correct inequity to the individual when the beneficiary's Part B premium was calculated incorrectly or a dis-enrollment was not processed timely. Therefore, when making retroactive adjustments to the Part B premium amount, caused by a change in a Medicare Advantage premium reduction period or a change to the reduction amount, equitable relief must be considered. For equitable relief to apply, the total past due premium amount (premium arrearage) must be greater than 5 times the current standard Part B premium. Please note that equitable relief is based on the amount of retroactive premiums due, not the number of months for which a premium is due.

Automatic consideration of equitable relief in cases involving changes in a Medicare Advantage premium reduction generally means that the initial notice that premiums are due explains the options to pay by installment and to request waiver of payment of the premiums if payment would cause financial hardship. Cancellation of Part B coverage for the months for which additional premiums are due cannot be considered.

Here is an example of how to determine the Part B arrearage in cases involving Medicare Advantage premium reductions:

Example 1 – Failure to Disenroll Timely

The beneficiary's Part B premium rate of \$88.50 has been reduced by \$75.00 because of the beneficiary's participation in a Medicare Advantage plan that offers this reduction. Notice is received from CMS in October 2006 that shows that the person actually left the plan in February 2006. Since the 9 months of additional premiums due for 02/2006 through 10/2006 ($9 \times \$75.00$ or \$675.00) is greater than 5 times \$88.50 (\$442.50), equitable relief must be considered.

3.2.110 Special Enrollment Period & Premium Surcharge Relief

- A. Medicare Secondary Payer for the Aged - Until 1983, Medicare was usually the primary payer of benefits. Any additional insurance the individual had was the secondary or last payer of benefits, which paid some or all of the expenses Medicare did not cover.

Effective 1-83, Medicare became secondary payer for those individuals, age 65 through 69, covered under an employer group health plan (EGHP). The EGHP had to cover 20 or more employees and be based on the individual's current employment or the current employment of a spouse age 65-69.

In 1986, the upper age limit of 69 was removed and Medicare became secondary payer for all those age 65 or over who were covered under an EGHP for 20 or more employees, based on current employment of the individual or spouse of any age.

- B. Enrollment Limits and Surcharge Revised - After Medicare had become the secondary payer for the "working aged," Congress decided (in 7-84) that the enrollment period limitations and the premium surcharge for late enrollment were penalties that should not apply when Medicare was the secondary payer of benefits.

Amendments provided for a special enrollment period (SEP) effective 11-84. In addition, months effective 1-83 when Medicare was the secondary payer of benefits were to be excluded from the calculation of any Part B premium surcharge on premiums payable from 9-84 on.

In 1986, Congress decided the "working aged" who were covered under EGHPs from employers of any size, based on their own or their spouse's current employment, should not be subject to the enrollment limitations and premium surcharge requirements for the period of time in which they had the EGHP coverage.

Thus, even though Medicare was secondary payer only when the individual was covered under a plan that covered 20 or more employees, the SEP and premium surcharge relief were possible for all those covered under an EGHP of any size based on current employment.

In addition, the SEP and premium surcharge relief provisions were applied to Premium-HI under the same conditions in effect for Part B.

A "catch up" SEP beginning 8-86 and a recalculation of the premium surcharge for premiums due for 6-86 on was made available for all persons who met these new requirements but had not met the old rules.

- C. Part B May Still Be Desirable Insurance - Even though the SEP is available for the members of a small employer's (less than 20 employees) EGHP, enrollment in Part B when the individual is initially eligible is encouraged because he/she is leaving himself or herself open to medical bills for which no payment may be made by the small EGHP.

Small EGHP's may voluntarily provide full coverage when the individual becomes eligible for Part A but later reduce the level of coverage. Only a GEP enrollment would be possible under this circumstance, unless the beneficiary terminates the EGHP coverage.

Even large EGHP's may have certain coverage omissions or deductible requirements that make Part B secondary payments an attractive option.

- D. Medicare as Secondary Payer for the Disabled - Effective 1-87, Medicare became the secondary payer for the disabled "active individual" who was covered under his or her own or any family member's large group health plan (LGHP)(a plan that covers 100 or more employee). The law was amended at the same time to allow these people to take advantage of the SEP and premium surcharge relief.

Under the 1989 amendments, effective for enrollments occurring in or after 7-90, and for premiums due beginning 7-90, the provisions were expanded so the disabled individual covered under his/her own or a spouse's EGHP (based on current employment) can also have SEP and surcharge relief, even though Medicare was the primary payer for such individuals. This change made the SEP requirements for the disabled the same as for the aged. However, the disabled also continue to have an SEP based on loss of LGHP coverage as an active individual.

The SEP based on loss of LGHP coverage as an active individual is the only type of SEP available to a family member other than a spouse. In addition, it applies to all "active individuals" where there is a change of coverage from LGHP to EGHP, as described in 3.2.115.

3.2.111 Description Of Terms Used In The Special Enrollment Period And Premium Surcharge Rollback Provisions

The terms described in this section are those used with the SEP and premium surcharge rollback. They may or may not be the same as terms used for Medicare as secondary payer. However, you must use the following description of terms in determining

- if an individual is eligible for the SEP,
- when the SEP should begin, and
- whether a premium surcharge rollback will apply and for what months.

A. Definition of Terms

- Employer Group Health Plan (EGHP) - An EGHP is any plan of, or contributing to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, or the families of employees. The employer does not have to be in the United States, and the employee does not have to be working in the United States. A person working for a foreign employer, who has a plan that meets the definition in the first sentence, is covered under an EGHP for purposes of the SEP and/or premium surcharge rollback.

For Medicare secondary payer purposes, the EGHP must be available to at least 20 employees. For SEP purposes, the EGHP can be of any size. However, when referring to an EGHP for the disabled, the term refers to a plan of any size below 100 employees. See 5., below.

When used in all of the following SEP and premium surcharge rollback instructions, EGHP means specifically an employer group health plan based on the current employment of the beneficiary or the beneficiary's spouse.

- "Based on Current Employment" - "Based on current employment" means the individual - under whose plan the Medicare beneficiary is covered - must continue to be employed and not retired. When EGHP coverage extends into retirement, the date of termination of employment is the date of termination of "EGHP coverage based on current employment."

Where the individual is employed on a contract basis (e.g., a teacher) and has completed the terms of the contract before the date the contract expires,

"current employment" ends when the contract expires. If a retirement pension begins prior to the date of the expiration of the contract, the date the retirement pension begins will be when employment terminates. Also, if there is any kind of "exit process" where the individual has clearly left the ranks of the employed" prior to the contract expiration date, that earlier date will be when employment terminates.

When a determination is made for monthly benefits purposes that employment has terminated on a certain date, that date is also used as the date "current employment" has ended for EGHP coverage purposes.

- Disabled Medicare Beneficiary - A "disabled Medicare beneficiary" is a disabled worker, a disabled widow(er), or disabled adult child who is entitled to Medicare because of his or her disability, except for those who have end stage renal disease. (There is no SEP or premium rollback for those who have ESRD).
- Large Group Health Plan (LGHP) - The term "LGHP" is used exclusively with information on the disabled. An LGHP is an employer group health plan that is available to employees of one or more employers who normally employed at least 100 employees on at least 50 percent of its business days during the previous calendar year.

A multi-employer plan (such as a union plan) may cover employees of some small employers as well as employees of at least one employer that meets the 100 or more employee requirement. In such a case, all the employers - large and small- in this multi-employer plan are considered "large," and their plan coverage is considered LGHP coverage.

When used in all the following SEP and premium surcharge rollback instructions, LGHP means specifically a large group health plan covering the disability beneficiary as an active individual.

- LGHP Is No Longer a Large Plan - An LGHP is no longer considered a large plan effective January 1 of the year following the year in which the employer no longer employed 100 employees on at least 50 percent of its business days in that year. For purposes of this instructions, it is to be treated as an EGHP at that point.
- Active Individual - This term is used exclusively with information on the disabled. An active individual is an employee, an employer, a self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any of these persons.

"Employers" are individuals and organizations that are:

- engaged in a trade or business

- Organizations exempt from income tax (i.e., religious, charitable, and educational institutions), and
- the governments of the United States, the 50 States, Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Mariana Islands, and the District of Columbia, including their agencies, instrumentalities, and political subdivisions.

The employer does not have to be in the U.S., as described above.

Often, the disabled person is the "family member" of the employee, employer, or individual associated with the employer in a business relationship. This means that a disabled person who is covered under an LGHP of a spouse, parent, or any other family member is considered to be an "active individual" even though the disabled individual is not actually the worker.

- B. Basic Difference in LGHP and EGHP - LGHPs and EGHPs are both employer group health plans. The differences in their use with the SEP are shown in the following sections. In addition, there are the following basic differences.

Family members other than a spouse (e.g., a disabled adult child) can qualify for an SEP under an LGHP, but not under an EGHP.

When an LGHP becomes an EGHP because of a reduction in the number of employees, an SEP begins. This is the only situation where an SEP begins even though there is not break in employer group health plan coverage.

3.2.112 The Special Enrollment Period

The special enrollment period (SEP) is the period for enrollment in Part B that is provided for individuals eligible for Part B on the basis of age or disability, and who have been covered by an EGHP or an LGHP. Beginning 3-1-1995, the SEP lasts for 8 calendar months. The individual cannot file for an SEP enrollment before the SEP actually begins. An SEP cannot begin because a small employer EGHP offering voluntary primary coverage changes the coverage to secondary.

- A. SEP Begins - The requirements for an SEP or subsequent SEP must be met (see 3.2.113, 3.2.114 and 3.2.115). The SEP begins with the earlier of the month of termination of the employment on which the EGHP or LGHP coverage is based, or the month of termination of the EGHP or LGHP coverage.

The reason for termination of the EGHP or LGHP coverage is immaterial. Termination of coverage may be due to termination of employment, or voluntary termination by the enrollee, or loss of coverage for any other reason.

An employee may voluntarily terminate EGHP coverage to begin an SEP, but the employer is still forbidden to offer him/her a Medicare supplement plan.

An SEP begins even if EGHP coverage is terminated for as little as one calendar day. However, employers and employees should be cautioned about the difficulty of finding insurance that would permit such an arrangement.

A change in the EGHP coverage from one health plan to another, when there is no day without coverage, does not begin an SEP.

- B. No SEP Enrollment During IEP - The SEP is for those who do not enroll in Part B during the initial enrollment period (IEP). When an individual enrolls in Part B during the IEP, the enrollment must be processed as an IEP enrollment, under all circumstances. This is true even if the individual is in, for example, the 7th month of the IEP (which means that Part B coverage begins three months later) at the time he or she loses EGHP or LGHP coverage.

EXAMPLE: Warren is age 65 in July. His IEP begins with April and ends with October. He is covered under an EGHP until he retires the first of October. He enrolls in Part B in October, which is both the last month of his IEP and the first month of the SEP. Part B coverage begins with the following January under the IEP rules which take precedence. If Warren waits until November to enroll, his Part B coverage begins with December, since he is enrolling in the second month of the SEP.

- C. SEP and GEP Overlap - The individual who enrolls in an "SEP month" that occurs in January, February, or March can elect to have the enrollment processed as either a general enrollment period (GEP) enrollment or as an SEP enrollment.

If an individual chooses a GEP enrollment, the premium surcharge is calculated using the months through the end of the GEP. However, the months of EGHP or LGHP coverage are subtracted from the calculation (see 3.2.119). The file is documented to show the individual chose the GEP enrollment even though coverage would begin earlier if the enrollment had been processed as an SEP enrollment.

3.2.113 Requirements For SEP For The Aged

Effective for enrollments beginning 8-1-86, an individual age 65 or over begins an SEP as soon as he or she is no longer covered under an EGHP based on current employment, if one of the requirements shown below is met.

- A. No Previous Part B Enrollment - If the individual did not enroll in the IEP, he or she had to be covered under an EGHP based on his or her own or a spouse's current employment when first eligible for Part B.
- B. Previous Part B Entitlement - If the individual enrolled in Part B during his or her IEP, and later terminated Part B, he or she had to be covered under an EGHP

based on his or her or a spouse's current employment at the time of Part B termination.

- C. Subsequent SEP - If the individual enrolled in Part B during an SEP, and later terminated Part B, he or she had to be covered under an EGHP based on his or her or a spouse's current employment at the time of Part B termination.

There is no limit on the number of subsequent SEPs. Reenrollment may occur any number of times depending only on how often EGHP coverage is lost and regained. However, to have any subsequent SEP, the individual must have enrolled during the earlier SEPs available to him or her. Enrollment during a GEP that falls within an SEP (with a choice of the July 1 date of entitlement based on the GEP) satisfies the requirement for an "earlier SEP enrollment."

3.2.114 Requirements For SEP For Disabled Beneficiaries Covered Under An EGHP

The following requirements are to be used only for the disabled beneficiary who has most recently been covered, based on current employment, under his or her own or spouse's EGHP. The requirements do not apply to "family members" other than a spouse. Other family members can have an SEP only on the basis of LGHP coverage.

The requirements a disabled beneficiary must meet are the same as those for the aged, shown in 3.2.113. There is however, one additional time a disabled beneficiary can begin an SEP which is not available to the aged.

As noted in 3.2.114, disabled beneficiaries who go from LGHP to EGHP coverage can have an SEP. If they do not enroll in that SEP, the non-enrollment does not bar them from an SEP when the EGHP coverage ends.

The SEP for the disabled beneficiaries covered under an EGHP as described above, is effective for enrollments and reenrollments that occur during or after 7-90.

3.2.115 Requirements For SEP For Disabled Beneficiaries Covered Under An LGHP

- A. Requirements - The requirements are to be used when a disabled beneficiary is seeking an SEP and has, most recently, been covered under an LGHP as an active individual.

The references in this section to EGHP coverage can only apply when the EGHP coverage was based on the current employment of the disabled beneficiary or his or her spouse.

A disabled beneficiary begins an SEP:

- as soon as he or she is no longer covered under an LGHP as an active individual (or the LGHP no longer meets definition of a LGHP as shown in 3.2.111; that is, when the plan is no longer a "large" plan) and
- one of the requirements in 1, 2 or 3 below is met.
 1. No Previous Part B Enrollment - If the individual did not enroll in Part B during his or her IEP, he or she had to be covered when first eligible for Part B under an LGHP as an active individual (or under his or her own or a spouse's EGHP based on current employment).
 2. Previous Part B Entitlement - If the individual enrolled in Part B during his or her IEP, and later terminated Part B, he or she had to be covered under an LGHP as an active individual (or under his or her own or a spouse's EGHP based on current employment) at the time of Part B termination.
 3. Subsequent SEP - If the individual enrolled in Part B during an SEP, and later terminated Part B, he or she had to be covered under an LGHP as an active individual (or under his or her own or spouse's EGHP based on current employment) at the time of Part B termination.

There is no limit on the number of subsequent SEPs as long as the individual met the requirements and enrolled in the previous SEPs. See the instructions in 3.2.116 concerning the conditions under which an SEP is deemed not to have occurred, thus permitting an SEP even where an earlier SEP seems to have been by-passed.

These requirements are effective for enrollments and reenrollments that occur during or after 1-87. If the requirement being used involves EGHP coverage (for example, the disabled beneficiary was enrolled in a spouse's EGHP based on current employment at the time of first eligibility for Part B), the requirements are effective only for enrollments and reenrollments beginning 7-90.

- B. Change from LGHP to EGHP - Disabled beneficiaries covered under an LGHP as an active individual, as described in A. above, begin an SEP when the LGHP is reduced in size to less than 100 employees. The LGHP, for all intents and purposes, becomes an EGHP.

If they do not enroll when the LGHP becomes an EGHP, these disabled beneficiaries have another chance for an SEP when such EGHP enrollment based on current employment eventually ends, as noted in 3.2.116. This is only true if this EGHP coverage is based on their own or their spouse's current employment. It does not include disabled adult children.

EXAMPLE: Mary, a disabled beneficiary since 1987, had been covered under her working husband's LGHP, which has been primary payer of benefits, since she first became eligible for Medicare.

In May 1990, her husband's employer made no other changes except the reduction of staff to less than 100 employees for the balance of that year. Medicare would be the primary payer of benefits beginning with January 1991, Mary has an SEP beginning January 1991.

- C. Change from EGHP to LGHP - If EGHP coverage changes to LGHP coverage as an active individual, an SEP does not begin. He or she will have an SEP when no longer covered under an LGHP as an active individual (assuming the requirements above are met).

3.2.116 SEP Deemed Not To Have Occurred

- A. Full 8-Month SEP - The law provides a full 8-month SEP for an individual to enroll in Part B.

Therefore, when an SEP begins but, before the 8-months of the SEP expires, the beneficiary is once again covered under an EGHP or LGHP as described in 3.2.111, the SEP is deemed to have not occurred. This protects the individual's rights to an SEP or a subsequent SEP.

EXAMPLE: Michele, age 67, and covered under the EGHP for many years based on her own employment, retired on 7-1-02. Her SEP would run from 8-02 through 3-03. However, in 10-02, before enrolling in Part B, she begins working again and is once more covered under an EGHP. When she retires in 10-05, her SEP will begin at that time because Michele never had the advantage of a full SEP at the first opportunity.

- B. LGHP Decreases in Size - When an LGHP is no longer a "large" plan, as described in 3.2.111, an SEP begins.

However, if the disabled beneficiary has EGHP coverage as a current employee or the spouse of a current employee and does not enroll in that SEP, he or she may nevertheless have an SEP when that EGHP coverage ends. In other words, the SEP that began when the LGHP became an EGHP is deemed not to have occurred.

EXAMPLE: Felix, a disabled beneficiary, did not enroll in Part B when first eligible because he was enrolled in his wife's employer plan. His wife's employer had more than 100 employees until 4-05. Beginning 1-06, the plan is no longer an LGHP; it becomes an EGHP at that point. Although he could have enrolled in Part B during the SEP beginning 1-06, Felix did not do so.

When his wife retires 10-1-06, Felix enrolls in Part B during the SEP that begins 10-06, since he has lost EGHP coverage based on current employment. The SEP that began 1-06 is deemed not to have occurred.

If Felix were a disabled adult child covered under his working parent's LGHP, he would have had only the one SEP beginning 1-06.

3.2.117 Part B Effective Date When Enrollment Occurs During The SEP

- A. Part B Effective Date - Enrollment during the first month of the SEP results in Part B coverage effective with the first day of that month or any of the next 3 months as chosen by the beneficiary.

Enrollment during the last 7 months of the SEP results in Part B coverage effective with the first day of the month after the month of enrollment.

EXAMPLE: Edward Rote, age 65, had coverage under an EGHP from 1970 until the end of the month during which he retired - 9-05. His SEP begins with 10-05 and runs through 5-06. If he enrolls in 10-05, Part B can begin 10-1-05 or any of the 3 months after – 11-1-05, 12-1-05, or 1-1-06, as chosen by Mr. Rote. If he enrolls during the balance of the SEP, Part B begins with the month after the month of enrollment.

- B. Partial Month of EGHP or LGHP Coverage - When EGHP or LGHP coverage is lost before the end of a calendar month, that partial month of EGHP/LGHP coverage is the first month of the SEP only if the individual enrolls in Part B during that month.

If enrollment does not occur during the first partial month of EGHP/LGHP coverage, the following month is the first month of the SEP.

EXAMPLE: Barbara Dooley has been covered under an EGHP based on her own employment since 2000. She retires on 6-15-02, at age 68. Her EGHP coverage ends on that same day. If she enrolls in June, her SEP begins with June and Part B will begin 6-1-02. If she does not enroll in June, the SEP will begin with July. If she enrolls in July, Part B will begin 7-1-02. If she enrolls during August through February (the balance of the 8-month SEP), Part B begins with the month after the month of enrollment.

3.2.118 SEP Enrollment

Field Office personnel must determine if the requirements for an SEP exist before they secure the necessary application for enrollment and evidence of coverage under an EGHP or LGHP. Therefore, the field office personnel must determine the following:

- if the health plan is an EGHP or LGHP, and

- if aged, was the EGHP coverage based on the individuals or individuals spouses current employment or if disabled, was the disabled individual covered under a LGHP as an active individual?

Self-employed individuals may be entitled to an SEP. In addition to meeting other requirements, until the end of 1990, the self-employed individual must be covered by an EGHP, under which two employees in addition to himself are eligible to be covered. As of 1-1-91, only 1 employee (in addition to the self-employed person) needs to be eligible for coverage under the EGHP for SEP and premium surcharge roll back purposes. The only exception is that disabled children must be covered by an LGHP.

- A. Application Requirements - If an individual is filing an application for railroad retirement benefits at the same time he or she is enrolling for Medicare Part B during a SEP, a separate application is not required. Instead, the field office personnel should answer the appropriate Medicare-related questions on APPLE. A separate application, Form G-44b, may be developed at that time, but it is not necessary. Also acceptable is a simple, signed and dated statement on any other piece of paper such as, "I want to enroll in Medicare Part B", and include claim of EGHP coverage and the chosen Part B effective date.

Mark in red at the top of the enrollment, "SEP Enrollment."

- B. Proof of EGHP - Preferred proof of EGHP coverage is on Form RL-311-F; however, stationary from the employer or insurance company is acceptable. It must show when coverage started and exactly when it ends.

See 3.2.160J for further information on applications and proofs.

3.2.119 Effect On The Premium Surcharge For Late Enrollment For The Aged And Disabled

- A. Elimination or Reduction of the Surcharge - The surcharge is determined by counting the number of months when an individual could have been, but was not, enrolled in Part B after the initial enrollment period through the end of the enrollment period in which enrollment occurs.

When calculating the number of months during which an individual could have been, but was not, enrolled in Part B, the months of EGHP or LGHP coverage are excludable, as described below.

1. Exclusion of EGHP Months For the Aged - Effective for premiums due for 6-86 and later months, the calculation of the surcharge for late enrollment will exclude:
 - those months beginning with 1-83 (or, if later, age 65) during which the individual can demonstrate he or she was enrolled in an EGHP based on his

or her or a spouse's current employment, even if the employer did not have 20 or more employees, and

- all months of Part B entitlement.
2. Exclusion of EGHP Months for the Disabled - The policies above are followed, except the months to be considered are those beginning with 1-87 and the earliest month for which the premium rollback can be effective is 7-90.
 3. Exclusion of LGHP Months for the Disabled - Effective for premiums due for 1-87 and later months, the calculation of the surcharge for late enrollment will exclude:
 - those months beginning 1-87 during which the individual can demonstrate he or she was enrolled as an active individual in an LGHP, and
 - the months of Part B entitlement occurring as a result of an SEP enrollment.
- B. Surcharge Reduction - The premium surcharge can be reduced or eliminated under the law even if the individual cannot have an SEP for any reason and is enrolling (or had enrolled) in a GEP.

The surcharge relief may be requested by any individual who is already entitled to Part B or who is filing a GEP request for enrollment, etc. and for whom the policy described in A. and B., above, would apply.

- C. How Request For Surcharge Relief Should Be Made - Make sure the beneficiary requests exclusion of months from the determination of the surcharge on a signed request or Form G-44B. The FO should have the beneficiary mention on the request (or the FO may complete a Report of Contact) the months during which the individual had EGHP coverage based on current employment or LGHP coverage as an active individual.

Most often, this request will be part of an SEP enrollment package.

If the request for the surcharge reduction is not part of an SEP enrollment package, the Field Office should mark the request prominently at the top in red "Premium Surcharge Rollback" when forwarding it to MS. Make sure that the annotated page is on top.

Whether it is part of an SEP enrollment package or not:

- attach evidence of EGHP or LGHP coverage as in 3.2.120 and include a Report of Contact giving the months the FO personnel have determined should be excluded from the surcharge computation.

3.2.120 Evidence Of Coverage Under An EGHP Or LGHP

A. EGHP Coverage - Evidence of EGHP coverage based on current employment is required for an SEP or premium surcharge rollback. The evidence may be in any form as long as all of the following are present:

- there is no question the evidence is from the employer or from the EGHP,
- the evidence permits a finding of when the individual was covered under an EGHP based on current employment, and
- the evidence permits a finding of when coverage, based on current employment, ended (except in GEP enrollment cases where the EGHP coverage need not end to have the premium surcharge rollback).

The evidence need not indicate how large the employer is or if the EGHP is primary to Medicare.

B. LGHP Coverage - The same requirement shown above apply to the disabled beneficiary covered under an LGHP, with the following exception in cases when an individual is not working and is not the spouse of a worker, it must be determined if the individual meets the definition of "active individual" in 3.2.111.

The FO should on a Report of Contact or other statement, there should be given the following information on whether the group health plan is an LGHP, as defined in 3.2.111:

- When it is common knowledge that the group health plan meets the definition of LGHP, a Report of Contact stating that fact is all that is required as evidence that this factor is met.
- If there is a question whether the definition of LGHP is met, the beneficiary's signed statement, or the signed statement of the employer or the group health plan, relating to the definition, is acceptable. However, if there is any question as to the accuracy of the statement, development must be done to assure that the group health plan meets the definition of LGHP in 3.2.111.

When an SEP is being sought because an LGHP has become as an EGHP (employee force has dropped to less than 100), the above development is required to determine if such is the case.

C. Other Evidence - A certification from an employer's records by an authorized FO employee (e.g., a Field Representative as to the information on EGHP coverage based on current employment (or LGHP coverage as an active individual) is also acceptable.

3.2.121 Examples Of The Elimination Or Rollback Of The Premium Surcharge For The Aged And Disabled

- A. Enrollment Occurred Years Ago - John attained age 65 in 2-83 and enrolled in Part A and Part B when he retired 1-1-85. He had primary EGHP coverage all months, but his Part A entitlement could only be retroactive 6 months, to 7-84.

Concurrent Part A/EGHP coverage was required prior to the 1986 amendments for exclusion of months from the surcharge calculation, as explained in 3.2.130. Since Part A/EGHP coverage existed only for 7-84 - 12-84, he had a premium surcharge of 10 percent because 13 months elapsed after the end of his IEP to his first month of entitlement to Part A (i.e., 6-83 through 6-84).

In 10-90, John learns of the changes made by the 1986 Amendments and applies for a rollback in the premium surcharge. His SEP file already contains evidence that he was covered under an EGHP based on current employment all months from age 65 until retirement. Consequently, his premium rate is re-established at the base rate, retroactive to 6-86, and he receives a refund of the overpaid premium amount; i.e., the amount due to the 10 percent penalty.

- B. Surcharge Relief, But No SEP - Rose, a beneficiary since age 62, was automatically enrolled in Part A when she attained age 65 in 12-89. She refused Part B because she had been covered under her husband's EGHP for many years while he was still working. She thought that her husband's EGHP was primary to Medicare. However, her husband works for an employer who has only 10 employees.

When Rose learns in 10-90 that the EGHP will not pay primary benefits, she decides to enroll in Part B. She cannot have an SEP because her EGHP coverage has not ended. She enrolls in the 1991 GEP, with Part B effective 7-91. There is no premium surcharge assessed for late enrollment because she submits evidence that she has been covered under an EGHP all months from age 65 on.

- C. Disabled Individual With LGHP - Ken Kahn has been entitled to Medicare as a disabled beneficiary since 5-84. He refused enrollment in Part B because he was assured of coverage under his working wife's LGHP. Mrs. Kahn works for an employer of 100 or more employees. On 8-11-88, Mrs. Kahn Retires.

Mr. Kahn inquires in 9-88 about enrolling in Part B. Since he was enrolled as an "active individual" (i.e., the "family member" of an "employee") in an LGHP when he was first eligible for Part B, but is no longer so enrolled upon his wife's retirement, he meets the requirements for an SEP. Since 9-88 is the first month of the SEP, his Part B begins with 9-1-88. (If Mr. Kahn had filed in 8-88, 8-88 would have been the first month of the SEP.)

He has to pay a premium surcharge for late enrollment because only the months from 1-87 through 8-88 are excludable. The computation of the surcharge includes the months from 9-84 (the first month after the end of the disability IEP) through 12-86, a total of 28 months, resulting in a 20 percent surcharge for late enrollment. (As in all cases of disabled Medicare beneficiaries, the surcharge is eliminated when he is entitled to Medicare at age 65 because he has a new IEP based on conversion to retirement benefits.

- D. Disabled Individual With EGHP - Same situation as example C, but Mrs. Kahn's employer always had less than 100 employees, and the EGHP was not a multi-employer plan encompassing at least one employer who had at least 100 employees (i.e., does not meet the definition of LGHP). Mr. Kahn had to wait until the 1989 GEP to enroll in Part B, with coverage effective 7-89, and a surcharge of 40 percent, based on the 55 countable months from 9-84 through 3-89.

The law did not permit either an SEP or premium surcharge rollback based on EGHP coverage of the disabled in 1988, when his wife retired.

However, if Mr. Kahn inquires at any time after the law's change in 12-89, his premium effective 7-90 will be refigured to exclude the months from 1-87 through 8-88 from the premium surcharge calculation. Therefore, as of 7-90, his premium surcharge for late enrollment would be reduced from 40 percent to 20 percent.

- E. Disabled Adult Child (DAC) Under LGHP - Lenny Backman, born 3-12-45, is a DAC entitled to Medicare since 3-75, based on the account of his deceased mother. He had been enrolled in Part B from 3-75 through 12-80 when his enrollment was voluntarily terminated.

From 1-81 through 8-87, when his father retired, he had coverage under his father's LGHP. His father had his own business with 185 employees. Since Lenny was enrolled in Part B when first eligible and terminated Part B when covered under and "LGHP" as an "active individual" (family member of a self-employed individual who had more than 100 employees), he may have an SEP that runs from 9-87 through 3-88. Assuming that he enrolls in 10-87, his Part B will begin 11-87.

Lenny's premium surcharge is established at 60 percent, counting the months of 1-81 through 12-86, plus 9-87 and 10-87 (a total of 74 months).

- F. Decreased in Employees Disability - Tim Pagnozzi was covered under his working wife's LGHP when he became entitled to Part A (and refused Part B) effective 1-86. From 1986 through 1990, his wife's employer had more than 100 employees all year. Therefore, from 1987 through 1991, Medicare was secondary payer of benefits.

In 1991, the workforce dropped to less than 100 throughout most of the year. In 5-92, Mr. Pagnozzi files for Part B during the SEP that began 1-92, the first

month for which Medicare would be the primary payer of benefits. Part B begins 6-92.

The premium surcharge for late enrollment excludes the months 1-87 through 12-91 when Medicare was the secondary payer of benefits because of coverage in the previous year as an active individual under an LGHP.

The months 5-86 through 12-86 (8 months) have to be included in calculating the surcharge because they occurred after the end of his IEP and prior to 1-87, the effective month of the provision.

In addition, the months 1-92 through 5-92 are included in the calculation of the surcharge because they are months during the SEP when Mr. Pagnozzi was not yet entitled to Part B.

This is a total of 13 months and results in a 10 percent surcharge for late enrollment.

3.2.122 SEP Would Begin After Application Is Filed

The law requires that an enrollment in Part B be filed only during an enrollment period.

The law is silent on when evidence of termination of employment or EGHP/LGHP coverage may be accepted. Thus, such evidence may be accepted in advance of the beginning of the SEP.

The individual who is covered by an EGHP/LGHP when he or she files for monthly benefits and Part A, but will shortly terminate employment, has the option of refusing Part B at that time and enrolling in Part B when the SEP begins. However, see 3.2.112 as a precaution when discussing delays in enrollment, if there is any chance that employment will end during the IEP. That section explains that there can be no SEP enrollment until after the IEP ends.

- A. Filing Before the SEP Begins - If the individual files for Part A and Part B after the IEP, alleging future termination of EGHP coverage (e.g., because of retirement), take a Part B application for processing as an SEP enrollment.

Although the SEP does not begin until the month the individual is no longer covered under the EGHP, the individual can still enroll for Medicare Part B under the SEP provisions while still employed. If an individual enrolls in Part B while still covered under GHP/LGHP or during the first full month when not enrolled in GHP/LGHP based on current employment status, the individual has the option of choosing an effective date for Medicare Part B. He or she may elect to have Part B effective either the first day of the first month of his or her enrollment or the first day of any of the following three months.

If the individual enrolls in Medicare Part B during any of the seven remaining months of the SEP, coverage begins with the first day of the month after the month of enrollment.

Examples of How Medicare Part B Effective Date is Determined

If an individual's last day of coverage under a GHP/LGHP based on current employment status is March 13, 2005, the following applies:

1. If the individual files for Part B in February 2005, he or she can elect coverage beginning February 1, March 1, April 1, or May 1.
2. If the individual files for Part B in March 2005, he or she can elect coverage beginning March 1, April 1, May 1, or June 1.
3. If the individual files for Part B in April 2005, he or she can elect coverage beginning April 1, May 1, June 1, or July 1.
4. If the individual files for Part B at any time during the period of May 1 through November 30, 2005, i.e. the remaining seven months of the SEP, the Part B coverage becomes effective the first day of the month after the month of enrollment.

Because of folderless processing in MS, the FO should make sure this evidence accompanies the SEP enrollment request when it goes to the MS, especially the requested beginning date of Part B.

- B. Effect of Automatic Enrollment - If an application is filed in a current GEP, or is processed as a "deemed filing" in the next GEP, any applicable premium surcharge is assessed based on a GEP enrollment. However, the documented months of coverage under the EGHP/LGHP are excluded from the surcharge calculation, as described in 3.2.119. The Part B enrollment is handled as if there will be no SEP involvement. This means Part B entitlement is effective with July 1 following the GEP.
- C. GEP Enrollment Followed by SEP Enrollment - Whether the application is filed in a current GEP, or is processed as a "deemed filing" in the next GEP, any applicable premium surcharge is assessed based on a GEP enrollment. However, the documented months of coverage under the EGHP/LGHP are excluded from the surcharge calculation. The Part B enrollment is handled as if there will be no SEP involvement. This means Part B entitlement is effective with July 1 following the GEP.

However, when the SEP enrollment and evidence (if not previously submitted) is eventually received after the SEP begins, the Part B determination is amended. Part B will begin under the SEP rules on when coverage begins, and the premium surcharge (if any) is adjusted as necessary.

3.2.123 Self - Employment And The SEP

- A. Treat Self-Employed Like Employees - All requirements and rights to an SEP and premium surcharge rollback that apply to employees apply also to the self-employed.
- B. Spouse Is Covered Under EGHP or LGHP - If the spouses of the self-employed individual's employees are eligible to be covered under the EGHP or LGHP, the self-employed individual's spouse is also eligible for coverage under the EGHP or LGHP.
- C. Number of Employees for SEP-EGHP - Until the end of 1990, the self-employed person seeking an SEP had to be covered by a group health plan under which at least 2 employees were eligible for coverage. As of 1-1-91, only 1 employee (in addition to the self-employed person) needs to be eligible for coverage under the EGHP for SEP and premium surcharge roll back purposes.
- D. Effective Date for Change in Number of Employees - The change in policy in C, above is effective for enrollments in 1-91 and later months. Months of such EGHP coverage beginning with 6-86 may, however, be excluded from the calculation of the premium surcharge for late enrollment for the aged or, effective with 1-87, for the disabled.

There is no need to search for cases that may be affected by this change in the number of employees. However, any premium surcharge cases that come to your attention which would be affected by the change in policy are to be processed.

Where the prior request for an SEP was denied because the self-employed individual had only one employee eligible for EGHP coverage, it may be reopened, if the individual wants it to be reopened and it would benefit him or her.

- E. Number of Employees for SEP - LGHP - The provisions relating to an SEP for the self-employed based on LGHP coverage require that the employer plan be available to 100 or more employees (in addition to the self-employed individual). Alternatively, the self-employed individual and his employees may be under a multiemployer group health plan that is available to employees of at least one employer group health plan that is available to employees of at least one employer who has 100 or more employees. (The law does not require that 100 or more individuals be enrolled in the plan, only that the plan cover employees of at least one employer that meets the 100-employee requirement.)

A disabled beneficiary may be either the self-employed individual (e.g., under a trial work period) or the "family member" of a self-employed individual and covered under the LGHP (if the family members of employees are offered the opportunity for such coverage).

- F. Insurance from Association, Lodge, Etc - The self-employed individual may also be covered under health insurance offered by a professional association, lodge, fraternal organization, etc. For example, an attorney may be under a plan sponsored by the local Bar Association.

If there is:

- one employee of the association, lodge, or organization, or
- one employee of a self-employed member of the association, lodge, or organization, who is eligible for coverage under the same plan as the self-employed individuals are covered, that plan is considered an EGHP (or LGHP, if there are 100 or more such employees).

Thus, the self-employed individual (and spouse, if the employees' spouses are also eligible under the same EGHP/LGHP) has health insurance coverage that meets the definition of EGHP/LGHP coverage.

If the association plan for the self-employed members is not available to any employees, that plan is not an EGHP or LGHP. The self-employed member is not eligible for an SEP based on the health insurance coverage from such a plan.

Obtain evidence of EGHP or LGHP coverage from the EGHP or LGHP when the claimant is the employer. Include the name of the self-employed individual's company, if needed for the group health plan to identify the firm.

For premium surcharge rollback requests received from an aged individual at any time:

- Premiums for months prior to 6-86:

Apply the rules in 3.2.130 if the self-employed individual was covered under an EGHP under which 20 or more employees were covered in addition to the self-employed person;

- Premiums for months after 5-86:

Apply the rules in 3.2.119, if the self-employed individual was covered under an EGHP under which at least 1 employee was eligible to be covered in addition to the self-employed person.

For premium surcharge rollback requests received at any time:

- Apply the rules in 3.2.114 for the disabled self-employed individual for months of coverage under an EGHP.
- Apply the rules in 3.2.115 for the disabled self-employed individual for months of coverage under an LGHP.

3.2.124 SEP And Premium Surcharge Rollback For Those Who Are ELIGIBLE For Premium-HI

The SEP and premium surcharge rollback provisions apply to Premium-HI in the same way as they apply to Part B.

The Premium-HI surcharge for late enrollment is limited by law to 10 percent no matter how late the individual enrolls in the program. Excluding months of EGHP or LGHP coverage will either remove the surcharge completely or limit the period of time during which a 10 percent surcharge must be paid.

EXAMPLE: Helen was born 3-21-22. She was covered under her husband's EGHP until he retired on 5-31-91 at age 61. She never worked, but she meets the requirements for Part B and Premium-HI.

Helen's SEP begins with 6-91 and she filed in 9-91. She is awarded Premium-HI and Part B effective with 10-91 (the month after enrollment). Her premiums for Premium-HI and Part B are not increased for late enrollment as the only months after age 65 when she was not covered under an EGHP (according to the evidence she submitted), and was not enrolled in Premium-HI and Part B, were 6-91 through 9-91.

3.2.125 "Sunset Provision" For The Disability Provisions

- A. Sunset Provision - The law contains a "sunset provision" for Medicare secondary payer, SEP, and premium surcharge limits for disabled beneficiaries. The date for the end of these provisions were originally 12-31-91, but has been changed by subsequent legislation to 9-30-95.

Therefore, as of 10-1-95, Medicare will be the primary payer of benefits for the disabled even if the disabled individual still has LGHP coverage. Since the provisions on Medicare as a secondary payer for the disabled person will expire then, the beneficiary will be able to meet the definitions in 3.2.111 after 9-30-95, as they will officially, no longer exist in the law.

- B. Last SEP - The last SEP based on LGHP coverage for all disabled Medicare beneficiaries who meet the requirements for an SEP in 3.2.115 will begin with 10-1-95 and end on 4-30-96. These are the 7 months after the last month that the law formally recognizes there is such a thing as "LGHP" coverage.
- C. Beneficiary Should Inquire in 1995 - The disabled Medicare beneficiary must understand that, if not entitled or re-entitled to Part B prior to 10-1-95, he or she should inquire as soon after 9-30-95 as possible to ensure that his or her rights under the law are protected.

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- C. Beneficiary Should Inquire in 1995 - The disabled Medicare beneficiary must understand that, if not entitled or re-entitled to Part B prior to 10-1-95, he or she should inquire as soon after 9-30-95 as possible to ensure that his or her rights under the law are protected.

3.2.127 Value Of Part B Coverage As A Supplement To An LGHP Or EGHP

- A. Background - Part B may be a valuable supplement to EGHP or LGHP coverage if health care expenses are high, or the plan coverage is poor.

Where Medicare is the primary payer because the plan is small, Part B coverage would often be a necessity.

In November 1991, however, certain open enrollment guarantees were legislated for those age 65 or over who purchase Medigap policies (insurance that helps to pay for expenses that Medicare does not cover). The open enrollment guarantees relate mainly to the availability and cost of Medigap policies.

The Medigap open enrollment period begins with the first month of entitlement to Part B on or after age 65 and continues for a total of 6 months.

In order to take advantage of these guarantees, the individual would purchase Medigap insurance within the open enrollment period. However, because of certain anti-duplication provision in current law, EGHP coverage (from any size employer) may prevent an individual from exercising his/her right to the guarantees. Once the open enrollment period has passed, the guarantees would be forfeited.

- B. Procedures - The FO should explain that there are certain Medigap open enrollment guarantees that apply to individuals if the individual enrolls in Medigap insurance within 6 months of the month of entitlement to Part B.

Do not try to explain the guarantees in other than the general terms used above. Tell the individual to secure a copy of the publication "Guide to Health Insurance for People with Medicare."

Also, refer the individual to the Local Office on Aging or to the State Insurance Commissioner for details on the Medigap guarantees and the effect of the provisions on his/her particular circumstances.

Document the file of any individual, age 65 or over, who elects Part B while covered under an EGHP. This is to show that he/she was told of the existence of Medigap open enrollment guarantees and was referred to the Office on Aging or the State Insurance Commissioner.

3.2.128 Policy Issues Arising From SEP Or Premium Surcharge Rollback Provisions

This section explains various policy issues that have arisen in the taking and processing of claims for the SEP and surcharge reduction.

- A. When Does SEP Begin for Those Who Are Covered Under Their Own and a Spouse's EGHP? - When coverage under two EGHPs (or LGHPs, or a combination of EGHP and LGHP) is involved, the SEP begins when the individual is no longer covered under any group health plan based on current employment (or an active individual).

For example, a man with EGHP coverage from his own employment retires. He retains EGHP coverage under his working wife's EGHP. His SEP does not begin until the earlier of his wife's retirement or termination of his coverage under he EGHP.

- B. Which SEP Rules Apply Where an Aged Person Is Covered Under a Disabled Spouse's LGHP? - An aged person who wants an SEP must meet the rules for the aged, even if he/she is covered under an LGHP of a disabled spouse who is, for example, working during a trial work period.

The aged person's SEP begins when he/she is no longer covered under an EGHP based on current employment. In this particular case, the LGHP would be considered an EGHP.

- C. Is the Surcharge Reduction Applicable Only When the Person Is Filing in an SEP? - No matter when an individual enrolls, in a GEP or in an SEP, the months as shown in 3.2.119 are excluded in determining the premium surcharge. In the case of a GEP enrollment while still employed, the evidence required to show the

months of EGHP coverage would not need to indicate an ending date for EGHP coverage. Be sure to show that retirement has not occurred to avoid redevelopment requests for retirement date.

D. If a Person Is Paid for Some Months After He/She Retires, When Does SEP Begin?

1. When pay received after retirement is attributed to the last month of employment for social security benefit purposes, that month is also the last month of "current employment" for SEP purposes. The SEP begins just as if no later payments were going to be received.
2. Disability payments, subject to FICA taxes, continue the duration of employment for up to 6 months.

E. Is a Former Employee Under "an EGHP Based on Current Employment" if He Has a Retirement EGHP but Has Been Rehired? - An employer group health plan based on former employment becomes an EGHP based on current employment when the individual is rehired by the former employer who is furnishing the retirement EGHP. In such a case, the coverage under the EGHP is attributed to current employment. This is true even if the payment for the EGHP coverage is being deducted from a pension or annuity payment.

If employed by an employer other than the one providing the group health plan coverage, however, the EGHP is a retirement plan and is not based on current employment.

F. If EGHP or LGHP Coverage Ends but Employment or Active Individual Status Continues, Does an SEP Begin? - An SEP begins when EGHP (or LGHP) coverage is terminated, even if the employment (or active individual status) on which it is based continues. This is true regardless of the cause of termination of the group health plan coverage, and whether or not the individual initiated the termination.

G. Are Clergy and Members of Religious Orders "Employee?" - If members of the clergy are covered for social security purposes as employed or self-employed individuals, they are employees for purposes of these provisions.

Those members of religious orders who have taken a vow of poverty are employees for purposes of the special enrollment period and premium rollback provisions as long as they are actively engaged in work for their Orders. This is true whether or not they are reported as employees by their respective Orders pursuant to an election by the Order under section 3121(r) of the Internal Revenue Code.

- H. What Is the Status of a Divorced Spouse? - If a divorced spouse is covered under the EGHP/LGHP of the former spouse, the divorced spouse is considered to be a "spouse" for purposes of these provisions.
- I. What About Furloughs or Lay-Offs? - In case where the employee is furloughed or laid off, a question arises as to whether the SEP begins with the first month of unemployment due to the furlough or lay-off. In such a case, the employer plan or the employer must be contacted and asked if, during these temporary non-work periods, enrollment in the EGHP/LGHP continues. The statement of the EGHP/LGHP (or employer) is accepted.
- J. Can Plan Coverage Remain Primary After Employment Ends? - EGHP coverage can remain primary only through the last day of employment, or (at the employer's or the plan's choice) through the end of the month during which employment ends. In no case, can it be primary later than that. LGHP coverage is primary as long as the disabled beneficiary meets the definition of "active individual," and is under age 65.
- K. Is TRICARE an EGHP? – TRICARE, formerly known as CHAMPUS, the Civilian Health and Medical Plan of the Uniformed Services, is an EGHP. However, only if the current coverage is based on an active duty military status, can loss of TRICARE result in an SEP.

For example, if a wife is covered under TRICARE based on her husband's current military service, TRICARE is an EGHP and she can have an SEP based on loss of TRICARE or termination of her husband's active duty status. If the wife is covered under TRICARE based on her husband's past military service (which is the most common case for the aged), loss of TRICARE does not begin an SEP.

- L. Does an SEP Begin If the One Who Is the Worker Dies? - The death of the worker begins the SEP for the surviving spouse (or family member, if disabled and an LGHP is involved). This is true if the survivor was covered under the worker's EGHP or LGHP at the time of the worker's death.

However, the SEP will not begin if the survivor is also covered under an EGHP based on his or her own current employment, or under an LGHP as an "active individual."

- M. Does an SEP Begin When an EGHP No Longer Covers 20 Employees? - An SEP does not begin because an EGHP no longer covers an employer who has "20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding year." The fact that the EGHP coverage is secondary because of the drop in the number of employees does not begin an SEP.

However, the drop in employees to less than 100 for an LGHP for the disabled does begin an SEP.

- N. Are Federal Judges Who Attain "Senior Status" Retired for SEP Purposes? - Yes, senior Federal judges are retired judges of the U.S. court system and the Tax Court. Whether or not they continue to adjudicate cases, they are entitled to full salary as a retirement benefit. They are not considered employees for Medicare secondary payer purposes or for SEP purposes.
- O. Are Domestic (or Life) Partners Considered Spouses for SEP Purposes? – No, beneficiaries age 65 or older or under age 65 and covered under a GHP based on the current employment status of a domestic (or life) partner are not spouses for SEP purposes and premium surcharge rollback purposes. However, under the equitable relief provisions, these beneficiaries are permitted to enroll in Part B as if the SEP provisions still apply. Grant equitable relief to the following individuals who:
- Refused Medicare Part B and whose initial enrollment period (IEP) begins 12/2004 or earlier; or
 - Enrolled in Medicare Part B during the IEP and voluntarily terminated coverage prior to 12/2004.

In addition, the individual must submit evidence of GHP coverage based on current employment of the domestic (or life) partner. The individual may enroll in Medicare Part B during any month in which he/she has coverage under a GHP based on current employment. The individual may also enroll in Medicare Part B during the 8-month period that begins with the first full month after the GHP coverage based on current employment ends. Coverage begins with either:

- the first day of the first month of Part B enrollment, or
- the individual's choice between the first day of any of the following three months after the first month of Part B enrollment.

If the individual enrolls in Part B during any of the remaining seven months of the SEP, coverage begins with the first day of the month after the month of enrollment.

Example: The employee attained age 65 in November 2004. He refused Part B coverage because he was covered under his domestic (or life) partner's group health plan (GHP). His partner, Mr. Smith, is working and the GHP includes domestic partner within the definition of spouse. In October 2011, the employee contacts a field office about enrolling in Part B because his partner is retiring January 1, 2012. Since a domestic partner, age 65 or older, cannot be recognized as a spouse, the SEP provisions no longer apply. However, under the equitable relief provisions, the employee may enroll in SMI during any month

in which he has coverage under the GHP based on current employment or during the 8-month period that begins with the first full month after the GHP coverage based on current employment ends.

3.2.129 SEP And Premium Surcharge Provisions For The Aged Prior To The 1986 Amendments

- A. Background - Effective with 1-83, Medicare became secondary payer of benefits for certain aged individuals who were covered under employer group health plans (EGHPs) by reason of current employment.

The persons affected were those who were aged 65 or over but not yet age 70, and were covered, by reason of current employment, under their own EGHP or the EGHP of a spouse who was age 65 or over but not yet age 70. The EGHP had to cover at least 20 employees.

Individuals affected by this provision enrolled in Part B even though they were collecting little or no benefits because of the premium penalties and delays in starting coverage that had to be applied in all cases of enrollment after first eligibility. Section 2338 of P.L. 98-369 was enacted 7-18-84 to alleviate this hardship.

3.2.130 SEP And Premium Requirements In Effect Prior To 8-86

- A. SEP Requirements When Part B Not Elected in IEP - Under Section 2338 of P.L. 98-369, the individual described in 3.2.129 was eligible for one SEP if he/she:
- was covered by an EGHP based on current employment when first eligible for Part B; and
 - was covered by Part A and an EGHP during one or more months after being first eligible for Part B.
- B. SEP Requirements When Part B Was Elected in IEP - The individual described in 3.2.129 was eligible for more than one SEP if he/she:
- Enrolled in Part B during the IEP, but later terminated Part B when covered under an EGHP based on current employment;
 - Was covered by an EGHP based on current employment during each month after the IEP during when he/she did not have Part B; and
 - Was covered by both Part B and EGHP during one or more months after Part B had been terminated.

If this individual enrolled in Part B during the SEP and later terminated Part B when again covered under an EGHP based on current employment, he/she could have another SEP when EGHP coverage was lost.

This situation could occur any number of time depending only on how often EGHP coverage based on current employment was lost and regained. However, to have the subsequent SEPs, the individual must have enrolled during the earlier SEPs.

- C. When SEP Began - The individual who met the requirements in above, had a 7-month SEP that began with whichever of the following resulted in earlier coverage:
- The month in which the individual was no longer covered by an EGHP by reason of current employment; or
 - The third month prior to the month of attainment of age 70 (under the original amendments, Medicare became primary at age 70 even if the individual continued to work).

No SEP could begin prior to 11-84. However, if an individual met the SEP requirements between 1-83 and 11-84, he/she began a special 7-month SEP as of 11-84.

- D. When Part B Began - If age 70 was not involved, enrollment during the first month of the SEP resulted in Part B coverage effective with the day of that month. Enrollment during the balance of the SEP resulted in Part B effective with the first day of the month after the month of enrollment.

If age 70 was involved, enrollment during the 3 months prior to the month of attainment of age 70 resulted in Part B coverage effective with the first day of the month of attainment of age 70. Enrollment in the last 4 months of that SEP resulted in Part B effective with the month after the month of enrollment.

- E. Premium Surcharge Rollback - Only months when the individual was covered under both Part A and an EGHP based on current employment were excludable in determining the premium surcharge for late enrollment. No months prior to 1-83 could be excluded in determining the surcharge. This provision was effective for premiums beginning with 9-84.

3.2.131 SEP and International Volunteers

Section 5115 of the Deficit Reduction Act of 2005, provides a 6-month SEP beginning January 1, 2007, for Medicare Part B and Premium Part A for an individual who is:

- serving as a volunteer outside of the United States through a program that is sponsored by a tax-exempt organization; and

- has (or had) health insurance that provided coverage to the individual while he/she was outside of the U.S. for the duration of the volunteer service.

EXCEPTION: Individuals who are entitled to Premium HI under the Premium HI for the Working Disabled provision are not eligible to enroll during the SEP for International Volunteers.

Under the SEP provision for international volunteers, qualifying volunteers can delay enrollment in Part B and Premium Part A, or terminate such coverage for the period of service outside of the U.S. and later re-enroll without incurring a premium surcharge for either late enrollment or re-enrollment. This section explains the necessary requirements for the SEP for Medicare Part B for international volunteers. Refer to FOMI 810.25.5 for additional information.

A. Evidence Requirements

Evidence of volunteer service, tax-exempt status of the sponsoring organization, and health insurance coverage outside of the U.S. is required for eligibility under the SEP provision for international volunteers and premium surcharge relief. **The evidence is gathered by the field offices and may be in any form as long as there is no question that the evidence is from the sponsoring organization, the health insurance plan, and all of the required information is present.** If evidence is obtained via telephone calls, field office personnel should record the information on the Contact Log.

- Evidence of Volunteer Service and Tax-Exempt Status of the Sponsoring Organization – The evidence must show that the individual served as a volunteer outside the U.S. through a program sponsored by a tax-exempt organization as defined in subsection B below.
- Evidence of Health Insurance Coverage Outside of the United States – The evidence must show that the individual had health insurance that provided coverage for the individual outside of the U.S. for the duration of the volunteer service.

See FOMI 810.25.5 on the evidence-gathering process performed by the field offices and the types of information that must be requested from and furnished by the individual. It is up to the individual to obtain the information from the necessary parties.

B. Definition of Sponsoring Organization

A sponsoring organization may be a social, religious, educational, scientific, and/or charitable organization as described in section 501(a) and (c)(3) of the Internal Revenue Code of 1986. The sponsoring organization can be a corporation, any community chest fund, or a foundation organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary or

educational purposes, or to foster national or international amateur sports competition. Organizations for the prevention of cruelty to children or animals are also acceptable.

C. General Eligibility Requirements

An individual is eligible to enroll during the SEP if he/she meets the requirements discussed above and one of the following requirements:

1. No previous Part B or Premium Part A enrollment – If the individual did not enroll during his/her initial enrollment period (IEP), he/she had to meet the requirements as an international volunteer in the first month of eligibility for Part B and all months thereafter. (The first month of eligibility for Part B is the fourth month of the IEP).
2. Previous Part B or Premium Part A entitlement – If the individual enrolled during his/her IEP and later terminated coverage, he/she had to meet the requirements as an international volunteer in the month of the Part B termination and all months thereafter. If the individual previously enrolled during the general enrollment period (GEP), he/she must have enrolled in Part B or met the requirements as an international volunteer in the first month of eligibility.

D. Effective Date of the SEP for International Volunteers

The SEP for international volunteers is effective January 1, 2007. Premium surcharge relief only applies to months of international volunteer service beginning January 1, 2007. An individual who meets the evidence and eligibility requirements for an international volunteer effective July 1, 2006 or later is eligible to enroll in Part B during the SEP. If the last month of the volunteer service was July 2006, then January 2007 is the last month of the SEP. If the last month of volunteer service was August 2006, then February 2007 is the last month of the SEP and so on.

E. When Enrollment for Volunteers Can Occur

The SEP for volunteers is the 6-month period that begins the earlier of the first day of the month following the month for which the:

- individual was no longer serving as a volunteer outside of the U.S;
- organization no longer has tax exempt status; or
- individual no longer has health insurance that provides coverage outside of the U.S.

NOTE: Enrollment in Part B may not occur prior to the end of the IEP.

F. Effective Date of Part B Coverage for International Volunteers

Part B coverage is effective the first day of the month following the month of Part B enrollment.

G. Processing Requests for Part B Termination for International Volunteers

Field Office Actions – If a beneficiary has current Part B coverage and requests termination of Part B because he/she will be serving as a volunteer outside the U.S., the field office will advise the individual of the eligibility requirements that must be met in order to re-enroll during the SEP for International Volunteers, once the beneficiary returns to the United States.

The Part B termination date is the last day of the following month after the termination request was received. The field office will tell the beneficiary the date Part B coverage ends and that the volunteer service outside the U.S. must begin the month Part B coverage ends or earlier.

In addition, the field office will notate the Contact Log and image the termination request to the Medicare Section (MS) enrollment inbox for processing by indicating, “Beneficiary Eligible for SEP for International Volunteers” as the reason for the termination request.

MS Actions – The MS examiner will process the Part B termination request, send an RL-336 letter to the beneficiary, and notate on USTAR, “Beneficiary eligible for SEP for International Volunteers” as the reason for the termination request.

H. Processing SEP Enrollments for International Volunteers

Field Office Actions – All Part B enrollment requests from international volunteers will be handled by the field offices upon the volunteers’ return to the United States. The field office will forward the SEP enrollment package containing the Part B enrollment request (evidence of volunteer service, tax-exempt status of the sponsoring organization, and health insurance coverage outside the U.S.) to the MS via Imaging.

1. Individual Entitled to Part A

- If the beneficiary already has Part A, use form G-44B for Part B enrollment. A signed and dated statement such as, “I wish to enroll in Medicare Part B” is also acceptable.
- Annotate “SEP for INT’L VOLUNTEERS” at the top of the enrollment request.

- Image the enrollment request and the evidence to the MS enrollment inbox.
2. Individual Filing for Monthly Benefits and/or Part A and Part B
 - If the individual files for monthly benefits and/or Medicare Part A and Part B after the end of his IEP, a G-44B is not required. However, follow the rest of the procedure listed in RCM 3.2.131 subsection H1 for the Part B enrollment request.
 3. Individual Filing for Medicare Only – Part A and Part B
 - If the individual is filing for Medicare only, prepare the appropriate application (AA-6 for employees, AA-7 for spouses/divorced spouses, and AA-8 for widow(er)s, surviving divorced spouses and remarried widow(er)s in accordance with current procedure.
 - Image the application and the evidence for the necessary actions by the MS to process the enrollment.

MS Actions – There is no time limit for requesting premium surcharge relief. An individual who is already entitled to Part B and meets the international volunteer requirements, may request relief from the premium surcharge (penalty premium rate) at any time.

After checking for all necessary evidence, MS will exclude the months that the individual had Part B entitlement when calculating the penalty rate. For premiums due January 2007 and later, exclude all months the individual was serving as a volunteer outside of the United States for a tax-exempt organization and had health insurance that provided coverage while he/she was outside of the United States.

NOTE: Beneficiaries eligible for Part B and Premium HI under the Premium-HI for the Working Disabled provision are not eligible to enroll during the SEP for International Volunteers.

I. GEP and Premium Surcharge Relief for International Volunteers

Since there is no time limit for requesting premium surcharge relief, an individual who is already entitled to Part B, or who is filing a GEP enrollment and meets the International Volunteer requirements, may request relief from the premium surcharge (penalty rate) at any time.

- If the individual is enrolling in Part B during the GEP, the field office will forward the enrollment request via imaging to the MS for processing. The field

office should notate “Premium Surcharge Relief – INT’L VOLUNTEERS” on the request. Include all necessary evidence as discussed in RCM 3.2.131A.

- If the individual is already enrolled in Part B and is requesting premium surcharge relief, the field office should notate “Premium Surcharge Relief-INT’L VOLUNTEERS” on the request. The field office should include all necessary evidence discussed in RCM 3.2.131A and send all to the MS via Imaging to re-calculate the penalty rate.

3.2.132 References

Sections 1877(i) and 1839(b) of the SS Act and SSA's Regulations 42CFR 406.21, 406.23, 407.20, 407.25 and 408.24 and Section 5115 of the Deficit Reduction Act of 2005 are references for the above procedure.

3.2.140 Reconsideration

Every applicant or beneficiary has a right to request reconsideration of a decision by someone other than the person who made the initial decision.

The applicant/beneficiary must be advised of his right to reconsideration (use AB-25 back) in the following situations:

- Initial determination of Part A and/or Part B effective dates,
- Change in Part A and/or Part B effective dates,
- Denial of Application for Part A and/or Part B,
- Award of Canadian Part A payment, and
- Termination of Part A and/or Part B coverage (exceptions: death and voluntary terminations).

NOTE: If Part B is canceled after the 3rd month of the IEP because beneficiary does not want Part B and claims he never received a G-41, reconsideration rights should be given with the notice of termination.

If a Medicare ID card (exception: duplicate cards) is released manually, prepare a letter with AB-25 back showing date(s) of Part A and/or Part B entitlement (see Exhibit 3), unless the ID card will be released with an option letter which includes information about reconsideration rights.

If a Medicare ID card is released mechanically (includes cards generated by MEDCOR activities) for initial Part A and/or Part B entitlement or for a change in Part A and/or Part B entitlement, examiners do **not** prepare a Part A and/or Part B entitlement notice with reconsideration rights.

3.2.141 Reconsideration Requests

The applicant/ beneficiary must submit a written request for reconsideration within 60 days after the date of the initial decision notice. The request need not specifically refer to "reconsideration" but it should clearly express the beneficiary's desire for further action.

Assessment and Training (A&T) - Recon Section will prepare the reconsideration decision. Refer to RCM 6.1 for instructions on examiner handling of reconsideration requests.

After the reconsideration notice is released, send the case to claim files. H&A will handle the case if the applicant/beneficiary appeals the reconsideration decision.

3.2.150 Termination Of Part A Coverage

- A. Beneficiary Under Age 65 - Disability Part A coverage, other than for end-stage renal disease ends the earlier of:
1. The day of death; or
 2. The month before the month age 65 is attained; or
 3. The month in which the disability benefit ends or if later the month after the month in which the notice of termination is mailed. If disability benefits stop because the beneficiary is working, but the person has not recovered from his or her disability, coverage may continue for after monthly disability benefits stop.
- See DCM 10.7.
- B. Beneficiary Age 65 or Over - Part A coverage ends with the day of death or when the person's eligibility for benefits under the RR and/or SS Acts ends. In case of death, protection continues through the month of death. However, a person over age 65 who no longer qualifies for benefits under either the RR or SS Act may reinstate the Part A protection if either of the following requirements are met.
1. Qualifies under the special transitional provision ; or
 2. Qualifies under the uninsured Part A provision.
- C. Premium-HI Beneficiary - Coverage under Premium-HI ends:
1. With the day of death;
 2. The last day of the month following the month the beneficiary files a notice of voluntary termination with SSA;

3. The last day of the second month following the due date for premium payment if the premium is not paid;
4. On the date of termination of Part B coverage;
5. With the first month of eligibility for Part A as an insured or deemed insured person at RRB or SSA.

3.2.151 Termination Of Part B Coverage

Part B coverage may be terminated for any of the following reasons:

- Death of the enrollee
- Recovery from disability (for those under 65 whose entitlement was based on disability)
- Non-payment of Part B premiums
- Enrollee voluntarily chooses to end his Part B coverage.

The effective date of termination in each circumstance is discussed below.

1. Death of the enrollee - Coverage extends into the month of death, up to and including the date of death. This allows payment for covered medical expenses incurred during the period of the enrollee's last illness.
2. Recovery from disability - The last month of entitlement to a monthly disability benefit, or if later the month after the month in which the notice of termination is mailed. If disability benefits stop because the beneficiary is working, but the person has not recovered from his or her disability, coverage may continue after monthly disability benefits stop. See DCM 10.7.
3. Non-payment of premiums - Part B coverage terminates at the end of the grace period provided for the payment of overdue premiums. Normally, the grace period for payment of premiums is the 90-day period following the month in which the bill is issued. The grace period may be extended for another 90 days if there was good cause for failure to pay the overdue premiums within the initial 90-day period.
4. Voluntary Termination-Non-State Buy-in - Any beneficiary not covered under a state buy-in agreement may request termination of his Part b coverage at any time. A request for termination must be made in writing, unequivocally stating his desire to end Part B coverage, and signed by the enrollee. If the enrollee is incompetent, the statement may be signed by someone approved to act in his behalf. Form G-718, though not required, has been designed for this purpose.

Effective 7-1-87, termination in these cases is effective with the last day of month after the month in which the written notice is officially filed. Previously, the effective date for disenrollment was the end of the quarter after the quarter the request was filed. Premiums must be paid through the effective month of termination.

Disenrollment requests should be made via the MS telephone recorder. The appropriate MS expeditor will terminate Part B coverage and release a confirmation letter to the enrollee.

A signed statement from the beneficiary must be submitted to confirm the call. This statement should be directed to the appropriate MS expeditor in a sealed white envelope addressed: BRC-MS EXPEDITOR "Do not open in mailroom."

Disenrollment requests filed between 4-1-87 and 6-30-87 will be deemed to be filed on 7-1-87.

EXAMPLE: Termination request filed 2-15-78. Effective date of termination is 3-78. Premiums must be paid through 3-78.

5. Voluntary termination following state buy-in deletion - People who wish to terminate their individual Part B coverage after State buy-in coverage ends, face the same disadvantages if delayed deletion occurs, as those beneficiaries who choose to continue coverage.

By law, the States may terminate buy-in coverage as early as 2 months prior to the month they actually report to SSA that a specific individual has been deleted from the buy-in rolls. Each month SSA furnishes RRB a tape of that month's accretion and deletion activity.

Because of administrative delays, several months may have elapsed between the date of the State's deletion and the date the individual is notified of the deletion. Such an individual would technically owe premiums for the elapsed months. The law was not intended to penalize such individuals who had no opportunity to request termination during the last month they were covered by the State. Therefore, if an individual was not advised by the State of the deletion in or before the month of deletion, equitable relief can be granted. This allows an individual's Part B coverage to end effective with the termination of buy-in coverage (thus allowing him to avoid entirely any premium liability), if all the following conditions are met:

1. The individual submits a written request to have his individual Part B coverage end effective with the end of State buy-in coverage.
2. Such request is filed within 30 days of the date of the notice informing the beneficiary that the State is no longer paying his premiums.

3. The individual certifies that he has incurred no medical services covered under Part B during the months after buy-in termination.

If an individual did receive medical service covered under Part B after the end of buy-in coverage, his individual entitlement must continue until the end of the month in which the termination request is filed (if the request is filed within 6 months of buy-in termination). No intermediate date may be selected for the termination effective date.

3.2.160 Application Requirements

- A. Beneficiary on the Rolls During IEP - An annuitant, a beneficiary of SS benefits certified by the RRB, or an IPI in a case currently on the rolls (whether payment is in force or in suspense) is not required to submit an application or additional evidence for Part A or Part B. The annuity application or supplement previously filed automatically establishes timely Medicare entitlement.

The automatic enrollment process begins 6 months prior to attainment of age 65. This is known as the attainments. A Medicare record is established and Form G-41 released before the beginning of the IEP. However, if an individual is receiving an annuity based on age and wishes to establish earlier Medicare eligibility based on disability, additional information will be required as described later in this section.

If an individual is automatically enrolled for Medicare (Part A and B), he may refuse the coverage any time before entitlement begins without penalty.

- B. Beneficiary Files for An Annuity During or After IEP - Providing this is the first application filed and the beneficiary has not previously refused Medicare Part B coverage, a separate application is not required to establish Part A or Part B entitlement. However, the applicant in these instances must answer the question on the annuity application referring to whether he wants Part B coverage.

Part A coverage effective date may retroact up to 6 months from the filing date (12 months for the divorced spouse of a disabled employee). However, the Part B coverage effective date will be determined as though the beneficiary enrolled in a GEP unless the application is filed during the IEP. Therefore, if the annuity application is filed between January 1 and March 31, and Part B is elected, Part B coverage begins July 1. Otherwise, the application deems his enrollment in the next GEP unless a "no" election was made on the annuity application. If a "no" election is made, the beneficiary must file Form G-44b or send a signed statement to elect Part B during a GEP or SEP.

If the beneficiary does not answer the question on the annuity application about Part B coverage and is not enrolled in Medicare under another record, Part B coverage would have to be elected during a SEP or GEP. Enrollment in this situation could not be automatic.

If there is EGHP involvement, the individual may be eligible to enroll in an SEP.

- C. Employee Filing For or Entitled to an Annuity Based on Age Wants to Establish Early Medicare Based on Disability - In addition to the annuity application and evidence that is being or has been developed previously, a supplemental AA-Id must be developed to establish entitlement to disability Medicare (Part A and Part B). The AA-Id should be marked "Application for Disability Freeze." In addition, proof of disability and Form G-25I should be developed.
- D. Widow(er), Surviving Divorced Spouse, or Remarried Widow(er) Filing for or Entitled to an Annuity Based on Age Wants to Establish Early Medicare Based on Disability - In addition to the annuity application and evidence required for payment of the annuity, an AA-I7b must be developed to establish entitlement to disability Medicare (Part A and Part B). In addition, proof of disability should be developed. Also develop Form G-251 for a widow(er), but not for a surviving divorced spouse or a remarried widow(er).
- E. Employee Filing for Medicare Only - An employee who does not wish to retire but wants to establish entitlement to Medicare only, must file an AA-6 and proof of age. The application will establish entitlement to Part A, and entitlement to Part B if the employee elects coverage and the application is filed during his IEP, a SEP or a GEP.

An employee who previously filed an informational application while age 62-64, to qualify his spouse for Medicare, must complete a new Form AA-6 during an enrollment period open to him, to qualify himself for Part A coverage and to enroll for Part B coverage.

RRASI application will not be entered on IC and will be processed manually. After making the QRRB determination, the Medicare examiner will create a MEDCOR Activity 12L to establish the Medicare.

In addition, the following evidence may be required as indicated:

Evidence	When Required
Proof of Military Service	If needed to establish service months, 120 months or if less than 120 months 60 months after 1995.
Prior Service	If needed to establish service months, 120 months or if less than 120 months 60 months after 1995.
Lag Service statement from employer)	If needed to establish service months, 120 months or if less than 120 months 60 months

after 1995.

The FO in a letter to the RR contact official, will request a report of the number of months of lag service through the application filing date. The FO will submit a copy of the letter with the application. The reply should be sent to MS.

- F. Spouse or Divorced Spouse Filing for Medicare Only - A spouse or a divorced spouse who meets the requirements and wants to establish entitlement to Medicare must file an AA-7.

The application will establish entitlement to Part A, and entitlement to Part B if the spouse or divorced spouse elects coverage and the application is filed during the IEP, a SEP or a GEP.

RRASI application will not be entered on IC and will be processed manually. After making the QRRB determination, the Medicare examiner will create a MEDCOR Activity 12L to establish the Medicare.

In addition, the following evidence is required:

Evidence	When Required
Proof of age of spouse or divorced spouse	Always.
Proof of age of employee	Always. (Will already be in file if employee is receiving annuity.)
Proof of marriage to employee	Always.
Proof of divorce from employee	Always from divorced spouse.
Proof of termination of prior marriage	Only if there is reason to doubt that the prior marriage terminated.
Proof of termination of latest marriage	Always from a divorced spouse who remarried.
Employee's Certification (G-346), completed by employee	Required when legal spouse is filing except when the spouse's application filing date is less than 90 days from the voucher date of the employee's initial award.

When the employee and spouse are separated, the FO will request the G-346 directly from the employee. If the employee refuses to complete Form G-346, the spouse must submit statements concerning the employee's prior marriages from two other persons who know the facts, preferably relatives of the employee. If she cannot do that, she should submit a statement explaining why. The material will be reviewed by the Medicare examiner to determine if additional evidence (e.g., a search of court records) is required.

Proof of employee's military service	If needed to establish service months, 120 months or if less than 120 months 60 months after 1995.
Employee's prior service	If needed to establish service months, 120 months or if less than 120 months 60 months after 1995.
Employee's lag service (statement from employer)	If needed to establish service months, 120 months or if less than 120 months 60 months after 1995.

The FO, in a letter to the RR contact official, will request a report of the number of months of lag service through the application filing date. The FO will submit a copy of the letter with the application. The reply should be sent to MS.

FO will mark "Do Not Key punch" on the G-230, for the AA-7 for a divorced spouse and route it to MS.

- G. Widow(er), Surviving Divorced Spouse, or Remarried Widow(er) Filing for Medicare Only - A widow(er), surviving divorced spouse, or remarried widow(er) who meets the requirements and wishes to establish entitlement to Medicare must file an AA-8.

The application will establish entitlement to Part A, and entitlement to Part B if the applicant elects coverage and the application is filed during the IEP, a SEP or a GEP.

All AA-8's are processed manually. After making the QRRB determination, the Medicare examiner will create a MEDCOR Activity 12L to establish the Medicare.

In addition the following evidence is required:

Evidence	When Required
Proof of death of employee	Always.
Proof of age	Always.
Proof of marriage to employee	Always.
Proof of termination of prior marriage	If there is doubt a prior marriage ended.
Proof of divorce from employee	Always from a surviving divorced spouse.
Proof of remarriage(s)	Always from remarried widow or a surviving divorced spouse who remarried.
Proof of employee's military service	If needed to establish service months, 120 months or if less than 120 months 60 months after 1995.
Employee's prior service	If needed to establish service months, 120 months or if less than 120 months 60 months after 1995.
Employee's lag service (statement from employer)	If needed to establish service months, 120 months or if less than 120 months 60 months after 1995.

The FO, in a letter to the RR contact official, will request a report of the number of months of lag service through the month of death. The FO will submit a copy of the letter with the application. The reply should be sent to MS.

H. Child Filing for Medicare Only

A child who is eligible and who meets the relationship, dependency and O/M requirements, but who is not receiving an annuity or considered in the payment of the employee or spouse annuity, must file an AA-I9a to establish entitlement to Medicare.

The application will automatically enroll the child for Part A and Part B when all entitlement requirements are met. If the child does not want Part B coverage, refusal of coverage can be made by notifying RRB upon receipt of the notice

informing of the entitlement effective date. In addition, the following evidence is required: proof of relationship, proof of the child's age and medical evidence.

I. All Beneficiaries, Electing Part B After Part A Established

1. Separate Application Not Required - A separate application to establish Part B coverage is not required, if a beneficiary:

- a. Filed an annuity application or a Medicare only application during the previous year, and
- b. Part A had not been established prior to that application at either SSA or RRB, and
- c. The beneficiary elected Part B coverage on the application.

Beneficiaries meeting the above requirements are deemed to have filed during a GEP.

2. Separate Application Required - Beneficiaries who do not meet the requirements in 1 above may apply for Part B coverage by submitting one of the following during a GEP (January 1 through March 31 of each year):

- a. G-44 - this form is released by headquarters to beneficiaries in the U.S. when Part B coverage was refused, withdrawn or terminated in the previous year, or
- b. G-44b, or
- c. A statement which clearly states the individual wants to enroll for Part B coverage.

The beneficiary will be enrolled for Part B effective July 1 of the year in which the G-44, G-44b or statement is submitted.

J. All Beneficiaries Filing In An SEP - Beneficiaries applying for Medicare in a SEP must officially file an application during any month in which an individual is enrolled in an EGHP/LGHP or during any of the 8 consecutive months following the last month in which the individual was last enrolled in the EGHP/LGHP based on current employment status. Usually, applications filed for annuity payments are also effective for Medicare purposes, automatically enrolling the beneficiary on a timely basis.

For all SEP election cases (not including the survivor annuity applications put on APPLE), the FO will develop Form G-44b, making certain that the official filing date complies with regulations. If applicable, the Part B effective date the enrollee has selected will also be shown. The FO will route the completed Form G-44b and proof of EGHP coverage to MS through Imaging. Preferred proof of

EGHP coverage is from the employer or insurance company. Mark the memorandum in red "SEP Enrollment". Show on the memorandum, whether a Form G-44b is being taken along with an application, the type of application and date of filing.

Form RL-311-F was developed to provide a uniformed method to allow field offices to secure the necessary information that is needed to process an SEP enrollment. It must show when coverage started and exactly when it ends.

If a disabled individual is enrolling in a D-SEP, additional material will be included. The letter from the employer to the employee with the following information 1) payment status has changed, 2) the effective date Medicare becomes the primary payer and a special enrollment period, and 3) the disability SEP, is available to those who wish to enroll in Part B will be included in the package. The letter from the Medicare carrier to the employer certifying that Medicare is now the primary payer and the effective date Medicare becomes the primary payer will also be included.

When filing a retirement annuity or Medicare only application and an SEP is involved, the FO will, when it is necessary, complete Item 114 on IC-AA-1, or Item 105 on IC-AA-3, or Item 18 of IC-AA-6 or Item 31 of IC AA-7 with a "NO" response to prevent mechanical enrollment for Medicare. In the "Remarks" section of the application indicate whether Form G-44b will be sent to MS with the annuity application or at a later date.

For survivor annuity applications put on APPLE, all the information is submitted on APPLE, the yes election and the proof of EGHP/LGHP coverage. For these survivor cases put on APPLE, a Medicare record is mechanically established for Part A only and MS will manually set up the Part B coverage by creating a MEDCOR Activity 22L.

A signed statement expressing intent can also be used to establish entitlement to Part A and Part B (for Part B - the statement must be sent in during a specified enrollment period). In certain cases, a hospital admission form may be considered a valid application for Part A, and will protect the person's filing date.

When 3.2.160 is revised, FOM 810.30 should also be updated (section are basically the same).

3.2.161 Handling Of AA-6 And AA-7

The FO will enter the data on IC. The material is routed to MS. The computer will activate the claim and produce Forms G-68 or, if discrepancy can be detected, a pre-edit referral or printout. If RASI is requesting additional data, the Medicare examiner will drop the application from the system and enroll manually.

RRISA Applications will be handled manually. The Medicare examiner will make the eligibility determination and create a MEDCOR Activity 12.

- A. MS - MS is responsible for processing all Forms AA-6 and AA-7 except in cases in which an annuity application is pending.

MS will refer a case to the retirement examiner for development action if:

1. A conflicting marriage or DOB is involved;
2. A common-law marriage is involved;
3. P/S must be developed or the creditability of M/S must be determined; or
4. Some other special circumstance is involved which makes handling by an adjudication unit desirable.

After the appropriate development action is completed, the retirement examiner will return the case to MS.

- B. Retirement Examiner – The retirement examiner is not responsible for processing an AA-6 or AA-7 to completion in any case in which an annuity application is pending. Any case in which the annuity is paid final, before the Medicare application is processed to completion, should be sent to MS for handling.

The retirement examiner is responsible for taking development action and making decisions in cases referred to them as shown in A above. However, these cases should be returned to MS after the appropriate action is completed, unless an annuity application is pending.

3.2.162 "Informational" AA-6

An "informational" Form AA-6 was secured from an employee age 62-64 who has never filed an AA-1 or AA-1d annuity application and whose age 65 spouse is filing an AA-7. It is no longer necessary to secure the "Informational" AA-6. Therefore, when the system call for one, the AA-7 should be dumped from RASI and after all necessary information is secured, the Medicare record should be established manually.

If an "Informational" AA-6 is submitted with an AA-7, close out the application and release an RL-323 to the employee with a copy to the FO. This letter instructs him to file for Part A at age 65 if he has not filed for an annuity by that time.

3.2.163 Establishing Age, Relationship And Service Months For AA-6 And AA-7

AA-6 and AA-7.--

The RRSIA Medicare only applications (AA-6's and AA-7's) will not be put on IC. Proofs will be entered on APPLE. The Medicare records for these applications will be established manually. The Medicare examiner will evaluate the proofs as shown in RCM Part 4 and create a MEDCOR Activity 12L. RASI is not being changed for RRSIA, if one of these applications would be put on RASI, RASI would dump it because there is not enough service months.

If a Medicare only application is put on RASI and if the Medicare record is established manually, dump the application from RASI and code a G-661.

The remainder of this section was updated for the RRSIA 5-year but is probably obsolete (MS no longer enters the 998 cards) and will be removed at a later date:

A. EE DOB.—

The EE's DOB is usually keypunched into the record from a G-91 or G-91c. However, a type 998 G-68 will be issued in AA-6 cases if the document weight of the POA (item 6(e) of the G-91) is less than 30 or if the employee has less than 120 months of subsequent service.

B. Spouse Relationship.—

Type 933 G-68's will be issued in all AA-7 cases. These G-68's are used to verify whether the applicant is the employee's wife and whether the employee's status qualifies his wife as a QRRB. If the Medicare DOE is 8-1-83 or earlier, "living with" must also be established.

To enter the required information in the RASI system, a G-68 must be submitted, see RCM 9.3

3.2.164 Establishing Service For AA-6 And AA-7

When there are less than 120 months or if less than 120 there are not at least 60 months after 1995 of subsequent service (S/S) on records, P/S, M/S, or lag must be developed. Once enough service months are developed and verified, establish the Medicare record manually by creating a MEDCOR Activity 12L.

The RRSIA 5-year application will not be put on RASI. If others are put on RASI and if the Medicare record is established manually, the application must be dumped from RASI and a G-661 coded.

Previously, a type 998 G-68 was completed and submitted as shown in 9.3 to allow the application to be processed to a completion on RASI.

Actions in Sections A through E below on how to develop the necessary service months is still valid, however, the 998s are no longer submitted.

- A. P/S - If a record of enough P/S is in the folder so that 120 service months of are established, enter the P/S data on a type 998 G-68. The retirement examiner will develop P/S if the total subsequent service, lag, and creditable M/S are less than the amount of service months needed, and P/S is claimed on the AA-6. When developing P/S, the retirement examiner will request verification of all service that could be used for annuity purposes, even though some of the service may not be needed to establish Part A entitlement.
- B. M/S - If subsequent M/S is claimed and the M/S is needed to establish service months, send the case to the retirement examiner. The retirement examiner will develop any proofs necessary and send Form G-563, prepared as shown in RCM Part 11, to determine the creditability of the M/S. Any creditable M/S should be entered on a type 998 G-68.
- C. Lag - When Form AA-6 indicates lag which is needed to establish service months, the FO will release a letter to the railroad contact official requesting the number of months of lag through the filing date of the AA-6. A copy of the letter will be submitted with the AA-6 and the reply will be sent to MS. Enter the lag on a type 998 G-68.
- D. Requesting Return of Credits From SSA - If 120 service months are established in a case in which credits were previously transferred to SSA, complete Item 3 of Form G-37c to notify the appropriate SSA PC that enough service months have been established and to ask whether the employee is entitled to SS benefits on wages alone.
- E. Commuted Value Cases - An employee who received a commuted value award is a QRRB, even if his award was based on less than required months of service. Therefore, if an AA-6 is filed in a commuted value case, enter enough service months on the type 998 G-68 to establish the service months. If there are not enough service months, the computer will dump the case.

3.2.165 Incompetency Cases

Forms AA-6 are not expected from incompetent employees because they would be filing for an annuity. However, incompetency may arise in spouse cases. The AA-7, has an item for indicating whether the application is signed by someone else on behalf of the spouse. However, the policy for determining incompetency is different in AA-7 cases. Since recurring payments are not being made, a formal determination under Section 19(a) of the RR Act is not required.

- A. Spouse in Mental Institution; Application Filed by Employee - If an application is received from an employee on behalf of his spouse who is in a mental institution, accept the application without further development of incompetency.
- B. Spouse Not in Mental Institution; Application Filed By Employee - If the spouse is not in a mental institution, the FO is instructed to secure a statement from her

doctor on Form G-478 of whether she can manage benefit payments in her own interest. If she cannot, accept the application from the employee. If the spouse can manage benefit payments, the FO will secure an AA-7 from her.

- C. Application Filed for Spouse by Person Other Than Employee - If an application is received from a person other than the employee for a spouse who is in a mental institution or who does not understand the act of endorsement, refer the case to RBD for development action.

3.2.166 AA-8

AA-8 are handled manually. After all necessary proofs are received and if the requirements are met, establish the Medicare manually.

3.2.167 Processing Disability Applications

- A. Application for Disability Freeze or Medicare Only - DSUBD will handle any application for Disability Freeze or Medicare only (AA-1d, AA-19a, or AA-17b). on behalf of an individual who is already receiving an annuity or is an IPI. DSUBD will develop the required medical evidence and rate the case on Form G-325.

The case is then routed to MS.

- B. Application for Annuity and Medicare - DSUBD will handle any application for Medicare (AA-1d, AA-19a, or AA-17b) when an individual is also filing for an annuity or is an IPI. DSUBD will develop the required medical evidence and rate the case on Form G-325.

Employees annuity application which is submitted along with a Medicare application will be handled by DPS for employees. DPS will also handle a spouse application where the employee has filed for or is receiving a disability annuity and the spouse's filing date is prior to the disabled employee's "paid final" date and spouse applications filed based on a disabled child.

The payment of survivor benefits is handled by SBD. DSUBD will determine if the individual is disabled.

If an application is for a disabled survivor child and the employee was receiving an annuity before his death, if the child was or could have been included in the O/M before the effective date of his survivor annuity, the case should be routed to MS. MS will make a special determination of the child's Medicare effective date. The Medicare effective date, in such a case, may not be based on the effective date of the survivor annuity.

If a Medicare claim is granted and the effective date of Medicare coverage is within 5 months, route the file to MS to establish the Medicare record.

3.2.168 Handling In MS

After receiving Medicare grants MS will:

- A. Create MEDCOR Activity 12L if the Medicare effective date is within 5 months.
- B. Establish a tickler call-up on Form G-65b for 5 months before the Medicare effective date in any non-disability annuity case in which the effective date is not within 5 months.
- C. Determine the Medicare effective date and create a MEDCOR Activity 12L or establish a tickler call-up for 5 months before the Medicare effective date in any case in which a disabled survivor child could have been included in the O/M prior to the effective date of his survivor annuity.
- D. If you are creating a MEDCOR Activity to enroll an individual, do not release a RL-310.

If the MEDCOR Activity will be created at a later date, a RL-310 should be released if an individual was not notified of their Medicare effective dates or if an individual was notified but the Medicare effective date was incorrect.

- E. Send all retirement cases to RBD for the O/M test and send survivor cases to claim files or to the controlling unit.

3.2.170 Allowance Notices

DPS will release the appropriate notice regarding the allowance on an application that was filed for Medicare based on disability.

3.2.171 General Rules Regarding Denials And Cancellations

Prepare Form G-183, Part III, except in a case denied by DPS, to cancel or deny an application for Medicare, including an application which is transferred to SSA. If a Medicare application that was filed with an annuity application is denied, handle as follows:

- A. If the annuity application is denied, prepare two G-183's, one for the annuity and one for Medicare.
- B. If the annuity is awarded, prepare a G-183 to deny the Medicare application only.

An application for a disability annuity is also considered an application for Medicare. When denying the annuity and Medicare, prepare only one G-183. If only the annuity is awarded, prepare a G-183 to deny Medicare.

A Medicare application, like an annuity application, must be closed out to remove it from the pending load. A Medicare application is closed out by the processing of a completed Form G-325 or Form G-299, with codes 1, 2, or 5 entered as the reason for the dump, or by sending the case to the coding clerk on a route slip marked "CWOA."

3.2.172 Denial Of Application As QRRB

- A. Under Age 65 or 62 - If a non-disabled applicant for Medicare will not attain age 65 within 3 months following the month in which a Part A application was filed, the computer will dump the application and print out a referral message. If the application must be denied, notify the applicant of the denial by using CL-872.

If a spouse application must be transferred to SSA because the employee is less than age 62 and does not have a DF, notify her of the transfer using CL-867.

- B. Less Than 60 Months of Service - If the employee has less than 120 months of service, the computer will dump the application and print out a referral message. If 120 service months cannot be established, transfer the application to SSA as shown in 3.5.21. Use CL-865 to notify an employee and CL-866 to notify a spouse of a transfer because of insufficient service.
- C. Failure to Prosecute Claim - If an applicant does not comply with a request to furnish evidence or data, and entitlement cannot be established on the evidence on record, dump the application and transfer it to SSA or deny it.
- Transfer the application to SSA if an application who meets the age 65 of disability requirements failed to establish some other factor of eligibility (e.g., 60 months of service).
 - Deny the application if the applicant failed to furnish evidence to establish that he or she has attained age 65, will attain 65 within 3 months of the month of filing, or is disabled. Notify the applicant of the denial, using CL-873.

If the applicant later submits the required evidence, apply the reopening procedures in the same manner as they are applied in regular annuity cases.

- D. Cancellation of Application - If an applicant requested the cancellation of a Medicare application before entitlement is established, notify the applicant of the cancellation and inform him that he must file a new application if he later wants Medicare coverage.

3.2.173 Denial Of Application As DQRRB

DSUBD will deny a Medicare application in a case in which eligibility for an annuity or for inclusion in the O/M has already been determined, by rating the applicant "not disabled" on Form G-325, and releasing the appropriate denial letter.

3.2.174 Notices Of Denial As QRRB

Notice	When Used
CL-865	Transfer of EE application - less than 120 months or if less than 120 months, less than 60 months after 1995.
CL-866	Transfer of SP application- less than 120 months or if less than 120 months, less than 60 months after 1995.
CL-867	Transfer of SP application - EE less than age 62 and does not have a DF.
CL-872	Denial - applicant not age 65.
CL-873	Denial - failure to prosecute claim.

3.2.175 Part B Election Not Filed In IEP Or GEP

A. First Filing Not in IEP or GEP

An individual filing for the first time (who has not previously declined Part A) after the IEP and not in a GEP can be deemed to have filed for the Part B in the next general enrollment period. (See POMS 00805.030.) Do not deny these cases.

Example: The employee was fully insured and attained age 65 in 9/80. He did not file for monthly benefits because he was still working and saw no immediate need for Part A coverage. In 11/82 he changed his mind and filed. Because filing occurred after his IEP, but not during a GEP, he is deemed to have enrolled in Part B during the next GEP 1-83 - 3-83 with coverage beginning 7-1-83.

B. Second or Later Filing Not in IEP or GEP

If the applicant either:

1. previously filed for Part A only; or
2. had previously Part B coverage that terminated, and an application with a Part B is later filed not in a IEP or GEP, deny the Part B election.

If the application is received after the IEP but before the GEP, use code letter 820 with AB-25 backing to notify the person.

If the application is receiving after the GEP, use Form Letter RL-394 to notify the person.

3.2.200 Authorization Process

Adjudicative actions involving arrearages and refunds must undergo a quality review. Sometimes an authorizer may not agree with an examiner's arrearage or refund action.

General instructions in this section for handling cases which are returned to an examiner for additional actions apply to the Medicare section only.

If a case involving an arrearage or refund must be returned to the examiner, the authorizer will write up all adjudicative exceptions requiring an examiner's attention on RRAILS Form G-97b, Authorization Return Form. See RCM 11 G97b for detailed instructions how to access and complete RRAILS Form G-97b.

STEP	ACTION
1	<p>The reviewer will print out 3 copies of the G-97b, attach them to the claim folder or folderless jacket, and give everything to the section supervisor.</p> <p>The authorizer shall ensure that appropriate remarks are entered into USTAR.</p>
2	<p>The section supervisor will review the G-97b and decide if any exception is chargeable. If an exception is chargeable, the supervisor will check the "Charged" box. If an exception is not chargeable, the supervisor will check the "Not Charged" box. In either situation, the supervisor will sign and date the "Examiner" box.</p> <p>Regardless of whether an exception is charged, the section supervisor may complete the "Supervisor Comments" section if needed.</p> <p>The section supervisor shall then walk the claim file or folderless jacket with the attached G-97b to the examiner for corrective action.</p>
3	<p>The examiner should review all comments and make the necessary corrections within 3 days regardless of the section supervisor has provisionally charged an exception.</p>
4	<p>If the supervisor has charged an exception, the examiner may protest it by providing a written explanation explaining why it should not be charged in the "Examiner" area on the G-97b. In this instance, the claim file or folderless jacket should be returned to the section supervisor.</p> <p>The section supervisor will review the explanation and decide if the exception</p>

	should be overturned. If an exception is no longer chargeable, the supervisor will cross out the "Charged" box, check the "Not Charged" box, if necessary, complete the "Supervisor Comments" section, sign and date the G-97b, and return that form back to the examiner.
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Exhibits

Exhibit 1 - Entitlement And Eligibility Provisions Determining The SMI Premium Rate In General Enrollment Cases

JULY 1984 THROUGH JULY 1986

DATE OF BIRTH		FIRST MONTH OF SMI ENTITLEMENT		
From	Through	07-84	07-85	07-86
-	04-01-01	140%	150%	160%
04-02-01	10-01-01	130%	140%	150%
10-02-01	04-01-02	140%	150%	160%
04-02-02	10-01-02	130%	140%	150%
10-02-02	04-01-03	140%	150%	160%
04-02-03	10-01-03	130%	140%	150%
10-02-03	01-01-04	150%	160%	170%
01-02-04	01-01-05	140%	150%	160%
01-02-05	01-01-06	130%	140%	150%
01-02-06	01-01-07	120%	130%	140%
01-02-07	01-01-08	110%	120%	130%
01-02-08	01-01-09	100%	110%	110%
01-02-09	01-01-10	90%	100%	110%
01-02-10	01-01-11	80%	90%	100%
01-02-11	01-01-12	70%	80%	90%

01-02-12	01-01-13	60%	70%	80%
01-02-13	01-01-14	50%	60%	70%
01-02-14	01-01-15	40%	50%	60%
01-02-15	01-01-16	30%	40%	50%
01-02-16	01-01-17	20%	30%	40%
01-02-17	01-01-18	10%	20%	30%
01-02-18	01-01-19	No Penalty	10%	20%
01-02-19	01-01-20	No Penalty	10%	
01-02-20	01-01-21	No Penalty		

JULY 1987 THROUGH JULY 1989

DATE OF BIRTH		FIRST MONTH OF SMI ENTITLEMENT		
From	Through	07-87	07-88	07-89
-	04-01-01	170%	180%	190%
04-02-01	10-01-01	160%	170%	180%
10-02-01	04-01-02	170%	180%	190%
04-02-02	10-01-02	160%	170%	180%
10-02-02	04-01-03	170%	180%	190%
04-02-03	10-01-03	160%	170%	180%
10-02-03	01-01-04	180%	190%	200%
01-02-04	01-01-05	170%	180%	190%
01-02-05	01-01-06	160%	170%	180%
01-02-06	01-01-07	150%	160%	170%

01-02-07	01-01-08	140%	150%	160%
01-02-08	01-01-09	130%	140%	150%
01-02-09	01-01-10	120%	130%	140%
01-02-10	01-01-11	110%	120%	130%
01-02-11	01-01-12	100%	110%	120%
01-02-12	01-01-13	90%	100%	110%
01-02-13	01-01-14	80%	90%	100%
01-02-14	01-01-15	70%	80%	90%
01-02-15	01-01-16	60%	70%	80%
01-02-16	01-01-17	50%	60%	70%
01-02-17	01-01-18	40%	50%	60%
01-02-18	01-01-19	30%	40%	50%
01-02-19	01-01-20	20%	30%	40%
01-02-20	01-01-21	10%	20%	30%
01-02-21	01-01-22	No Penalty	10%	20%
01-02-22	01-01-23	No Penalty	10%	
01-02-23	01-01-24	No Penalty		

JULY 1990 THROUGH JULY 1992

DATE OF BIRTH		FIRST MONTH OF SMI ENTITLEMENT		
From	Through	07-90	07-91	07-92
-	04-01-01	200%	210%	220%
04-02-01	10-01-01	190%	200%	210%

10-02-01	04-01-02	200%	210%	220%
04-02-02	10-01-02	190%	200%	210%
10-02-02	04-01-03	200%	210%	220%
04-02-03	10-01-03	190%	200%	210%
10-02-03	01-01-04	210%	220%	230%
01-02-04	01-01-05	200%	210%	220%
01-02-05	01-01-06	190%	200%	210%
01-02-06	01-01-07	180%	190%	200%
01-02-07	01-01-08	170%	180%	190%
01-02-08	01-01-09	160%	170%	180%
01-02-09	01-01-10	150%	160%	170%
01-02-10	01-01-11	140%	150%	160%
01-02-11	01-01-12	130%	140%	150%
01-02-12	01-01-13	120%	130%	140%
01-02-13	01-01-14	110%	120%	130%
01-02-14	01-01-15	100%	110%	120%
01-02-15	01-01-16	90%	100%	110%
01-02-16	01-01-17	80%	90%	100%
01-02-17	01-01-18	70%	80%	90%
01-02-18	01-01-19	60%	70%	80%
01-02-19	01-01-20	50%	60%	70%
01-02-20	01-01-21	40%	50%	60%
01-02-21	01-01-22	30%	40%	50%
01-02-22	01-01-23	20%	30%	40%

01-02-23	01-01-24	10%	20%	30%
01-02-24	01-01-25	No Penalty	10%	20%
01-02-25	01-01-26	No Penalty	10%	
01-02-26	01-01-27	No Penalty		

JULY 1993 THROUGH JULY 1995

DATE OF BIRTH		FIRST MONTH OF SMI ENTITLEMENT		
From	Through	07-93	07-94	07-95
-	04-01-01	230%	240%	250%
04-02-01	10-01-01	220%	230%	240%
10-02-01	04-01-02	230%	240%	250%
04-02-02	10-01-02	220%	230%	240%
10-02-02	04-01-03	230%	240%	250%
04-02-03	10-01-03	220%	230%	240%
10-02-03	01-01-04	240%	250%	260%
01-02-04	01-01-05	230%	240%	250%
01-02-05	01-01-06	220%	230%	240%
01-02-06	01-01-07	210%	220%	230%
01-02-07	01-01-08	200%	210%	220%
01-02-08	01-01-09	190%	200%	210%
01-02-09	01-01-10	180%	190%	200%
01-02-10	01-01-11	170%	180%	190%
01-02-11	01-01-12	160%	170%	180%

01-02-12	01-01-13	150%	160%	170%
01-02-13	01-01-14	140%	150%	160%
01-02-14	01-01-15	130%	140%	150%
01-02-15	01-01-16	120%	130%	140%
01-02-16	01-01-17	110%	120%	130%
01-02-17	01-01-18	100%	110%	120%
01-02-18	01-01-19	90%	100%	110%
01-02-19	01-01-20	80%	90%	100%
01-02-20	01-01-21	70%	80%	90%
01-02-21	01-01-22	60%	70%	80%
01-02-22	01-01-23	50%	60%	70%
01-02-23	01-01-24	40%	50%	60%
01-02-24	01-01-25	30%	40%	50%
01-02-25	01-01-26	20%	30%	40%
01-02-26	01-01-27	10%	20%	30%
01-02-27	01-01-28	No Penalty	10%	20%
01-02-28	01-01-29	No Penalty	10%	
01-02-29	01-01-30	No Penalty		

Exhibit 2 - Claim Number Changes In Computer Record

A1. ACTION WHEN INCORRECT CLAIM NUMBER IS ASSIGNED

In processing incoming applications, supply and service will sometimes find that the wrong SS number has been shown on the application. In other cases, the computer program may create a referral because of a possible error in the SS number or the existence of a six-digit claim number for the person. Depending on the circumstances, take on or all of the following actions:

- Prepare G-299, Code 1 in col. 35, to dump the application from the computer and remove it from the pending load if the SSA number is wrong.
- Correct a six-digit claim number on the computer, by means of a G-394. (This action will not be involved if the record was dumped.)
- Drop any MIRTEL record previously established using Form G-811.
- Request the destruction of the delayed claim control card showing the wrong claim number.
- Correct the records in processing if they were set up under the wrong claim number.

Exhibit 3 – RASI processing of HI Applications

B1. General

The RRISA applications will not be entered on IC. They will be processed manually. Most Medicare only applications are handled manually. Non-RRISA Application are entered on IC, however, if a G-68 is required, MS dumps the application and enrolls the individual manually. The following was not updated for RRISA because RASI is not being changed. If a RRISA application is entered into the system, it will automatically be dumped because there is not 120 months of service.

A G-68 generated by the computer when additional data is required for the mechanical adjudication of an employee or spouse claim. The type of referral and certain identifying information is shown in the shaded "Type" space at the top of the form. Examiner entries are made in the line(s) at the bottom following the appropriate type code.

Enter examiner number 100 in the appropriate boxes on all Forms G-68 submitted by HB. Enter the date of completion and the examiner's initials in the lower right hand corner of the form.

Make an entry in each box of any item which must be completed. If necessary, precede an entry with zeros. For example, show 85 prior service months as /0/8/5/.

Occasionally, form G-354a and 805 referrals are produced for information and/or instructional purposes.

B2. TYPE 998

- A. General - A type 998 G-68 is issued if the employee has less than 120 months of subsequent service. The identifying information at the top of the G-68 includes the type Code 998, the RRB unit, SS number, code name, subsequent service months with full lag assumed, subsequent service months through 1946, the claimed DOB, and the proper general file symbol as shown in RCM sec. 9.2.6.

- B. Service Entries - Entries for P/S, M/S or lag are needed if the EE has less than 120 months of subsequent service as shown at the top of the G-68. NOTE: 30 years of service must be verified when the employee is 60-61 but not under a DF. RCM 3.2.58 indicates how the service is developed. After enough service of all types has been developed to establish entitlement, make the following entries:

1. O in the METHOD box, and
2. the number of P/S, M/S and lag months established in the P/S MONTHS boxes.

B3. TYPE 933

- A. General - Type 933 G-68's with the notation ELG are issued in all AA-7 cases. Before completing the entries shown below, review the evidence in file in accordance with RCM Chapters 4.3, 4.6, and 3.2 to determine whether the applicant is the employee's wife and whether the employee's status qualifies the wife as a QRRB. The employee must be at least age 62 (or age 60 with 30 years service), or be entitled to a DF before the wife is qualified as a QRRB. If the Medicare DOE is 8-1-83 or earlier, "living with" must also be established.

If the not "living with" spouse is age 65 prior to September 1, 1983,

- prepare G-299 to dump case (code 7 in column 35),
- discard G-68, and
- create a MEDCOR Activity 12L to manually enroll with Medicare DOE no earlier than 9-1-83.

If the not "living with" spouse is 65 in September, 1983 or later, RASI will handle correctly.

District offices will submit additional information regarding support/court order only if spouse's entitlement date for Medicare could retroact prior to 9-1-83.

- B. ELG Notation - Make the following entries on a G-68 marked "ELG."

ITEM	ENTRY
ELG	<ol style="list-style-type: none"> 1. The applicant qualifies as a spouse QRRB as defined in RCM 3.2.9, i.e., she must meet the duration of the marriage requirement to qualify for an annuity. When code "1" is entered RASI will establish the earliest entitlement date possible. See code "3" if a male non-dependent spouse is involved.

	<ol style="list-style-type: none"> 2. The applicant does not qualify as a spouse QRRB. 3. Enter code "3" solely for male non-dependent spouses who first qualify as a spouse 3-1-77 or later. (Beginning 3-1-77 the dependency requirement for male applicants was eliminated.) If a male applicant established entitlement beginning before 3-1-77, i.e. dependency, enter code "1."
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If a code 2 is entered in the ELG item, the spouse claim will be dumped from the computer.

B4. 805 REFERRALS

These referrals are labeled RASI Input Rejects. They result from the following situations:

A discrepancy exists between the claimed and verified DOB. The message reads, Verified DOB Not As Claimed - 901 Required.

Review the evidence and either correct the date, or dump the record if the verified date makes the applicant ineligible. If the verified date is correct, prepare Form G-394 to correct the claimed DOB, and resubmit the G-91 to keypunch.

A spouse's keypunched POA does not match with an AA-103. This situation occurs when an AA-103 is a keypunch reject. This 805 is labeled G-91 Not Required. Submit both the application and G-91 for repunching.

B5. G-354a REFERRALS

1. The spouse's DOB will be accepted if the claimed DOB is established by the proof of age. If the weight of the POA is less than 30, the system generates a "review only" G-354a after the HI record is established. Review the POA for acceptability. If the proof is unacceptable, refer to RCM 4.2.17.
2. In rare spouse cases when neither RASI-II nor the Research file contains an employee master file, the system will generate a G-354a referral with message, No Research Record For AA-103 - Submit Information AA-101.

3.3.1 Introduction

This chapter describes, in general terms, the functions of the health insurance computer system, i.e. the MIRTEL system (Medicare Information Recorded, Transmitted, Edited and Logged), and instructions for preparing input.

3.3.2 MIRTEL

MIRTEL records and maintains health insurance information for all eligible QRRBs and deemed QRRBs, both aged and disabled. Records are accreted to the MIRTEL file by manual input (MEDCOR activities), mechanical attainment selection and applications input through APPLE. Information in the MIRTEL file is maintained by manual input, premium payment, validation with the CHICO file, information received from SSA in the screening process, and information received from CMS in the state buy-in operation. MIRTEL generates screening records for jurisdictional clearance with SSA, records their replies, generates bills for the collection of SMI premiums or adjusts monthly benefit payments to deduct premiums, and transmits record changes to CMS's Enrollment Database (EDB).

3.3.3 Contents Of MIRTEL

The MIRTEL master file contains a record for all eligible aged and disabled beneficiaries regardless of enrollment or annuity status. The record contains information about the beneficiary's current and prior enrollment status, state buy-in information and activity. Addresses are maintained only for beneficiaries not entitled to annuity. Those records not containing an address pick up the address from CHICO when it is required for an activity.

In addition to the record under the RRB claim number, pseudo numbers are set up as a special cross-reference type record. This cross reference record is set up mechanically whenever a record is established with a pseudo number. The record is mechanically dropped whenever the primary record is dropped. The cross reference record allows activity from SSA to come in under the pseudo number and be mechanically associated with the RR number and processed.

3.3.4 MIRTEL Records

The MIRTEL master file is a flat file. Information from records on the MIRTEL master file can be obtained from the following sources:

- A. MIRF (MIRTEL Film) is a monthly film of all records on MIRTEL. Included are both active and inactive records. Note: Production of the MIRF file was discontinued in 2006. See RCM 3.3, Exhibit 2 for instructions on reading the MIRF file.

- B. MMAC (Microfilm of MIRTEL Activity) is a weekly record of all activity processed in MIRTEL. In addition to a record of the activity, the MMAC file shows the MIRTEL record both before and after updating. See RCM 3.3, Exhibit 3 for details on reading the MMAC file. Effective with MMAC files from January 2007, MMAC files are available on CD-ROM, rather than microfilm.
- C. MOLI (MIRTEL OnLine Inquiry) allows direct on-line access to selected data on the MIRTEL file. Any new data entered and processed into MIRTEL during a nightly computer run will appear on the MOLI screens the next morning. See FOM-I-1540 for additional information about MOLI.
- D. MEDDAR (Medicare Daily Activity Report) is produced on each business day on which there is a MIRTEL run, and provides a cumulative record of all activities processed in the MIRTEL runs from the beginning of the calendar month. The report is in claim number order and shows the most recent and all previous activities processed in MIRTEL in the calendar month to date. See RCM 3.3, Exhibit 1 for a list of Activity Codes. The date of the MIRTEL run is also shown for each activity processed. In addition, the report shows the Paid Thru Date and any Excess Premium Amount recorded on the MIRTEL master as of the date of the most current activity processed in MIRTEL.
- E. MEDMAR (Medicare Monthly Activity Report) is produced following the last business day of each month and provides a cumulative record all activities processed in the MIRTEL runs during the calendar month. The report is in same format and contains the same information as the MEDDAR reports. Upon completion of each MEDMAR report, the MEDDAR reports for the month are deleted.

Note: MEDDAR and MEDMAR reports are available to authorized users by logging on to ftp://ftp_prod/Production/MAINFRAME/ and accessing the folders named MEDDAR and MEDMAR. Examiners should add a link to the reports to their Favorites or desktop.

Medicare examiners can use one or a combination of these sources to assist in adjudicating and processing referrals, inquiries and other work items. Examiners can use the MEDDAR and MEDMAR reports to find the date(s) on which a record appears on the MMAC files.

3.3.5 MIRTEL Input Forms

There are two input forms and the premium payment notices that update or change the MIRTEL file.

Note: Forms G-810 and G-811 were replaced in 1994 by MEDCOR. See RCM 3.13.

- A. Medicare Input, G-810 is the basic input that can be used to set up a record, change fields and generate certain actions that will be transmitted to CMS for updating of the EDB. See Appendix A for G-810 instructions.

- B. Medicare Input (Short Form), G-811 is an OCR form that requires minimal coding to generate a variety of activities, i.e., rescreening option change, etc. See Appendix B for coding instructions.
- C. Premium Payment Notices, G-800, G-801, G-802, and G-803, are turnaround documents that are used to notify the beneficiary of the amount paid into the MIRTEL record. See RCM Section 3.10 for more information.

3.3.6 Activities

- A. Screening - Screening records are taken into the MIRTEL file from the Retirement Adjudication System - Initial (RASI) operation, attainment selections and manual input (Form G-810, activity code 12). This incoming information is used to set up a MIRTEL record with a pending record status and to send a screening record to SSA for jurisdictional clearance.
- B. Screening Replies from SSA - When the reply is received by MIRTEL, the screening request code (SREQ) is updated. If the reply is valid, the record status is cleared, the MIRTEL record is changed to reflect a new or different HI date of birth or entitlement information, an ID card is released and if appropriate, SMI premium collection initiated.
- C. Rescreening - A record can be rescreened with the information from the existing MIRTEL record by using a G-811, activity code 21. The screening information can be changed by completing any of the optional fields on the G-810, activity code 21. If the record status shows that a screening reply was previously received, the new information will not be reflected in MIRTEL until the rescreening reply is received.
- D. Internal Record Changes - There are few internal record changes that can be made without affecting the HIM. These changes are restricted to premium payment, third party and state buy-in information.
- E. Record Change - All other change activities update the MIRTEL record and generate a universal RIC to change the HIM. These activities fall into several general categories.
 - 1. Option Change - An option change can be made in the IEP or GEP. A withdrawal can be accepted any time to terminate Part B coverage.
 - 2. Utilization Transfers - Utilization transfer activity codes can be used to establish or change a MIRTEL and send a universal RIC to the HIM to transfer a record and cross refer from one number to another. This can be done from either an SSA or RRB number to an RRB number.

3. Kill Credits - Kill credits are similar to utilization transfers in that they transfer a record in the HIM from one number to another, but they leave the former number open for a subsequent record.
4. Terminations - Terminations due to death, cessation of disability or loss of QRRB status are processed in the MIRTEL and conveyed to the HIM. Records terminated due to death, or loss of QRRB status, are retained in the MIRTEL for 18 months after the terminating event. Records terminated due to cessation of disability are reactivated when the beneficiary attains age 65 or becomes disabled again.
- F. Inquiries - Printouts can be obtained of a MIRTEL record or of a MIRTEL and a matching CHICO record. See Exhibit 4 for instructions on reading the MIRTEL inquiry printout.

3.3.10 Monthly Operations

In addition to the processing done daily in the MIRTEL, certain action is taken monthly to validate and adjust CHICO.

All records on the MIRTEL file and all records on the CHICO file are compared to assure that the two files are consistent in record status and SMI option. When a MIRTEL record with a yes option and no paid through date, or one that is current or in the past matches a CHICO record with no deductions, an award is generated to initiate premium deductions. Adjustments are also made to stop SMI deductions on state buy-in accretions or voluntary terminations, if processed timely.

The MIRTEL record is updated to reflect any change in annuity status, i.e., a suspense or termination. Inconsistencies in SMI options or rates will be referred out for manual review. See RCM 3.6 for the handling of monthly referrals.

Changes of address processed in CHICO during the month are noted in MIRTEL and transmitted to the EDB.

3.3.20 Health Insurance Master Records - EDB

Although the RRB establishes entitlement, enrolls, collects premiums and maintains a record for all QRRBs and deemed QRRBs, the Centers for Medicare & Medicaid Services in Baltimore maintains the health insurance master records on the Enrollment Database (EDB). The EDB and updates to the Common Working File (CWF) permit and record payment of HI-SMI benefits. The EDB and CWF contain personal characteristics and utilization data. Data from the EDB may be obtained by accessing BERT or the Medicare Beneficiary Database (MBD).

Appendices

Appendix A - Medicare Input (G-810)

Note: Form G-810 was replaced in 1994 by various on-line MEDCOR screens.

Use

Use to manually create a health insurance record in MIRTEL and to secure jurisdictional clearance from SSA. HB also uses the G-810 to correct the MIRTEL and health insurance master (HIM) at SSA.

Completion

* Coding of this field is mandatory for all activities.

Item	Entry	
* 1	Enter the symbol, prefix and claim number for the beneficiary. In a spouse IPI or AA-103 case enter MA. For a disabled child enter CA if no RR annuity or SS benefit is in force. If either payments are in force, enter WCA. Enter the symbol W for a widow. Do not use the same symbol for two beneficiaries. If a distinctive symbol is not available or was previously assigned, ask HB to assign a pseudo number	
* 2	Enter the appropriate code as shown below.	
	Code	Use
	12	Establish HI Record and Screen. Creates a MIRTEL record, secures clearance from SSA and when jurisdiction clears, initiates the release of a G-41 (automatic enrollment) or G-43 (regular) ID card and if necessary, initiates premium collection. In addition to the regular mandatory entries, items 8, 11, 12, 19, 22 and 31 must be completed. Items 6, 7, 9, 13, 14, 23, 24, 25 and 26 may be coded if appropriate.
	13	Establish HI Record Only. For HB use only, Creates a MIRTEL record, but does not send any information to SSA. In addition to the regular mandatory entries, items 8, 11, 12, 19, 22 and 31 must be completed. Any other item may be coded if appropriate.
	20	Internal Record Change. For HB use only. Makes limited record changes without sending the information to SSA. To be used primarily to record state buy-in information and to remove a termination prior to the termination date. In addition to the regular mandatory entries, items 6, 12, 13, 14, 15, 16, 17, 18, 20, 22, 23, 25,

		26, 27, 28 and 29 may be completed depending on the changes being made.
	21	Internal Record Change and Rescreen. For HB use only. Makes limited record changes and sends a new screening record to SSA. In addition to the regular mandatory entries, items 6, 7, 8, 9, 11, 12, 13, 14, 19, 22, 23, 24, 25, 26, and 31 may be completed depending on the changes being made.
	22	Internal Record Change and Universal RIC. Makes internal record changes and sends a universal RIC to SSA. In addition to the regular mandatory entries, all items except 7, 8, and 9 may be coded depending on the changes being made. To change the name, address, date of birth, name and address or address and date of birth, item 31 must be completed. To change the address or date of birth, the name entered in item 31 must exactly match the name on the MIRTEL master record. To change the name on the HI record, the date of birth must match the master exactly. In the case of a name change, item 22 should be completed to issue a new HI I.D. card. Changes in the date of birth which would affect the date of entitlement to Medicare should only be done by HIO personnel.
	31	Establish Record and Transfer Utilization SSA to RRB. For HB use only. Establishes a MIRTEL record and sends a Universal RIC to transfer utilization from an SSA number to an RRB number. In addition to the regular mandatory entries, items 8, 9, 11, 12, 19, 22 and 31 must be completed. Items 6, 7, 13, 14, 15, 16, 17, 18, 23, 24, 25, 26, 27 and 28 may be coded if applicable.
	32	Internal Record Change and Utilization Transfer SSA to RRB. For HB use only. Makes internal record changes and sends a Universal RIC to transfer utilization from an SSA number to an RRB number. In addition to the regular mandatory entries, item 9 must be completed. All other items except 7, and 8 may be completed.
	33	Establish Record and Transfer Utilization RRB to RRB. For HB use only. Establishes a MIRTEL record and sends a Universal RIC to transfer utilization from one R number to another. In addition to the regular mandatory entries, items 8, 9, 11, 12, 19, 22 and 31 must be completed. Items 6, 7, 13, 14, 15, 16, 17, 18, 23, 24, 25, 26, 27, and 28 may be coded if applicable.
	34	Internal Record Change and Utilization Transfer RRB to RRB. For HB use only. Makes internal record changes and sends a universal RIC to transfer utilization from one RRB number to another. In addition to the regular mandatory entries, item 9 must be completed. All other items except 7 and 8 may be completed.

* 3	Enter the appropriate beneficiary code as shown below:	
	Code	Use
	01	Employee, age 65
	11	Employee, disabled
	21	Employee, previously disabled not 65
	02	Spouse, age 65
	12	Spouse, disabled
	22	Spouse, previously disabled now 65
	03	Widow, age 65
	13	Widow, disabled
	23	Widow, previously disabled now 65
	04	Survivor child age 65
	14	Survivor child disabled
	24	Survivor child, previously disabled now 65
	05	Parent age 65
	06	IPI, age 65
	16	IPI, disabled
	26	IPI, previously disabled now 65
* 4	Enter the appropriate sex code, M-Male, F-Female.	
* 5	Enter the beneficiary's date of birth that was used to pay benefits.	
* 5a	Enter the beneficiary's date of birth that was used to establish entitlement to HI. If it is the same as the DOB in item 5, reenter it in item 5a.	
	NOTE: This date of birth is used to match an existing MIRTEL record therefore, if you are changing this date you must also enter the name and address.	
6	Enter the beneficiary's pseudo number, if applicable. If the pseudo number is a	

	six digit number, enter zeros in the first three boxes.	
7	Enter the beneficiary's own SSA number for all beneficiaries other than an employee. If no SSA number or the entry in item 2 is code 22, leave blank.	
8	Enter the RR employee's SSA number. If the employee did not have an SSA number enter 999 99 9999. If the entry in item 2 is code 22, leave blank.	
9	Enter the beneficiary's SSA claim number and suffix, even if it is the same number that was entered in item 7 or 8. If the entry in item 2 is code 22, leave blank.	
* 10	Code	Enter the appropriate record status code as shown below:
	01	Annuity Application Filed - Jurisdiction Pending. Use to screen a case in which the annuity is in pay status or is pending.
	02	No Annuity Application Filed - Jurisdiction Pending. Use to screen a case in which an AA-101 or AA-103 was filed.
	03	Annuity in Suspense (Year-End Billing) - Jurisdiction Pending. Use to screen a case in which the annuity is in suspense for other than return to LPS or excess earnings.
	04	Annuity in Suspense (Quarterly Billing) - Jurisdiction Pending. Use to screen a case in which the annuity is in suspense and quarterly billing is required, i.e. annuity is in suspense because of excess earnings or return to LPS.
	05	Attainment - Jurisdiction Pending. Use to manually screen an attainment case in which a G-41 is required.
	11	Annuity Application Filed - Jurisdiction Cleared - No Deduction Required. For HB use only. Use with activity codes 13, 20, 21, 22, 31, 32, 33 and 34 when the annuity is in pay status and no premium deductions are required because of a SMI option of 2, 3, 4, 6 or 8.
	12	No Annuity Application Filed - Jurisdiction Cleared. No Billing Required. For HB use 22, 31, 32, 33, and 34 when an AA-101 or AA-103 has been filed and no billing is required because of a SMI option of 2, 3, 4, 6 or 8.
	13	Annuity in Suspense - Jurisdiction Cleared. No Billing Required. For HB use only. Use with activity codes 13, 20, 21, 22, 31, 32, 33 and 34 when the annuity is in suspense and no billing is required because of a SMI option of 2, 3, 4, 6 or 8.

	21	Annuity Application Filed - Jurisdiction Cleared - To be Adjusted. For HB use only. Use with activity codes 13, 20, 21, 22, 31, 32, 33 and 34 when the annuity is in pay status or the annuity application is pending and deductions are required because of a SMI option of 1, 5, A, B, or C.
	22	Medicare Only Application Filed or Annuity in CPS Without Sufficient Funds to make Deductions - Jurisdiction Cleared - Direct Billing Required - For HB use only. Use with activity codes 13, 20, 21, 22, 31, 32, 33 and 34 when billing is required because of a SMI option of 1, 5, A, B, or C.
	23	Annuity in Suspense - Jurisdiction Cleared - Year-End Billing Required. For HB use only. Use with activity codes 13, 20, 21, 22, 31, 32, 33 and 34 when the annuity is in suspense and year-end billing is required because of a SMI option of 1, 5, A, B, or C.
	24	Annuity in Suspense - Jurisdiction Cleared - Quarterly Billing Required. For HB use only. Use with activity codes 13, 20, 21, 22, 31, 32, 33 and 34 when the annuity is in suspense for excess earnings or return to LPS and quarterly billing is required because of a SMI option of 1, 5, A, B, or C.
	1	Annuity in Force With Premium Deductions - Note: Enter record status "21" on G-810 when MIRTEL Master shows record status "31" (follow instructions for status "21").
	90	Cessation of Disability - For HB use only. Use with activity codes 13, 22, 31, 32, 33 and 34 when the beneficiary's Medicare coverage has terminated because of cessation of disability.
	99	Death - For HB use only. Use with activity codes 13, 22, 31, 32, 33 and 34 when the beneficiary is deceased.
11	Enter the correct SMI option filing date. The date must be in the beneficiary's initial enrollment period or a general enrollment period. Show a deemed GEP election as January of the following year. For enrollment requests filed from April 1, 1981 through September 30, 1981, enter the actual filing date in this item. That period is considered a valid general enrollment period. Do not complete this item when using activity code 20.	
12	Enter the applicable SMI option code as shown below:	
	Code	Use
	1	1st Enrollment

	2	No Response
	3	Refusal
	4	1st Termination
	5	2nd Enrollment
		3rd or Subsequent Enrollment (with "OMN" entered in item 30)
	6	2nd Termination
	7	Reserved
	8	State Buy-In
	9	Dual Annuitant
	A	First Enrollment - Good Cause
	B	Second Enrollment - Good Cause
	C	Third or Subsequent Enrollment - Good Cause
		NOTE: To process a third or subsequent enrollment, special coding is necessary.
		If <u>no</u> MIRTEL record appears on the MIRF tape.
		1) Prepare G-810, activity code 13. Enter "5" in item 12. Enter correct SMI premium rate in item 14. (Consult RCM 3.7.3.) Enter "OMN" in item 30. - WAIT 3 DAYS
		2) Prepare G-811, activity code 22 to forward information to HIM at SSA.
		If a MIRTEL record appears on the MIRF tape, regardless of status.
		1) Prepare G-811, activity code 05 to drop the existing record. - WAIT 3 DAYS
		2) Prepare G-810, activity code 13. Enter "5" in item 12. Enter correct SMI premium rate in item 14. (Consult RCM 3.7.3.) Enter "OMN" in item 30. - WAIT 3 DAYS
		3) Prepare G-811, activity code 22 to forward information to HIM at SSA.

13	Enter the SMI effective date whenever the SMI option is 1, 5, 8 or A. With SMI option 4 or 6 enter the SMI effective date from the terminated period.	
14	Enter the SMI premium rate if the SMI option is 1, 5, 8 or A. With SMI option 4 or 6 enter the last premium that was in effect for the terminated period. See RCM 3.7.3 for computation of penalty premium rates.	
15	Enter the paid through date, if applicable with activity codes 13, 20, 21, 22, 31, 32, 33 and 34.	
16	Enter the excess premium amount, if applicable with activity codes 13, 20, 21, 22, 31, 32, 33 and 34. If the excess premium amount is less than \$10.00, leave the first box blank. With activity codes 20 and 22 the excess premium may be removed from the master by entering XXXX in this item.	
17	Enter the SMI termination date with SMI options 4 and 6. Enter the termination date due to cessation of disability with record status 90 and any option. A future SMI termination date may be removed by entering XXXX in this item on activity code 20 or 22. Any termination date may be removed by entering XXXX on activity code 22 if the SMI option does not change, i.e., removing a termination due to recovery from disability.	
18	Enter the appropriate delinquency date to generate billing when the record status is 22, 23 or 24.	
19	Enter the HI effective date. In age 65 cases, this date must not be earlier than the month of attainment of age 65 or one year before the application filing date, whichever is later. (Determine the effective date for disabled beneficiaries in accordance with RCM 3.2.)	
20	Enter the appropriate HI termination date to indicate termination due to cessation of disability. (The date should be the last month of entitlement.) A future HI termination date may be removed from the master by entering XXXX in this field on activity code 20. A current or prior termination date may be removed by entering XXXX on activity code 22.	
21	Enter the date of death when applicable with activity codes 13 and 22. The date of death may be removed from the master by entering XXXX in this item on activity code 22.	
22	Enter the applicable ID issue code as shown below:	
	Code	Use
	1	G-41 Required. Will release a G-41 enrollment for attainments.
	2	G-43 Required. Will release a G-43 for either Part A only or Parts A

		and B with activity code 12. HB can also use with other activity codes to generate an ID card.
	3	G-41 Released. For HB use when a G-41 has previously been released.
	4	G-43, Part A Released. For HB use when a Part A only ID card has previously been released.
	5	G-43, Part A and B Released. For HB use when an ID card for parts A and B has previously been released.
23	Enter the appropriate payee code if the beneficiary is in pay status or suspense.	
24	Enter the appropriate representative payee code, if applicable.	
25	Enter the appropriate annuity beginning date, if applicable.	
26	Enter the first full month and year of disability, if applicable.	
27	If the SMI option is 8, enter the latest state buy-in accretion date, when applicable, with activity codes 13, 20, 22, 31, 32, 33 and 34.	
28	Enter the latest state buy-in deletion date, if applicable, with activity codes 13, 20, 22, 31, 32, 33 and 34.	
29	Enter the appropriate third party code, if applicable, with activity codes 13, 20, 22, 32 and 34.	
*30	Enter the initials and/or number of the unit submitting the G-810.	
31	Enter the name and address of the payee, including a representative payee, in the usual manner. (See RCM 8.1, Appendix D.) In completing this section for an individual with a representative payee, show the name of the payee on the first line and " For (beneficiary's name)" on the second line. The work "For" <u>must</u> be placed at the beginning of a line. (Be sure that Item 24 is completed if a representative payee is entered in Item 31.)	
	Sign and date the form in the space provided.	

Disposition

Release the original G-810 to a central desk in the unit for forwarding to the keypunch section. File the duplicate on the right side of the folder.

Appendix B - Medicare Input Short Form (G-811)

Note: Form G-811 was replaced in 1994 by various on-line MEDCOR screens.

Use

Use to take the following actions:

To terminate a MIRTEL record because of death, cessation of disability or loss of QRRB status.

To prevent year end billing when:

- (a) The annuity is being withheld to recover an overpayment. Do not submit the G-811 until after the G-96 is processed.
- (b) An annuity is reinstated at the end of the year (after December G-96 cutoff).

To obtain an informational printout of the MIRTEL record.

It is also used by MS to drop, change or correct records on MIRTEL, update the HIM, rescreen and obtain informational printout of MIRTEL and CHICO records.

Completion

Item	Entry	
1	Enter the beneficiary symbol, if any, and the prefix by entering an "X" in the appropriate handprint box.	
2	Enter the claim number. In six-digit claim number cases, begin handprinting in the last six boxes (just below the green shading). In terminal-digit claim number cases, begin handprinting in the first box.	
3	Enter the appropriate activity code as shown below:	
	Code	Use
	05	Drop MIRTEL Record. For HB use only. Will drop an internal record when a record was established incorrectly, i.e., when a pseudo number is required. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if there is a pseudo number involved, and 10.
	06	Drop MIRTEL Record and Universal RIC. For HB use only. Will drop an internal record and send a universal RIC conveying one of the following messages:

		1) To delete the entire HIM record when a record was set up erroneously
		Entries are required in items 1, 2, 3, 4, 5, 6, 7 if there is a pseudo number involved, and 10.
		or
		2) To drop a record from the HIM while leaving a valid period of entitlement intact
		Entries are required in items 1, 2, 3, 4, 5, 6, 7 if there is a pseudo number involved, 8 and 10. Enter "9" as the event code in item 9. The event date is the date coverage should have terminated. (The event date in this case cannot be in the future.)
	21	Rescreen. For HB use only. Will generate a new screening record from the information on MIRTEL. If an SSA number is entered in item 9, a screening record will be sent on that number. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, and 10. Item 9 may be coded.
	22	Universal RIC. For HB use only. Will generate a universal RIC from the information on MIRTEL. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, and 10.
	23	Withdrawal. For HB use only. Will calculate the termination date on MIRTEL record, stop SMI premium deduction and send a universal RIC to SSA. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 8 (should be coded 3), and 10.
	24	Withdrawal after SBI Deletion. For HB use only. Will enter the termination date on MIRTEL and send a universal RIC to SSA. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 8 (should be coded 4), and 10.
	25	Option Change. With event codes 1 and 2 will change an option in the initial enrollment period; with event code 5 will enter a yes option and effective date based on good cause; or with the event code 8 will change the record to dual annuitant. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 8 (should be coded 1, 2, or 5).
	26	Reverse Termination. For HB use only. Will remove the termination information from both MIRTEL and the HIM. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, and 10.

27	GEP Enrollment. Will process either an actual or deemed enrollment GEP. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 8 (should be coded 1 or 2), and 10.
30	Transfer Utilization from SSA to RRB. For HB use only. Will send a universal RIC to SSA to cross refer and transfer utilization from an SSA number to an RRB number. Will not change MIRTEL. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 9, and 10.
32	Clear Jurisdiction and Transfer Utilization from SSA to RRB. For HB use only. Will change the record status to show a cleared jurisdiction and will send a universal RIC to SSA to cross refer and transfer utilization from an SSA number to an RRB number. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 9, and 10.
34	Clear Jurisdiction and Transfer Utilization from one RRB number to another. For HB use only. Will change the record status if it is pending and will send a universal RIC to cross-refer and transfer utilization from one RRB number to another RRB number. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 9, and 10.
35	Kill Credit from one RRB to another. For HB use only. Will send a universal RIC to SSA to transfer utilization from one RRB to another RRB number and will leave the first number open for a subsequent record. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 9, and 10.
36	Kill Credit from SSA to RRB. For HB use only. Will send a universal RIC to SSA to transfer utilization from an SSA number to an RRB number and will leave the SSA number open for a subsequent record. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 9, and 10.
50	Death - Will terminate the MIRTEL record and send a universal RIC conveying the date of death to SSA. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 8 (should be coded 6), and 10.
51	Cessation of DIB - Will terminate the MIRTEL record and send a universal RIC conveying the Part A and B termination dates resulting from cessation of disability. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved, 8 (should be coded 7), and 10.
52	Loss of QRRB Status. Will make the MIRTEL record inactive and will

		send a universal RIC advising SSA to expect a transfer from that number. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved and 10.
	60	Manual Award - Stop Billing: Will change the record status to show that an annuity is being paid and will prevent the release of subsequent bills. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved and 10.
	61	Prevent Year - End Billing. Will prevent the release of the year-end bill when the annuity is being withheld through the end of the year to recover an overpayment. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved and 10.
	62	Release ID Card. Will release a duplicate G-43 ID Card based on the information in the MIRTEL record. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved and 10.
	98	Combined CHICO. MIRTEL Inquiry. Will provide a printout of the CHICO and MIRTEL records. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved and 10.
	99	Inquiry. Provide a printout of the MIRTEL record. Entries are required in items 1, 2, 3, 4, 5, 6, 7 if a pseudo number is involved and 10.
		NOTE: To obtain a printout of the entire family group, enter a beneficiary symbol and type beneficiary that does not appear on the MIRTEL file, i.e., MIRTEL has records for an A, MA and CA enter "PA" and type beneficiary "05" on the G-811.
4	Enter the appropriate beneficiary code as shown below:	
	Code	Use
	01	Employee, age 65
	11	Employee, disabled
	21	Employee, previously disabled now 65
	02	Spouse, age 65
	12	Spouse, disabled
	22	Spouse, previously disabled now 65
	03	Widow, age 65

	13	Widow, disabled
	23	Widow, previous disabled now 65
	04	Survivor child, age 65
	14	Survivor child disabled
	24	Survivor child, disabled now 65
	05	Parent, age 65
	06	IPI, age 65
	16	IPI, disabled
	26	IPI, previously disabled now 65
5	Enter the beneficiary's date of birth that was used to establish entitlement to HI.	
6	Enter the appropriate sex code, 1 - Male, 2 - Female.	
7	If applicable enter the beneficiary's pseudo number. If it is a six digit number enter zero in the first three boxes.	
8	Enter the appropriate event code and date as shown below:	
	Code	Use
	1	Yes Option. Use with Activity codes 25 and 27. With activity code 25 enter a filing date within the beneficiary's initial enrollment period. With activity code 27 enter a filing date within a general enrollment period. For a deemed GEP election enter March (03) of the following year. The system will calculate the correct effective date and premium rate.
	2	No Option. Use with the activity codes 25 and 27. With activity code 25 enter a filing date within the beneficiary's initial enrollment period.
	3	Withdrawal. Use with activity code 23 to terminate a beneficiary's SMI coverage. With activity code 27 enter a filing date within a general enrollment period.
	4	Withdrawal after SBI. Use with activity code 24 when a beneficiary requests withdrawal within three months after SBI deletion. Enter the correct termination date.
	5	Good Cause. Use with activity code 25 when a beneficiary's initial

		enrollment was delayed. Enter the SMI effective date. The system will enter the basic premium rate.
	6	Death. Use with activity code 50 to enter the date of death on MIRTEL and the HIM for a non-annuitant. Can also be used to change the date of death on MIRTEL and the HIM. Enter the date of death.
	7	Cessation of DIB. Use with activity code 51 to terminate a beneficiary's Medicare coverage when he recovers from disability. Enter the date the Medicare coverage should terminate. The date cannot be more than one month prior to the Part A effective date.
	8	Dual Annuitant. Use with activity code 25 to enter a SMI option 9 on the MIRTEL record. Enter the current date.
	8	Former Number. Use with activity code 21 to screen on a new SSA number. Use with activity codes 30, 32, 34, 35 and 36 to transfer utilization either as a cross-reference or kill credit action. With activity codes 30, 32 and 36 enter the SSA number and suffix. Start the entry in the first box on the left, and convert the suffix to the appropriate numeric code. If the suffix is a single letter, enter the code in the first two boxes after the number, leave the last two boxes blank. If the suffix consists of a letter and a number, show the code for the letter in the usual place and enter the number in the following box; leave the last box blank. If the suffix consist of two letters, convert each to the appropriate codes and enter them in the last four boxes.
		With activity codes 34 and 35 enter the former or erroneous RRB number. Enter the number in the first nine boxes. If the number is six digits or less, enter zeros in the first boxes. A pseudo number may be entered in this item. Convert the symbol and prefix to the appropriate numeric BIC as shown on the form. Enter this code in the two boxes following the number. Leave the last two boxes blank.
	10	Unit Designation. Enter the numeric codes for the unit preparing the form.
	11	Reserved.
	Sign and date the form in the space provided.	

Disposition

Release the original G-811 to a central desk in the unit for forwarding through HB to the computer room. File the duplicate on the right side of the folder.

Appendix C - Preparation Of SSA/CMS Forms

Certain actions can be taken only through the use of manual SSA/CMS forms, i.e., reactivating a skeleton record, changing data in the history field.

On all SSA/CMS forms, the RRB claim number must be converted to an eleven (11) digit number with a numeric equivalent for the symbol and prefix at the end of the number. The first digit of the number must be converted as follows:

0	{
1	A
2	B
3	C
4	D
5	E
7	G

Our prefix and symbols convert as follows:

A	10
H	80
MA	14
WA	16
WD	46
WH	86
WCA	13
WCD	43
WCH	83
CA	17
PA	15
PD	45

PH 85

JA 11

EXAMPLE: A713-01-6295 WOULD BE G13-01-6295-10

Always slash the number zero (0) except on Form HCFA-1365.

The date of birth, when required, must always be a six position numeric date.

When surname is required, enter up to six positions.

- A. Form SSA-1364 - Request for Adjustment of HI Entitlement is used to correct selected fields on the Master Identification record. These fields are: current Part A entitlement, current Part A termination, current Part A option, current or prior Part B entitlement, current or prior Part B termination, current or prior Part B option, and the date of death.

If it is necessary to correct both the prior and current record, prepare an SSA-1364 for the prior entitlement first. Control the case until the corrected record is returned. At this time, prepare another form to correct the current record.

Completion

*Item must be completed or form will be returned to examiner for completion.

Item

- *1. Claim Number

Enter converted RRB claim number

- *2. Surname

Enter first six letters of beneficiary's last name.

- *3. First Initial

Enter the first initial of the beneficiary's first name.

- *4. Sex

Enter the appropriate sex code, M - male or F - female.

- *5. Date of Birth (MMDDYY)

- a. Month - enter a two position numeric in columns 20-21. The month must be between 01 and 12.

- b. Day - enter a two position numeric in columns 22-23. The day must be between 00 and 31 and be consistent with the possible number of days in a given month. If day of birth is unknown, use 15.
- c. Year - enter a two position numeric date to correct or enter a Part A entitlement date on the Master Identification record.

6. Part A Entitlement (MMYY)

- a. Enter a four position numeric date to correct or enter a Part A entitlement date on the Master Identification record.
- b. Enter **** (four asterisks) to remove Part A entitlement date or to indicate no entitlement.

Note: If an entry is made in this item also complete items 7, 8, and 9.

Note: Part A Entitlement date can not be changed if there is a Part A third Party Code in Master Identification record (the code will be other than zero).

7. Part A Termination (Date - MMYY)

- a. Enter a four position numeric date in order to correct or insert a Part A termination date in the Master Identification record.
- b. Enter **** (four asterisks) to remove Part A termination date from the Master Identification record or to indicate no termination.
- c. Enter XXXX (four X's) to disable Part A coverage which was established erroneously.

Note: If an entry is made in this item also complete items 6, 8, and 9.

Note: The Part A Termination item cannot be changed if the Part A Third Party Code in the Master Identification record indicates third party buy-in (the code will be other than zero).

8. Part A Option Code

- a. Enter one of the following one position alphabetic codes which describes the beneficiary's Part A status:

C - Cessation of disability

D - Denied

E - Automatic enrollment - no premium necessary

F - Terminated or voided; invalid enrollment

G - Good cause

H - Not eligible for Part A

R - Refused

S - Terminated; no longer entitlement under CRD provision

T - Non-payment termination

W - Withdrawal

X - Free Part A entitlement terminated

Y - Yes, premium is payable

Note: If the option code is C or S, the Part B Option Code item must contain a consistent entry.

- b. If an entry is made in this item, also complete items 6, 7, and 9. The following chart illustrates allowable entries for the Part A Entitlement and Part A Termination items to be used in conjunction with the one-position alphabetic option codes:

PART A ENTITLEMENT				PART A TERMINATION			
FIELD		FIELD		FIELD		FIELD	
OPTION							
CODE	DATE	ASTERISKS	X's	DATE	ASTERISKS	X's	
C	X		X				
D		X				X	
E	X					X	OR X
F	X		X				
OR F		X				X	
G	X					X	OR X

H	X			X
OR H		X		X
P	FOR DBPS ONLY - RRB JURISDICTION			
R		X		X
S	X		X	
T	X		X	
W	X		X	
X	X		X	
Y	X			X OR X

9. Part A Period of Entitlement

- a. Enter code "C" to designate current period.
- b. Enter code "P" to designate prior period.

Note: If an entry is made in this item, also complete items 6, 7, and 8.

10. Part B Entitlement (Date - MMY)

- a. Enter a four position numeric date to correct or insert the Part B entitlement date in the Master Identification record.
- b. Enter **** (four asterisks) to remove Part B entitlement date from the Master Identification record or to indicate no entitlement.

Note: If an entry is made in this item, also complete items 11, 12, and 13.

Note: The Part B Entitlement Date item cannot be changed to a later (adverse) date if either the Part A or Part B Third Party Code in Master Identification record indicates third party buy-in (the code will be other than zero).

11. Part B Termination (Date - MMY)

- a. Enter a four position numeric date in order to correct or insert a Part B termination date in the Master Identification record.
- b. Enter **** (four asterisks) to remove Part B termination date from the Master Identification record or to indicate no termination.
- c. Enter XXXX (four X's) to disable Part B coverage which was established erroneously.

Note: If an entry is made in this item, also complete items 10, 12, and 13.

Note: The Part B Termination item cannot be changed if either the Part A or Part B Third Party Code in the Master Identification record indicates third party buy-in (the code will be other than zero).

12. Part B Option Code

- a. Enter one of the following one position alphabetic codes which describes the beneficiary's Part B status:

C - Cessation of disability

D - Denied

F - Terminated; invalid enrollment

N - No response to enrollment form

R - Refused Part B

S - Terminated; no longer entitlement under CRD provision

T - Terminated for non-payment of premiums

W - Withdrawal

Y - Yes, premium is payable

Note: If the option code is C or S, the Part A Option Code item must contain a consistent entry.

- b. If an entry is made in this item, also complete items 10, 11, and 13. The following chart illustrates allowable entries for the Part A Entitlement and Part A Termination items to be used in conjunction with the one-position alphabetic option codes:

PART B ENTITLEMENT				PART B TERMINATION			
FIELD		FIELD		FIELD		FIELD	
OPTION		OPTION		OPTION		OPTION	
CODE	DATE	ASTERISKS	X's	CODE	DATE	ASTERISKS	X's
C	X		X				
D		X					X
F	X		X				
G	X						X
N		X					X
P	FOR DBPS ONLY - RRB JURISDICTION						
R		X					X
S	X		X				
T	X		X				
W	X		X				
Y	X					X	OR X

13. Part B Period of Entitlement

- a. Enter code "C" to designate current period.
- b. Enter code "P" to designate prior period.

Note: If an entry is made in this item, also complete items 10, 11, and 12.

14. Previous BIC

Leave this item blank.

15. Date of Death (MMDDYY)

- a. Enter a six position numeric date in order to correct or insert the date of death in the Master Identification record.
 1. Month - either a two position numeric in columns 48-49. The month must be between 01 and 12.
 2. Day - enter a two position numeric in columns 50-51. The day must be between 00 and 31 and be consistent with the possible number of days in a given month. A day of 00 should be entered when the actual day of death is unknown.
 3. Year - enter a two position numeric in columns 52-53.
- b. Enter ***** (six asterisks) to remove an incorrect date of death.

16. Remarks

Leave this item blank.

17. Prevent HI Card

Enter a "T" to suppress issuance of an HI card.

*18. Sequence

- a. The sequence number determines the order in which multiple transactions will be applied to the Master Identification record.
- b. If corrections are being made to only one period of entitlement, make all the entries in the columns on the left hand side of the form. Sequence code "1" is preprinted in column 74 to accommodate these entries.
- c. If corrections are being made to both the current and prior periods of entitlement:
 1. Make all entries for the current period on the left hand side of the form.
 - Code "C" must be present in the Part B Period of Entitlement item. Refer to item 13 instructions.
 - Sequence code "1" is preprinted in column 74 to accommodate these entries.

*19. Requestor's Identification

Enter "02RR".

*20. Record Identification

Code "/" is preprinted on the form.

Sign and date the form in the space provided.

SSA-1364 TRANSACTION CONFIRMATION

1. A Health Insurance Printout (HIPO) is electronically generated and is delivered to the individual who initiated the action to adjust HI entitlement as soon as final disposition is made of the transaction.
 2. If the transaction is accepted, the HIPO will display the legend PROCESSED 1364 10.
 3. If the transaction is alerted by the HDHIDUP program, the HIPO will display the legend PROCESSED 1364 followed by a two position alpha numeric disposition code. Refer to RCM 3.3 Appendix D (PM 7107, Chapter 26), for a description of the HDHIDUP disposition codes.
 4. If the transaction is rejected by the HMERMA program the HIPO will display the legend REJECTED 1364 followed by a two position alphabetic disposition code. Refer to RCM 3.3 Appendix D (PM 7107, Chapter 26), for a description of the HMERMA disposition codes.
 5. If the transaction is rejected by the HDHIDUP program the HIPO will display the legend REJECTED 1364 followed by a two position alpha numeric disposition code. Refer to RCM 3.3 Appendix D (PM 7107, Chapter 26), for a description of the HDHIDUP disposition codes.
 6. The HIPO which is generated to confirm the transaction will display the master record (Master Identification record including Master Part A, Master Part B, and control records; the Cross-reference, Kill Credit; Skeleton; or RRB Flag record) which is present on the master file. If no master record is present, the word NIF will appear.
- B. Form HCFA-1365, Request for Preparation of HIB Part B Query is used to retrieve a skeleton record from the inactive portion of the HIM and enter it on the active portion of the HIM. The use of this form is restricted to MS unit supervisor and GS-9 Claims Specialists.

This form must be followed by a fully coded RIC B to enter a complete record on the HIM; or by a HCFA-1364 to correct an erroneous date of death on the HIM.

Completion

For this form only the letter "O" (0) not the number zero should be slashed (keypunching will not be done at RRB).

Required Entries

Items 1, 2, 3, 4, 5, 6, 7, 15 and 16.

Item

1 - Enter the nine digit converted RRB claim number followed by the two digit converted RRB prefix/symbol.

2 - Enter K in column 13.

3 - Enter up to six positions of the beneficiary's last name. (Slash the letter "o").

4 - Enter the first initial of the beneficiary's first name.

5 - Enter "M" for male, "F" for female.

6 - Enter a six position numeric date of birth.

7 - Enter "10071".

15 - Enter "STATUS".

16 - Enter "02RR".

Sign your name, RRB, MS, and the date in the space provided.

- C. Form SSA-1664, Request for Name/Sex Correction of HI Master Record is used to change a name and/or sex code.

Completion

Follow the instructions on the form. In item 6, Requester's Identity enter "02RR".

1. A Health Insurance Printout (HIPO) is electronically generated and is delivered to the individual who initiated the name/sex correction record as soon as final disposition is made of the transaction.
2. If the transaction is accepted, the HIPO will display one of the following legends:

PROCESSED NAME CHANGE 10

PROCESSED SEX CHANGE 10

PROCESSED NAME/SEX CHANGE 10

3. If the transaction is alerted by the HDHIDUP program, the HIPO will display one of the following legends:

PROCESSED NAME CHANGE

PROCESSED SEX CHANGE

PROCESSED NAME/SEX CHANGE

The legend will be followed by a two position alpha numeric disposition code. Refer to PM 7107, Chapter 26, for a description of the HDHIDUP disposition codes.

4. If the transaction is rejected by the HMERMA program, the HIPO will display one of the following legends:

REJECTED NAME CHANGE

REJECTED SEX CHANGE

REJECTED NAME/SEX CHANGE

The legend will be followed by a two position alphabetic disposition code. Refer to PM 7107, Chapter 26, for a description of the HMERMA disposition code.

5. If the transaction is rejected by the HDHIDUP program, the HIPO will display one of the following legends:

REJECTED NAME CHANGE

REJECTED SEX CHANGE

REJECTED NAME/SEX CHANGE

The legend will be followed by a two position alpha numeric disposition code. Refer to RCM 3.3 Appendix D (PM 7107, Chapter 26, for a description of the HDHIDUP disposition codes.

6. The HIPO which is generated to confirm the transaction will display the master record (Master Identification record including Master Part A, Master Part B, and control records; the Cross-reference, Kill Credit; Skeleton; or RRB Flag record) which is present on the master file. If no master record is present, the word NIF will appear.

- D. Form HCFA-1605 - MBR - BCM Printout Request is used to request a Master Benefit Record (MBR) Printout for a Social Security claim number.

Completion

Enter only the nine digit Social Security claim number(s). All other items should be blank.

- E. Form HCFA-1607 - Health Insurance Locator Cards is used to request a Health Insurance Printout (HIPO) for an RRB or Social Security claim number.

Completion

Enter only the 11 character Social Security or converted RRB claim number and BIC code. All other items should be blank. Leave BIC blank if you want all beneficiaries on a claim number.

example:

+

RRB claim number A O13-O1-6295 would be 013-01-6295-10.

Social Security claim number 316-O1-5566 B3 would be 316-01-5566 B3.

Transaction Confirmation

1. A Health Insurance Printout (HIPO) is electronically generated and delivered to the individual who requested the HIPO as soon as a final disposition is made of the transaction.
2. If the transaction matches a master record without qualification, the HIPO will display the master record which will be one of the following:
 - the Master Identification record, including Master Part A, Master Part A, and control records;
 - the Kill Credit record;
 - the Cross Reference record;
 - the Skeleton record; or
 - the RRB Flag record.
3. If the transaction fails to match a master record, the HIPO will display the legend NIF.
4. If the transaction matches a family blockage/freeze record, the HIPO will display the legend BLCK/FRZ.
5. If the transaction is rejected by the HMERMA program, the HIPO will display the legend REJECTED HIPO REQ followed by a two position alphabetic disposition code.

Appendix D - HCFA PM 7107 chapter 26, HIM Record Codes

Health Insurance Master Record Approval/Alert/Exception Codes

A. HMERMA CODES

This list contains all HMERMA alerts and exception that may require clerical investigation. Some of the exceptions and alerts are from clerical input data and others are from intermediary, carrier and RRB input records.

1. ALERT CODES

CODE	INVALID FIELD
AB	Beneficiary name contains other than alpha characters or blanks or is improperly structured
AC	First Line of Address Code
AD	Last Line of Address Code
AE	Sex Code
AF	BIC is inconsistent with sex
AG	Future withdrawal/termination date
AH	Program Service Center
AL	HI Card Code
AN	CN and XREF CN Same
AO	Change in Age/SOBER force indicator
AP	Prior Part A option code
AQ	Change in Part A/Part B indicator
AR	First part A entitlement date
AS	Date of disability benefits cessation
AT	Prior Part A option of C with invalid Prior Date of Entitlement to Part A
AU	Prior Part A option of S with invalid Prior Part A Entitlement

AV	Prior Part B option code
AW	First Part B entitlement date
AX	Date of death present with no LAF code of X1 or T1
AY	Part B refusal date
AZ	Date of suspension or termination

2. EXCEPTION CODES

CODE	INVALID FIELD
CA	Record Identification Code
CB	Requester's Identification is not present
CC	Freeze Indicator (Action Code) is invalid or it is associated with an invalid Requester's Identification Code
CD	Sex Code or Race Code
CE	HI Card Code
CF	State Code
CG	County Code
CH	Message area is blank
CI	lock number
CJ	Beneficiary name contains other than alpha characters or blanks or is improperly structured
CK	Part B Third Party Code
CL	Last Action Date
CM	Update Month Indicator
CN	Transaction Code or Type of Action Code
CO	Entitlement Period Code or Kill Credit Code is invalid or is not consistent

	with other fields in the transaction
CP	Expense Date First Nine Months
CQ	Control Code or Source Code
CR	Master Pending Date and Counter
CS	Reject Code
CT	Reinstate Code is invalid or is not in proper relationship to other fields in the record
CU	Year to be Adjusted field is missing or is invalid
CV	Home Health Visits Remaining
CW	Part B Blood Deductible
CX	Medical Expense
CY	Psychiatric Charge
CZ	Fourth Quarter Expense
EA	Claim Number
EB	Beneficiary Identification Code
EC	BIC and Sex Code are inconsistent
ED	Date of Birth
EE	Part A Entitlement Date
EF	Part A Entitlement Date is not consistent with other fields in the transaction
EG	Part B Option is invalid or is not consistent with the Type of Action Code
EH	Part B Entitlement Date
EI	Part B Entitlement Date is not consistent with other fields in the transaction
EJ	Part B Termination Date
EK	First Part B Termination Date is not consistent with other fields in the transaction

EL	Premium Billing Buy-in Code
EM	Delete Premium Billing Buy-in Code
EN	Effective Date
EO	Accretion Date
EP	Action Date or Date Record Created
EQ	Transaction code or RIC
ER	Event Code is invalid or is not consistent with other fields in the transaction
ES	Effective Date is not consistent with other fields in the transaction
ET	Reinstate Code and the Transaction Code are inconsistent
EU	Cross-reference Claim Number
EV	Cross-reference BIC
EX	Kill Credit or Cross-Reference Code is invalid or is not consistent with other fields in the transaction
EY	Dual Entitlement/Payee Indicator is invalid or is not consistent with other fields in the transaction
EZ	Part A fields are present which should be blank
FA	Previous BIC
FB	Date of Death
FD	Intermediary Number
FE	Intermediary Control Number
FF	Part A Termination Date
FG	Lifetime Psychiatric Days Remaining
FH	Full Hospital Days Remaining
FI	Coinsurance Hospital Days Remaining
FJ	Skilled Nursing Facility Full Days Remaining

FK	Skilled Nursing Facility Coinsurance Days Remaining
FL	Home Health Visits Remaining
FM	Inpatient Deductible Remaining
FN	Part A Blood Deductible
FO	Earliest Benefit Period
FP	Latest Benefit Period
FQ	Spell number contains an invalid entry
FR	Lifetime Reserve Days Remaining
FS	Benefit Period Code is invalid or is not consistent with other fields in the transaction
FT	Query Code
FU	Data Indicator change
FV	Entry present; field should be blank
FW	Delete Code, Reply Data or Source Code
FX	Run Processing Date
FY	Agency Code
FZ	Proven date of death
HA	Disability Code
HB	Part A Entitlement Date (Disability Case)
HC	Part B Entitlement Date (Disability Case)
HD	Claim Account Status Code
HE	First SSA Claim Number is missing
HF	Data Indicator
HG	Reason for Entitlement Code
HH	Renal Insured Status Account

HI	Disability Indicator and Date of Entitlement to Disability Benefits are inconsistent
HJ	Date of Entitlement to Disability Benefits
HK	Part A Option
HL	Part A Entitlement Date for beneficiary with chronic renal disease
HM	First Part A Termination Date
HN	First Part Termination Date is not consistent with other fields in the record
HO	Provider Number
HP	Attainment/Accretion Record Indicator
HQ	Force/Delete Record Indicator
HR	Death/Termination/Suspension Indicator
HS	Part A Entitlement Date for Old Age Beneficiary with prior disability
HU	BIC and Reason for Entitlement Code are inconsistent
HV	Part B Termination Date
HW	Part A Entitlement Date for disabled beneficiary with chronic renal disease
HX	Second Part A Entitlement Date
HY	Second Part A Entitlement Date is inconsistent with other fields in the record
JB	Control Code and Disability Entitlement Date are inconsistent
JD	Part A Entitlement Date for Buy-in
JE	Part A Option for buy-in is not consistent with other fields in the record
JF	Part A Option, non buy-in cases, is not consistent with the BIC
JG	Part A Option is not consistent with Reason for Entitlement Code
JH	Part B Option is not consistent with Reason for Entitlement Code
JI	Part B Option is not consistent with the BIC

JJ	Part A Option and Part B Option are not consistent
JK	Part A Third Party Code
JL	Part A Third Party Termination Date
JN	Part B Entitlement Date for old age beneficiary with prior disability
JO	Part B Entitlement Date for Disabled Beneficiary
JP	Part B Entitlement Date for beneficiary with chronic renal disease
JQ	Part B Entitlement Date for disabled beneficiary with chronic renal disease
JR	Part B Third Party Termination Date
JS	Second Part B Termination Date

B. HDHIDUP CODES

This list contains all HDHIDUP approvals alerts and exceptions. The approval codes indicate that the transaction has been accepted. The alert codes indicate that although a transaction has been accepted it contains a questionable condition which may require clerical investigation. The exception (reject) codes indicate that an error condition is present which precludes acceptance of the transaction. (These records require clerical investigation.) Some of the exceptions, alerts and approvals are from clerical input data and others are from intermediary, carrier and RRB input records.

1. APPROVAL CODES

CODE	DEFINITION
10	The transaction has been accepted and applied.
11	The transaction has been accreted to the master file and should be accreted to the alpha file (Universal RIC) or the master identification record was inserted at active location (RIC G).
12	The transaction overlaid a cross-reference record.
14	A change record transaction has been processed by HDHIDUP and should be accreted to the alph file (e.g., BIC change).
15	A change record transaction has been processed by HDHIDUP and should

	be accreted to the alpha file as a change record (e.g., date of birth change) (Universal RIC) or the purge record (AFT) has been processed (RIC C).
16	A transaction has been processed by HDHIDUP but need not be sent to the alpha file since it does not affect claim number or personal characteristics.
17	A Master Part A for Master Part B record has been retrieved from the inactive master file and reaccreted to the active master file.

2. ALERT CODES

CODE	DEFINITION
AA	The name and/or the address portion of a master record does not conform to establish specifications. The remaining fields have been updated.
LO	The transactions contains an adverse Part A entitlement date with an adverse Part B entitlement date together with a corresponding change in either the date of birth or date of entitlement to disability. The adverse Part A and Part B entitlement dates have been applied.
L1	The transaction contains an adverse Part A entitlement date without a corresponding change in the date of birth or date of entitlement to disability. The adverse Part A entitlement date has not been applied.
L2	The transaction contains an adverse Part A entitlement date and a corresponding change in either the date of birth and date of entitlement to disability. The adverse Part A entitlement date has been applied.
L4	The transaction which does not contain a Part B entitlement date matches an HI master record which contained two periods of Part B coverage.
L5	The transaction contains an adverse Part B entitlement date. The adverse Part B entitlement date has been applied.
L8	A data indicator in the Universal RIC shows that it is a delete transaction form the MBR; however, the matching HI master record contains utilization.
9	A transaction containing a Part B option of T or W is attempting to terminate a recently entitled master record. The termination date in the transaction is not greater than the month of Part B entitlement contained in the HI master plus one month.
N1	Transaction which does not contain a Part A entitlement date matched an HI master record which contained two periods of Part A coverage.

N2	The transaction is conveying the deletion of Part A - third party involvement.
N3	The transaction is conveying the reinstatement of Part A entitlement.
N4	The transaction is establishing a prior period of Part A entitlement.
N6	The transaction contains CRD data which is in conflict with the CRD data in the master record. The CRD data in the master record is protected.
XX	The transaction has been placed in orbit for systems' purposes.
Z1	The transaction contains a request to freeze a particular claim number and BIC; however, the record already is frozen.
Z2	The transaction contains a request to defrost a particular claim number and BIC; however, the record is not frozen.

3. EXCEPTION CODES

CODE	DEFINITION
AO	Master Part A or Master Part B record rejected in read error recovery routine.
A1	The transaction failed to match the HI master record on claim number, BIC name and/or two out of three personal characteristics (sex, race, and date of birth). This does not apply if the transaction is changing one of the personal characteristics.
A2	The transaction is a Part A utilization correction and matched an HI master record that was not frozen.
A3	Master Identification, Master Cross-reference, or Master Skeleton record rejected in read error recovery routine.
A4	Part A clerical correction record matched an HI master record for which no Part A data is present. This does not apply if it is the first spell of illness that is being accreted to the master record.
A5	Part B clerical correction record matched an HI master record for which no Part B data is present.
A6	The clerical correction record matched a record that was other than an HI master identification or a cross-reference record.

A7	The attachment to the clerical correction record is other than a master identification record, a cross-reference record, a master Part A record, or a master Part B record; therefore, the attachment is invalid.
A8	A clerical correction for a master identification record matched a master cross-reference record.
A9	A "non-cross-reference" clerical correction record matched a master cross-reference record.
B1	The AFT Indicator in the clerical correction record is set indicating that the transaction is to AFT the HI master record. However, an inconsistency exists because one or more other data indicators are set indicating that other corrections are intended as well.
B2	The transaction is an AFT record which failed to match a master identification record on BIC.
B3	The data indicator in the clerical correction which designates which field is to be changed is in conflict with the data intended to bring about the change.
B4	The clerical correction record is conveying a kill credit action which would result in no change to the existing cross-reference record.
B5	The data indicator in the clerical correction record is set to show that the cross-reference claim number in the HI master record is to be changed; however, the clerical correction record does not convey a cross-reference claim number change (RIC C) (see also alert codes, paragraph B.2 of this section).
C1	A clerical accretion record has an invalid attachment - i.e., the attachment is other than cross reference, kill credit, RRB Flag, or Skeleton record and the transaction did not match an HI master identification record on claim number and BIC.
C2	The transaction matched a master skeleton record rather than a full master identification record or a clerical accretion record with an RRB flag attachment matched a family in which an RRB flag already has been established.
C3	A clerical accretion record matched an existing master record on BIC.
C4	A clerical accretion record matched an existing record on surname and three personal characteristics (RIC C) (see also alert codes, paragraphs B.2 of this section).

C5	The transactions which contains an accretion for civil service or other private third party matched an HI master identification record in which the beneficiary has no Part B entitlement.
C8	The transaction contains an invalid third party code (the code is other than 1-9).
C9	A transaction containing a third party accretion matched the HI master identification record of a beneficiary whose entitlement to disability benefits has ceased and whose terminated period of Part B entitlement does not coincide with the entitlement period contained in the third party transaction.
D1	The transaction is attempting to correct the Part B home health visits field in the HI master record; however, the number of home health visits contained in the transactions exceeds 100.
D2	A clerically requested Universal RIC has been rejected because the HI master record contains more recent data or the transaction contains a Part B expense year which does not match a Part B expense year in the HI master.
D4	A Universal RIC in which the force indicator is turned on match one HI master record on claim number and another HI master record on personal characteristics.
D5	A Universal RIC matched an HI master record on claim number and BIC but the personal characteristics in the two records are unequal.
D7	A temporary record matched a permanent HI master record.
E0	The transaction contains an invalid current or prior Part A option.
E1	The previous BIC in the transaction is equal to the current BIC in the HI master identification record.
E2	The transaction is attempting to change a proven date of death.
E3	The transaction contains a current or prior Part A termination date which is invalid when compared to the HI master record because it is prior to the beneficiary's attainment date, or because the beneficiary is entitled to benefits due to disability or chronic renal disease, or because Part A buy-in is present.
E4	The transaction contains a current or prior Part A termination date which is invalid when compared to the HI master record because it is not later than the Part A entitlement date, or because the beneficiary is entitled to benefits due to disability or chronic renal disease, or because Part A buy-in is

	present.
E5	The termination contains a Part B entitlement date which is invalid when compared to the HI master record because it is prior to the beneficiary's attainment date, or because the beneficiary is entitled to benefits due to disability or chronic renal disease, or because Part A buy-in is present.
E6	The transaction contains a Part B termination date which is invalid when compared to the HI master record because the master record does not contain any Part B entitlement or because the beneficiary is entitled to benefits due to disability or chronic renal disease or because Part A buy-in is present.
E7	The transaction contains Part B termination date which is invalid because it is not greater than the month of Part B entitlement contained in the HI master identification record plus one month.
E8	The transaction contains Part B entitlement data; however, the HI master identification records does not contain a current period of Part B entitlement.
F1	The transaction is attempting to correct a spell of illness; however, it contains a Part A spell number which does not appear in the HI master record. This does not apply if it is the first spell of illness that is being accreted to the master record.
F2	<p>The transaction is attempting to accrete a spell of illness which would overlap an existing spell of illness, i.e., the date of earliest billing action in the transaction is within 60 days of the date of the latest billing action in the preceding spell or a Universal RIC containing a Part B option other than P matched an RRB flag record.</p> <p>NOTE: A Universal RIC for a disabled adult child will be accreted despite the presence of an RRB flag record.</p>
F3	The transaction is attempting to delete a spell of illness; however, the date of earliest billing action and the date of latest billing action in the transaction do not match the corresponding fields in the HI master record.
F4	The transaction is attempting to correct a spell of illness; however, neither the date of earliest action in the transaction matches the corresponding field in the HI master record for the spell which is being corrected.
F5	The transaction is attempting to correct the date of earliest billing action or data of latest billing action; however, the date of earliest billing action in the transaction is within 60 days of the date of latest billing action in the preceding spell of illness. If the transaction were applied it would link the

	two spells or a Universal RIC matched an HI master skeleton record.
F6	The transaction is attempting to correct coinsurance days; however, the number of full hospital days in the transaction exceeds zero or the number of coinsurance days in the transaction exceeds 30.
F7	The transaction is attempting to correct the inpatient hospital deductible; however, the amount of deductible contained in the transaction is greater than the amount of deductible allowed for the year of the earliest billing action contained in the transaction.
F8	The transaction is attempting to correct the number of Christian Science skilled nursing facility days remaining field in the HI master record; however, the number of full SNF days in the transaction exceeds zero or the number of coinsurance days exceeds 30.
F9	The transaction is attempting to combine two spells of illness; however, the date of earliest billing action in the transaction is not equal to the date of earliest billing action in the HI master record.
H4	The RRB RIC G type 5 (Part B termination record) matched an HI master identification record which contains no Part B entitlement (see also Alert codes).
H5	The RRB RIC G type 5 (Part B termination record) contains a Part B termination date which is invalid because it is not greater than the month of Part B entitlement contained in the HI master identification record plus one month.
H6	The RRB RIC G type 5 (Part B termination record) is attempting to terminate Part B entitlement on an HI master record in which there is Part B third party involvement.
H7	The RRB RIC G type 5 (Part B termination record) contains an event code which is other than NP, EW or CD.
H8	The RRB RIC G type 5 (Part B termination record) contains a termination of entitlement to disability benefits; however, the current reason for entitlement in the HI master identification record shows that entitlement is for other than disability.
H9	The RRB RIC G type 5 (Part B termination record) contain a termination of entitlement to disability benefits which precedes the date of entitlement to disability benefits in the HI master record by more than one month.
I1	The RRB RIC G type 1, or type 4, or type 5 did not match a master record on either claim number or BIC.

I2	The RRB RIC G type 1, or type 4, or type 5 matches a cross reference or skeleton record.
I3	The RRB RIC G type 4 (death notification) contains a date of death which disagrees with the bill date of death contained in the HI master identification record.
I7	The RRB RIC G type 1 (Part B option change) is attempting to reinstate Part B entitlement to an account on which Part B entitlement has terminated due to cessation of disability.
I8	The RRB RIC G type 1 (Part B option change) contains a refusal option, however, the HI master identification record contains a Part B termination.
I9	The RRB RIC G type 1 (Part B option change) is attempting to remove entitlement or to establish disadvantageous entitlement on an account in which there is third party involvement.
J2	A transaction containing a third party accretion matched an HI master identification record which does not contain Part A entitlement.
J3	A transaction containing a Part A third party accretion matched an HI master identification record which does not contain Part B entitlement.
J4	The transaction contains an invalid third party code (the code is other than I-9).
M1	An RRB RIC B skeleton record failed to match an HI master record on claim number, BIC, or given name.
M2	Although a Universal RIC failed to match an existing HI master record, it was not inserted because it contained a Part B option of P (RRB jurisdiction).
M4	The Universal RIC matched a master cross-reference record.
M6	The Universal RIC contained a Part B option of P and matched an SSA cross-reference number.

C. HMMHISAC CODES

1. APPROVAL CODES

CODE	DEFINITION
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10	The master identification record overlaid a master identification record at new location or a cross-reference legend was inserted at the inactive location (see also paragraph B.1 of this section).
11	The master identification record was inserted at active location (see also paragraph B.1 of this section).
12	The master identification record overlaid a master cross-reference record at the active location (see also paragraph B.1 of this section).

2. ALERT CODES

CODES	
26	A master identification record containing an SSA claim number is present at the inactive location while only an RRB flag record is present at the active location.
27	A master cross-reference record is present at the active claim number which shows that the master record was cross-referred to a claim number other than the one contained in the cross-reference transaction.
28	A master cross-reference record is present at the active claim number which shows that the master record was cross-referred to a claim number other than the one contained in the cross-reference transaction.
39	A master cross-reference record is present at the inactive claim number which shows that the master record was cross-referred to the same claim number as the one contained in the cross-reference transaction. The transaction is a duplicate transaction.
81	The transaction is duplicate RRB flag record.
90	The transaction is a duplicate RRB flag record.
99	The transaction is an initial RIC G type 8 or type 9, in which the sequence counter is other than 0 or 50.

C. 3. EXCEPTION CODES

CODE	
20	The transaction encountered a NIF condition at the inactive claim number

	(see code 90).
22	The transaction matched a master skeleton record at either the active or inactive claim number.
25	The transaction matched a master record on claim number at both the active and inactive number however, the personal characteristics in the two ends of the cross-reference do not agree.
45	The beneficiary paid the Part B deductible on two different claim numbers. When the two master records were combined, the excess deductible payment became known.
49	The transaction matched on claim number at the active location but failed to find a match on BIC; however, the personal characteristics in the inactive record matched a record at the active location on two out of three personal characteristics.
50	Two master records containing discrepant Part A entitlement dates were combined. The beneficiary was given the most advantageous date.
51	Two master records containing discrepant Part A termination dates (i.e., one record contained a termination date and one did not or the termination dates conflicted) were combined. The beneficiary was given most advantageous date.
53	Two master records containing discrepant Part B entitlement dates were combined. The beneficiary was given the most advantageous date.
54	Two master records containing discrepant Part B termination dates (i.e., one record contained a termination date and one did not or the termination dates conflicted) were combined. The beneficiary was given the most advantageous date.
55	Two master records containing conflicting prior period of coverage data were combined.
56	Two master records containing psychiatric medical expenses were combined resulting in the psychiatric maximum being exceeded.
57	Two master records each containing blood deductible charges were combined resulting in a blood deductible overcharge.
58	Two master records were combined resulting in recorded medical expense in excess of \$99999.99.
59	Two master records each containing physical therapy expenses were

	combined resulting in physical therapy expenses for one year in excess of \$100.
60	Two master records each containing Part B home health visits were combined resulting in home health visits for one year in excess of 100 days.
61	Two master records were combined and due to a balancing error the amount of expenses posted to the 4th quarter exceeds the medical charges plus 62.5% of the psychiatric charges.
F0	The transaction is an RRB flag record. It is being inserted at a location at which an HI master record has been established.

Exhibits

Exhibit 1 - Glossary of HI Terms and Codes

MIRTEL GLOSSARY

The following is a glossary of terms and abbreviations used in the MIRTEL system for microfilms, referrals, folder notices, and other records:

ACCOUNTING DATE (ACCTG DT) - Month, day and year an activity enters the MIRTEL system for processing.

ACCRETION/DELETION CODE (A D CD) - Code given by third parties to describe status of beneficiary.

Codes: blank - not applicable

1 - accretion

2 - deletion - annuitant

3 - deletion - death

4 - prepaid

5 - deletion - other

ACTIVITY CODE (ACTIVITY, LAP CD) - Type of activity processed. The Activity Code may be followed by an alpha Type of Activity code. Valid Type of Activity codes include:

C	CHICO monthly
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D	Death match
E	Medicare Advantage Part B premium reduction transaction; only valid with Activity Code 17
I	IRMAA transaction; only valid with Activity Code 17
L	Long form activity
M	Mechanical input
R	Annual premium rate change
S	Short form activity
T	Variable rate

Note: In some situations, a Type of Activity code may erroneously be carried over from a previous transaction. Ignore the Type of Activity code if it is not relevant to the Activity Code. For example, if a code “40I” is displayed in a record, ignore the Type of Activity code of “I” since Type of Activity code “I” is only valid with an Activity Code of “17.”

Type of Activity codes not included in the chart above, e.g codes A, B, C and D, have no significant value.

Activity 02 - reply from monthly recert query
Codes:

03 - name and & address query response record from CHICO

04 - drop cross-reference record (internally generated only)

05 - drop record internally only (MEDCOR)

06 - drop record - deletion to SSA (MEDCOR)

07 - maintenance exception record

08 - mechanical replies

09 – SS application from PAM

10 - RASI application establish and screen or change record (mech)

11 - attainments - establish and screen or change record (mech)

- 12 - establish HI record and screen (MEDCOR)
- 13 - establish HI record only (MEDCOR)
- 14 - create cross reference record (internally generated only)
- 17 – premium rate change
- 17E – Medicare Advantage premium reduction activity
- 17I – IRMAA activity
- 17M – variable premium rate change
- 17R – annual premium rate change
- 20 - internal record change (MEDCOR)
- 21 - internal record change and rescreen (MEDCOR)
- 21 - rescreen only (MEDCOR)
- 22 - internal record change and RIC to SSA (MEDCOR)
- 22 - RIC to SSA (MEDCOR)
- 23 - withdrawal (MEDCOR)
- 24 - withdrawal after SBI (state buy in)
- 25 - option change (MEDCOR)
- 26 - reverse termination for non-payment (MEDCOR)
- 27 - GEP enrollment (MEDCOR)
- 30 - transfer utilization SSA-RRB (G-811)
- 31 - establish record and transfer utilization SSA-RRB (MEDCOR)
- 32 - transfer utilization SSA-RRB, internal record change (MEDCOR)
- 32 - transfer utilization SSA-RRB, clearance pending (MEDCOR)
- 33 - establish record and transfer utilization RRB-RRB (MEDCOR)
- 34 - transfer utilization RRB-RRB, internal record change (MEDCOR)
- 34 - transfer utilization RRB-RRB, clearance pending (MEDCOR)

- 35 - kill credit RRB-RRB (MEDCOR)
- 36 - kill credit SSA-RRB (MEDCOR)
- 40 - premium payment
- 41 - one payment only
- 50 - death termination
- 51 - cessation of disability (MEDCOR)
- 52 - (loss of QRRB status), deactivate number (MEDCOR)
- 60 - prevent billing in manual award case (MEDCOR)
- 61 - prevent year end billing (MEDCOR)
- 62 - release ID card (MEDCOR)
- 63 - release ID card - SSA request (mechanically generated only)
- 63D – CMS death match
- 98 – double inquiry of both MIRTEL and CHICO records (MEDCOR)
- 99 – inquiry of MIRTEL record only (MEDCOR)

ANNUITY BEGINNING DATE (ABD) - beginning date of entitlement to any RR annuity, even if the annuity is not in current pay status

AVERAGE DUE AMOUNT (ARRG DUE, ARRG AMT) - total amount of SMI premiums due for previous months

ARREARAGE DUE CODE (ARRG CD)

Codes blank - not applicable

1 - premium deductions started, previous arrearage due

ASSUMED PAID THRU DATE (*) - used to show that the paid thru date in our system has not been actually established. This usually occurs in cases where jurisdiction is being transferred from SSA to RRB.

BATCH NUMBER (BTCH #), see also DATE OF LAST PAYMENT (DT LST PYMT) - for Premium Collection Group use only. This number provides a way of tracing the location of a particular premium payment.

BENEFICIARY'S NAME (BENE NAME) - space is provided in the MIRTEL system for ten letters of the first name, the middle initial, and twelve letters of the last name.

BENEFICIARY'S SS NUMBER (BENE SSA) - actual SS number of the beneficiary.

BILL RELEASE DATE (BILL REL DT) - month and year the last SMI premium bill was released.

CLAIM NUMBER (RRB CLAIM NO.) - symbol, prefix and six or nine digit RRB claim number.

CONVERSION REFERRAL INDICATION (CONV REF, C) also called HI
CONVERSION CODE (HI CONV CD) - See RCM 3.6.10.

DATE OF DEATH (DOD) - month and year of beneficiary's death.

DATE OF LAST PAYMENT (DT LST PYMT) - first three digits of this field represent the batch number. The last three digits represent the sequential date. See also BATCH NUMBER, SEQUENTIAL DATE.

DATE UNIVERSAL RIC SENT (RIC REL DT) - month, day, and last digit of the year the most recent universal RIC sent to SSA.

DELINQUENCY DATE (DELQ DT, DQ) - last month and year payment can be made before coverage will be terminated for non-payment of premiums.

DISABILITY FREEZE DATE (DIS FRZ DT) - last month and year payment can be made before coverage will be terminated for non-payment of premiums.

EMPLOYEE'S SS NUMBER (EE SSA) - social security number of the railroad employee.

EVENT CODE AND DATE (EVENT CD.DT) - code and month and year entered on G-811 item 8. The "event" provides the reason for a specific "activity" in item 3 of the G-811.

Codes: 1 - yes option

2 - no option

3 - withdrawal

4 - withdrawal after state buy in

5 - good cause

6 - death

7 - cessation of DIB

8 - dual annuitant

EXCESS PREMIUM AMOUNT (EXC PREM AMT, EXC PREM, EX PR) - a premium payment amount that cannot be applied to the beneficiary's account at this time because it is less than a full month's premium amount.

G-44 GEP CODE (G-44 GEP) - mechanically produced code

Codes: blank - No G-44 required

1 - G-44 required

2 - G-44 released

3 - G-44 returned - no option

4 - G-44 returned - yes option

5 - deemed enrollment

GEOGRAPHIC CODE (GEO CD) - For ESA use-a mechanically produced code which refers to the region of the beneficiary's residence

Codes: 000-539 and 541-599 apply to non-foreign addresses

540 and 600-698 apply to foreign addresses

999- unknown

HI EFFECTIVE DATE (HED) - month and year of entitlement to Medicare Part A, Hospital Insurance.

HI TERMINATION DATE (HI TRM DT) - month and year HI coverage terminates, due to cessation of disability

HI DATE OF BIRTH (HI DOB) - date of birth used to establish entitlement to Medicare

ID ISSUE CODE (ID ISS) - pertains to Medicare identification cards

Codes: blank - no card required

1 - G-41 required

2 - G-43 required

3 - G-41 released

4 - G-43 Part A released

5 - G-43 Part A & B released

LAST ACTIVITY PROCESSING CODE (LAP CD) - last activity processed in the MIRTEL system for this beneficiary. See ACTIVITY CODE.

LAST ACTIVITY PROCESSING DATE (LAP DT) - month, day and year of last activity processed in the MIRTEL system for this beneficiary.

ORBIT COUNT (ORB CNT) - for ESA only.

PAID THRU DATE (PD THRU DT) - month and year thru which SMI premiums have been paid.

PAYEE CODE (PC) beneficiary's payee code, if applicable

POSTMARK DATE (POSTMARK) - for Premium Collection Group use only - month and year of postmark on a premium payment

RRB DATE OF BIRTH (RRB DOB) - date of birth used to establish entitlement to an annuity under the RR Act,

PREVIOUS ACTIVITY PROCESSING CODE (PRAC) - second most recent activity processed in the MIRTEL system for this beneficiary (shown in the "Previous information" fields of the MIRTEL INQUIRY and MIRTEL FOLDER NOTICE. See "ACTIVITY CODE."

PREVIOUS ACTIVITY PROCESSING DATE (PRAD) - month and year of the second most recent activity processed in the MIRTEL system.

PREVIOUS RR NUMBER OR SECOND SS NUMBER (RRB/SSA/NO/SUF) - another claim number on which beneficiary is, was, or could be entitled to Medicare.

PSEUDO NUMBER (PSEUDO NO) - number (other than RRB claim no) assigned only by HB to identify a beneficiary.

RECORD STATUS CODE (REC STAT) - beneficiary's current situation in the MIRTEL record.

Codes: 00 - cross reference record

 01 - annuity application filed, screening reply pending

 02 - no annuity application filed, screening reply pending

 03 - annuity in suspense - screening reply pending

 04 - annuity in suspense, quarterly billing required, screening reply pending

 05 - attainment, screening reply pending

 11 - annuity in force, no deductions required

 12 - no annuity, no billing required

 13 - annuity in suspense, no deductions required

 21 - annuity in force, adjustment required

 22 - no annuity, quarterly billing required

 23 - annuity in suspense, year end billing required

 24 - annuity in suspense, quarterly billing required,

 31 - annuity in force, deductions made

 90 - cessation of disability

 98 - inactive - no longer QRRB under this number

 99 - death

REFERRAL CODE (REF CD) - most recent referral reason. See RCM 3.3 Exhibit 1a.

REFERRAL CODE DATE (REF DT) - month, date and year of most recent referral.

REF PAYEE CODE (REP PAY) - type of representative payee appointed for beneficiary.

Codes: blank - not applicable

 1 - court appointed guardian

2 - Board appointed guardian

3 - parent for child

SCREENING REPLY DATE (SREP DT) - month and year RRB receives reply from SSA to RRB screening activity

SCREENING REQUEST CODE (SREQ CD) - type of screening request processed

Codes: 1 - initial screening request

2 - tracer request

3 - screening reply received

4 - rescreening request

A - initial screening request, SSA follow-up required

B - tracer request, SSA follow-up required

C - screening reply received SSA follow-up required

D - rescreening request, SSA follow-up required

SCREENING REQUEST DATE (SREQ DT) - month and year of most recent screening activity

SECTION UNIT CODE (SEC UNIT) - three letter abbreviation of the unit requesting MIRTEL information

SEQUENTIAL DATE (SEQ DT), see also DATE OF LAST PAYMENT (DT LST PYMT) - for Premium Collection Group use only. This number represents the day of the year a SMI premium payment is made (Example: January 20, 1978 is 020; December 28, 1978 is 362).

SEX CODE (SEX, SX) - sex of beneficiary

Codes: M - male

F - female

blank - unknown

SSA CLAIM NUMBER/SUFFIX (SSA CLM NO/SUF) - SSA claim number and suffix of account on which beneficiary is entitled to SS benefits.

STATE BUY IN ACCRETION (ACCR DT) - month and year state begins paying SMI premiums

STATE BUY IN DELETION DATE (DEL DT) - last month and year state pays SMI premiums

STOP BILL DIRECT/PAYMENT (STP BIL CD) - reason premium bills should no longer be released when coverage is still intact

Codes: blank - not applicable

1 - annuity in force, stop releasing bill

2 - annuity in force, payment accepted, possible refund due

3 - annuity in force, stop releasing bill and accepting payment

SMI AMOUNT PAID (AMT PAID) - amount of payment from G-323 or premium bill currently being processed

SMI EFFECTIVE DATE (SED) - month and year of entitlement to Medicare Part B, Medical Insurance

SMI OPTION CODE (SOC) - SMI enrollment status of beneficiary

Codes: 1 - first enrollment

2 - no response

3 - no election

4 - first termination

5 - second enrollment

6 - second termination

7 - SSA jurisdiction

8 - state buy in

9 - dual annuitant

SMI OPTION FILING DATE (SOF DT) - month and year beneficiary filed current SMI option

SMI PREMIUM RATE (RPD) - beneficiary's SMI monthly premium amount

SMI TERMINATION CODE (SMI TERM CD, also part of SMI TRM CD/DT) - reason for termination of SMI coverage

Codes: blank - not applicable

1 - terminated for non payment

2 - withdrawal

9 - old delinquency/date should be terminated for non-payment

THIRD PARTY CODE (3 PTY CD) - type of third party involvement

Codes: blank - no third party involvement

01 - third party investigation

51 - Palmetto GBA

52 - Metro - North Commuter Railroad Co.

53 - Illinois Central Hospital Assn.

55 - M-K Employees Hospital Assn.

56 - Northern Pacific Beneficial Assn.

57 - Union Pacific Railroad Co.

58 - U.S. Steel and Carnegie Pension Fund

60 - A.T. & S.F. Employees Hospital Assn.

61 - Santa Fe Coast Lines

62 - Santa Fe Employees Hospital Assn.

69 - Texas and Pacific Railway Employees Hospital Assn.

70 - Wabash Memorial Hospital Assn.

98 - death

99 - deletion

TYPE OF APPLICATION (TYPE APPL) - Source of record used to establish Medicare entitlement

Codes: blank - unknown

1 - EDP (RASI)

2 - manual accretion

3 - mechanical attainment (AGE)

4 - mechanical attainment (DISABILITY)

5 - force

6 - withdrawal

7 - SSA - RRB transfer

8 - SSA - RRB transfer (uninsured SSA)

9 - disability

TYPE OF BENEFICIARY (TYPE BEN)

Codes: 01 - employee

02 - spouse

03 - widow, widower, JA

04 - survivor child

05 - parent

06 - IPI

11 - disabled employee

12 - disabled spouse

- 13 - disabled widow, widower, JA
- 14 - disabled survivor child
- 16 - disabled IPI
- 21 - disabled employee - 65 or over
- 22 - disabled spouse - 65 or over
- 23 - disabled widow, widower, JA - 65 or over
- 24 - disabled survivor child - 65 or over
- 26 - disabled IPI - 65 or over

TYPE OF BILL (TYPE BILL) also TYPE OF LAST BILL (LST BIL CD) - type of last premium bill released.

Codes: blank - unknown or not applicable

0 - G-800

1 - G-801

2 - G-802

3 - G-803 (year end)

TYPE OF RECORD (TYPE OF REC) - shows whether the record is the HI record of the beneficiary or a cross reference number to the beneficiary's record.

Codes: blank - HI record

1 - cross reference record

VOUCHER DATE (VCHR DT) - month and year of most recent voucher action, usually a mechanical adjustment to deduct SMI premiums.

VOUCHER NUMBER (VCHR NO) - number of the most recent voucher action.

YEAR END CODE (YEC) - code used in suspense cases to denote year end billing status.

Codes: blank - not applicable

1 - prevents year end billing and termination for non payment

ZIP CODE (zip) - beneficiary's zip code.

Exhibit 1a - Referral Codes

HEALTH INSURANCE SYSTEMS REFERRAL CODES

DAILY MIRTEL REFERRALS (MEDREF)

REFERRAL CODE - REFERRAL MESSAGE

1001 - INVALID OR INCORRECT ACTIVITY CODE

1002 - INVALID OR INCORRECT PREFIX

1003 - INVALID OR INCORRECT CLAIM NUMBER

1004 - INVALID OR INCORRECT BEN SYMBOL

1005 - INVALID OR INCORRECT TYPE BENEFICIARY

1006 - INVALID OR INCORRECT DATE OF BIRTH

1007 - INVALID OR INCORRECT SEX CODE

1008 - INVALID OR INCORRECT PSEUDO NUMBER

1009 - INVALID OR INCORRECT EVENT CODE

1010 - INVALID OR INCORRECT EVENT DATE

1011 - INVALID OR INCORRECT FORMER NUMBER

1012 - INVALID OR INCORRECT SUFFIX/SYMBOL

1013 - INVALID OR INCORRECT UNIT DESIGNATION

1014 - INVALID OR INCORRECT RRB DATE OF BIRTH

1015 - INVALID OR INCORRECT HI DATE OF BIRTH

1016 - INVALID OR INCORRECT BEN SSA NUMBER

1017 - INVALID OR INCORRECT EE SSA NUMBER

- 1018 - INVALID OR INCORRECT SSA CLAIM NUMBER
- 1019 - INVALID OR INCORRECT SSA SUFFIX/SYMBOL
- 1020 - INVALID OR INCORRECT RECORD STATUS
- 1021 - INVALID OR INCORRECT SMIB OPTION FILING DATE
- 1022 - INVALID OR INCORRECT SMIB OPTION
- 1023 - INVALID OR INCORRECT SMIB EFF DATE
- 1024 - INVALID OR INCORRECT SMIB PREMIUM RATE
- 1025 - INVALID OR INCORRECT PAID THRU DATE
- 1026 - INVALID OR INCORRECT EXCESS PREMIUM
- 1027 - INVALID OR INCORRECT SMIB TERM DATE
- 1028 - INVALID OR INCORRECT DELINQUENCY DATE
- 1029 - INVALID OR INCORRECT HIB EFF DATE
- 1030 - INVALID OR INCORRECT HIB TERM DATE
- 1031 - INVALID OR INCORRECT DATE OF DEATH
- 1032 - INVALID OR INCORRECT ID ISSUE CODE
- 1033 - INVALID OR INCORRECT PAYEE CODE
- 1034 - INVALID OR INCORRECT REP PAYEE CODE
- 1035 - INVALID OR INCORRECT ANN BEG DATE
- 1036 - INVALID OR INCORRECT DIS FREEZE DATE
- 1037 - INVALID OR INCORRECT SBI ACCR DATE
- 1038 - INVALID OR INCORRECT SBI DEL DATE
- 1039 - INVALID OR INCORRECT 3RD PARTY CODE
- 1040 - IDENTIFYING DATA INCONSISTENT
- 1041 - IMPROPER USE OF RESERVED AREA
- 1042 - INCONSISTENT DATA ON MECHANICAL INPUT

1043 - UNABLE TO ISOLATE NAME

1044 - INVALID OR INCORRECT STATE ABBREVIATION

1045 - INVALID OR INCORRECT FOREIGN COUNTRY NAME

1046 - INVALID OR INCORRECT CITY NAME

1047 - ZIP CODE IS MISSING

1048 - INVALID OR INCORRECT NAME AND ADDRESS

1049 - INVALID OR INCORRECT ZIP CODE

1050 - INVALID OR INCORRECT GEO CODE

1051 - INVALID OR INCORRECT STATE FOR APO-FPO

1052 - REP PAYEE DATA INCONSISTENT

1053 - DOM APPLIES ON AUTOMATIC ENROLLMENT

1054 - NO VALID SSA NUMBERS PRESENT

1055 - EE AGE OR D/F AFFECTS SPOUSE ENROLLMENT

1056 - ATTAINMENT TOO OLD TO PROCESS

1057 - INVALID UNIT TO ESTABLISH PSEUDO NUMBER

1075 - NO CHICO MASTER PRESENT ON INQUIRY REPLY

1076 - MONTHLY AWARD ACTION NOT PROCESSED

1150 - RRB BENEFICIARY CODE REJECT

1151 - RECORD DROPPED AS A DUPLICATE

1152 - DUPLICATE RECORD HAS JURISDICTION DISCREPANCY

1153 - PROGRAM REJECT-EXCESS REPLY RECORDS

1154 - REPLIES NOT EQUAL TO REQUESTS

1155 - INCONSISTENT INFORMATION ON MBR

1157 - JURISDICTION CODE DISCREPANCY

1158 - SSA AND RRB SMIB OPTION DISCREPANCY

1159 - DUPLICATE SSA/RRB TRANSFER

1160 - SSA SUFFIX MISSING

1161 - TRANSFER MANUALLY-PAID THRU DATE UNDETERMINED DUE TO P-OPTIONS

1162 - POSSIBLE ENROLLMENT UNDER DISABILITY PROVISIONS

1163 - P-OPTION ENCOUNTERED IN MBR

1164 - MANUAL TRANSFER REQUIRED-SSA TERM AFTER RRB SMIB DATE

1165 - MEANINGLESS DISPOSITION CODE FOUND IN RECORD

1166 - DUPLICATE MAINTENANCE EXCEPTION RECORDS

1167 - DUPLICATE MAINTENANCE EXCEPTION RECORDS - EXCEPT FOR DISPOSITION CODES

1200 - RECORD STATUS IN ACTIVITY CONFLICTS WITH MIRTEL

1201 - SMIB OPTION IN ACTIVITY INCONSISTENT WITH MIRTEL

1203 - RECORD STATUS IS INCONSISTENT WITH MIRTEL

1204 - RECORD STATUS IN ACTIVITY INCONSISTENT WITH MIRTEL SMIB OPTION

1205 - UNABLE TO PROCESS ACTIVITY WITH THIS MIRTEL

1206 - ACTIVITY MATCHED MIRTEL WITH LAP CODE 06

1207 - ACTIVITY/MIRTEL SSA NUMBERS NOT EQUAL

1209 - RR DOB IN ACTIVITY AND MIRTEL NOT EQUAL

1210 - SMIB EFFECTIVE DATE IN ACTIVITY AND MIRTEL NOT EQUAL

1211 - MIRTEL HAS NO SSA NUMBERS

1220 - MIRTEL HAS NO ADDRESS - MUST SUPPLY

1221 - SMIB OPTION INVALID FOR THIS MIRTEL

1222 - ACTIVITY INVALID FOR INACTIVE MIRTEL

1223 - TOB INVALID FOR THIS MIRTEL

- 1224 - SBI INFORMATION MISSING OR INVALID FOR THIS MIRTEL
- 1225 - ACTIVITY INVALID AGAINST DUAL ANNUITANT
- 1226 - SMIB TERM DATA INVALID FOR THIS MIRTEL
- 1227 - ENROLLMENT DATA MISSING OR INVALID FOR THIS MIRTEL
- 1228 - UNABLE TO CHANGE ENTITLEMENT DATA OR DOB WITH THIS ACTIVITY
- 1229 - MIRTEL SHOWS CHICO IN FORCE WITH DED - ACTIVITY HAS NO PAID THRU DATE
- 1230 - MIRTEL SHOWS CHICO IN FORCE WITH DED - ACTIVITY SHOWS NO ANNUITY
- 1231 - SBI ACTIVITY CONVEYING DEATH - MIRTEL NOT UPDATED
- 1232 - UNABLE TO PROCESS ACTIVITY WITH THIS MIRTEL
- 1233 - NAME AND DOB IN ACTIVITY AND MIRTEL NOT EQUAL
- 1234 - MIRTEL SHOWS CHICO IN FORCE WITH DED - ACTIVITY INVALID
- 1235 - SEX CODE ON ACTIVITY AND MIRTEL NOT EQUAL
- 1236 - ACTIVITY 17 INVALID AGAINST NON-CONVERSION REFERRAL RECORD
- 1237 - ATTAINMENT MATCHED EXISTING MIRTEL - PROCESS MANUALLY
- 1238 - TOB, DOB OR EFF DATES INCONSISTENT BETWEEN ACTIVITY AND MIRTEL
- 1239 - HIB TERM DATE INVALID FOR THIS MIRTEL
- 1240 - PAM MATCHED MIRTEL - PROCESS MANUALLY
- 1300 - CHANGE ACTIVITY NOT MATCHED TO MIRTEL
- 1301 - ACTIVITY TO ESTABLISH RECORD MATCHED EXISTING MIRTEL
- 1302 - CROSS REFERENCE RECORD MATCHED EXISTING ENTITLEMENT RECORD
- 1303 - SAME AS 1301 - ACTIVITY TO ESTABLISH RECORD MATCHED EXISTING MIRTEL
- 1304 - ACTIVITY MATCHED CROSS REFERENCE RECORD

1305 - REFERRAL CODE 1305

1306 - NO ADDRESS IN MIRTEL OR ACTIVITY, UNABLE TO OBTAIN FROM CHICO

1307 - UNABLE TO PROCESS ACTIVITY - MIRTEL HAS CONVERSION REFERRAL

1308 - UNABLE TO PROCESS ACTIVITY - SCREENING REPLY OUTSTANDING

1309 - ACTIVITY MATCHED MIRTEL CODED FOR DROP

1310 - ADDRESS UNAVAILABLE - MIRTEL DROPPED - NO RIC SENT

1311 - ADDRESS OR SEX CODE REQUIRED FOR ID CARD

1312 - NO REPLY TO SCREENING TRACER OR TO RESCREENING REQUEST

1313 - PAID THRU DATE AFTER SMIB TERM POSSIBLE REFUND

1316 - MONTHLY AWARD ACTION TAKEN MIRTEL RECORD STATUS INVALID

1317 - DEEMED OR SELECTED FOR GEP - MIRTEL HAS CONVERSION REFERRAL

1318 - SELECTED FOR YEAR END BILLING MIRTEL HAS CONV REF 9

1319 - DUAL ANNUITANT W/O RECORD FOR PRIMARY EMPLOYEE

1326 - PAYEE CODE REQUIRED FOR CHICO ADDRESS INQUIRY

1327 - SAME AS 1311 - ADDRESS OR SEX CODE REQUIRED FOR ID CARD

1328 - SAME AS 1306 - NO ADDRESS IN MIRTEL OR ACTIVITY, UNABLE TO OBTAIN FROM CHICO

1329 - MASTER NOT ESTABLISHED – POSSIBLE DUAL ANNUITANT

1400 - PREMIUM PAYMENT REJECT - NO MASTER

1401 - PREMIUM PAYMENT REJECT - MIRTEL JURISDICTION PENDING

1402 - PREMIUM PAYMENT REJECT - ANN INF W/O PREM DEDUCTION - CHECK PART B OPTION

1403 - PREMIUM PAYMENT REJECT - CHECK OPTION

1404 - PREMIUM PAYMENT REJECT - ANNUITY IN SUSPENSE

1405 - PREMIUM PAYMENT REJECT - PREMIUM BEING DEDUCTED

1406 - PREMIUM PAYMENT REJECT - NO LONGER QRRB UNDER THIS NUMBER

1407 - PREMIUM PAYMENT REJECT - CESSATION OF DISABILITY

1408 - PREMIUM PAYMENT REJECT - DEATH NOTICE

1409 - PREMIUM PAYMENT REJECT - ANNUITY IN FORCE

1410 - PREMIUM PAYMENT REJECT - INVALID RECORD STATUS

1411 - PREMIUM PAYMENT REJECT - DUPLICATE PREMIUM PAYMENT

1412 - PREMIUM PAYMENT REJECT - POSSIBLE REFUND

1413 - PREMIUM PAYMENT REJECT - INVALID SMIB RATE IN MIRTEL

1414 - PREMIUM PAYMENT REJECT - UNABLE TO COMPUTE - SMIB EFF DATE PRIOR TO 9/73

1415 - PREMIUM PAYMENT REJECT - EXCESS PREM EXCEEDS SMIB PREM RATE/ADJ OR REF

1416 - PREMIUM PAYMENT REJECT - CHANGE IN THIRD PARTY

1450 - PREMIUM BILLING REJECT - SMIB RATE NOT FOUND IN TABLE

1451 - PREMIUM BILLING REJECT - INVALID DELINQUENCY DATE

1452 - PREMIUM BILLING REJECT - BILLED AMOUNT EXCEEDS 999.99

1453 - PREMIUM BILLING REJECT - UNABLE TO COMPUTE

1501 - INVALID OR INCORRECT CHANGE INDICATOR

1502 - INVALID OR INCORRECT SMIB RATE TABLE INDICATOR

1503 - INVALID OR INCORRECT SMIB VARIABLE RATE INDICATOR

1504 - INVALID OR INCORRECT SMIB PENALTY PCT INDICATOR

1505 - INVALID OR INCORRECT CAT EFF DATE

1506 - INVALID OR INCORRECT ENTRY MADE

1507 - ADDRESS DOES NOT MATCH RESIDENCY TABLE

1508 - VARIABLE RATE EFFECTIVE IN JANUARY

1509 - CAT EFF DATE BEFORE SMIB EFF DATE

1510 - SMIB PREMIUM RATE NOT CONSISTENT WITH INDICATOR

1511 - INVALID OR INCORRECT SMIB OPTION

1512 - NAME AND ADDRESS NOT COMPLETED

1513 - REJECT - COL VARIABLE - NO MATCHING MIRTEL RECORD (17M)

1514 - REJECT - COL VARIABLE - MIRTEL SMIB OPTION OTHER THAN 1 OR 5 (17M)

1515 - REJECT - COL VARIABLE - MIRTEL DOES NOT HAVE DEDUCTION STATUS (17M)

1516 - REJECT - COL VARIABLE - VERIFY SMIB EFF (17M)

1517 - CAT EFF DATE LESS THAN MASTERS DATE - ACTIVITY 17 REJECTED

1518 - RPD ON ACTIVITY AND MIRTEL NOT EQUAL - SUBMIT G-810-17

1551 - CAT EFF DATE LESS THAN HIB EFF DATE - MASTER NOT UPDATED (17M)

1813 - SCREENING REPLY RECEIVED - MIRTEL NOT PENDING

2101 - ALERT - INCORRECT HI DATE CHANGED TO AGREE WITH OTHER DATA

2102 - ALERT - INCORRECT SMIB DATE CHANGED TO AGREE WITH OTHER DATA

2103 - ALERT - REP PAYEE CODE CHANGED TO AGREE WITH OTHER DATA

2104 - ALERT - DATA IN ZIP CODE AREA INCONSISTENT WITH FOREIGN ADDRESS

2109 - ALERT - ZIP CODE INCORRECT OR OMITTED - DEVELOPED FROM ZIP MASTER

2110 - ALERT - ZIP CODE OMITTED - NOT FULLY DEVELOPED FROM ZIP MASTER

2111 - SAME AS 2109 - ALERT - ZIP CODE INCORRECT OR OMITTED - DEVELOPED FROM ZIP MASTER

2112 - ALERT - ZIP CODE OMITTED - DEVELOPED IN ISOLATED AREA ONLY

2113 - ALERT - CHECK ZIP CODE - UNABLE TO VERIFY IN ZIP MASTER

2114 - ALERT - CHECK EFF DATES WITH DATE OF MARRIAGE

2115 - ALERT - PAYEE CODE MISSING -RECORD STATUS SHOWS ANNUITY IN FORCE

2116 - ALERT - EE AGE OR D/F USED TO DETERMINE SPOUSE EFF DATES

2175 - REPLY - ALERT REFERRAL PRODUCED

2176 - REPLY - RR ANNUITY IN SUSPENSE - VERIFY ADDRESS FOR ID CARD

2177 - REPLY - MANUAL TRANSFER - CESSATION OF DIB

2178 - REPLY - DEEMED QRRB FROM SSA

2208 - ALERT - CHECK PREV ARREARAGE

2210 - ALERT - UNABLE TO COMPUTE RPD - CURRENT BASIC RATE IN MIRTEL

2211 - ALERT - UNABLE TO COMPUTE RPD - PAID THRU DATE NOT ADJUSTED

2212 - ALERT - VARIABLE RATE INVOLVED - CURRENT HI-RPD USED

2213 - ALERT - VARIABLE RATE INVOLVED - PENALTY ADDED TO VARIABLE BASE RATE

2220 - ALERT - SMIB TERMINATED - ARREARAGE DUE

2221 - ALERT - SMIB OPTION CHANGED FROM 1ST TO 2ND ENROLLMENT

2222 - ALERT - SBI PRIOR TO SMIB TERM DATE POSSIBLE REFUND OR ARREARAGE DUE

2223 - ALERT - SMIB EFF DATE CHANGED TO LATER DATE

2224 - ALERT - PAID THRU DATE AFTER DOD - CHECK FOR POSSIBLE REFUND

2225 - ALERT - TOB CHANGED - RPD CHANGED TO BASIC - CHECK FOR REFUND

2226 - ALERT - ANNUITY ADJUSTED - ARREARAGE DUE

2227 - ALERT - CESSATION OF DIB - ARREARAGE DUE

2228 - ALERT - BENEFICIARY DECEASED - ARREARAGE DUE

2229 - ALERT - RESCREENING CONVEYED LESS ADVANTAGEOUS INFO

2230 - ALERT - SCREENING REJECT RECEIVED - MIRTEL STILL PENDING

2231 - ALERT - SMIB TERM DATE AFTER CESSATION OF DIB

2232 - ALERT - PREMIUMS PAID AFTER SBI - POSSIBLE REFUND DUE

2233 - ALERT - PREMIUMS DUE FOR PERIOD PRIOR TO SBI

2234 - ALERT - PREVIOUS ARREARAGE - CHECK ACCTS RECEIVABLE OR ARREARAGE

2235 - ALERT - PREVIOUS ARREARAGE - AMT UNKNOWN - CHECK ACCTS RECEIVABLE

2236 - ALERT - SBI CONVEYING EARLIER SMIB EFF DATE - MIRTEL UPDATED

2237 - SBI DEL - VARIABLE RATE IN PREV YR - CHECK PREM AMOUNT DUE FOR PREV YR

2238 - SBI DEL - PREV VARIABLE RATE NOT FOUND - SECURE AND UPDATE

2239 - SBI ACCR - PREV YR VARIABLE - POSSIBLE REFUND DUE

2314 - ALERT - TERMINATED DIB ENROLLED FOR AGE-DIB HAD ARREARAGE

2412 - ALERT - PREMIUM PAYMENT POSSIBLE REFUND

2415 - ALERT - PREMIUM PAYMENT RECEIVED - CHECK ACCTOUNTS RECEIVABLE

2416 - ALERT - PREMIUM PAYMENT CHANGE IN 3RD PARTY CODE

2417 - ALERT - PREMIUM PAYMENT APPLIED TO MONTHS PRIOR TO PREV CAT EFF DATE

2418 - ALERT - PREMIUM BILLED FOR MONTHS PRIOR TO PREV CAT EFF DATE

2420 - ALERT - TERMINATED FOR NON-PAYMENT

2517 - ALERT - COL VARIABLE RESIDENCY CHANGED - VERIFY SMIBB RATE

2518 - ALERT - COL VARIABLE MIRTEL PCT RETAINED - POSSIBLE REFUND OR ARREARAGE

2519 - ALERT - COL VARIABLE - POSSIBLE REFUND OR ARREARAGE (17T)

2601 - ALERT - RPD CHANGED TO REFLECT NEW RESIDENCY AND PENALY PCT

2602 - ALERT - RPD AND RESIDENCY CODE CHANGED TO REFLECT NEW ADDRESS

2603 - ALERT - RPD CHANGE FOR NEW RESIDENCY - NEW RATE LESS THAN VARIABLE

2604 - ALERT - RPD CHANGED TO CONFORM TO MASTER CATASTROPHIC CODING

2605 - ALERT - CAT EFF DATE EARLIER THAN PREV ADJUST DATES

2606 - ALERT - CATASTROPHIC HISTORY OUT OF SEQUENCE – ADJUST MANUALLY

2620 - ALERT - PENALTY PCT CHANGED TO AGREE WITH RPD

2621 - ALERT - PENALTY PCT AND RES CODE CHANGED TO REFLECT NEW RPD AND RES

2630 - ALERT - SBI ACCR ON VARIABLE CASE - NO VARIABLE RATE

2640 - ALERT - VARIABLE RATE EXCEEDS LIMIT FOR PENALTY PCT - CORRECT RATE OR CODE

2641 - ALERT - RESIDENCY CHANGED - NEW VARIABLE RATE DEVELOPED - REVIEW

2642 - ALERT - RESIDENCE CHANGED AND RATE ASSUMED VARIABLE - VERIFY

2660 - ALERT - PRIOR YR VARIABLE RATE CLEARED - POSSIBLE ERRONEOUS ADJUSTMENT

2675 - ALERT - PREMIUM PAYMENT YIELDS PTD PAST DEC - CHECK EXCESS PREMIUM

2676 - ALERT - PREMIUM PAYMENTS - EXCESS PREMIUM EXCEEDS \$99.99

2694 - ALERT - CATASTROPHIC DATA DEVELOPED - RPD ASSUMED VARIABLE - VERIFY

2695 - ALERT - CATASTROPHIC DATA DEVELOPED - RPD NON-VARIABLE - VERIFY

2696 - ALERT - CATASTROPHIC DATA DEVELOPED - INVALID RPD - ASSUME VARIABLE

2697 - ALERT - RPD NOT MATCHED TO TABLE - ASSUMED VARIABLE - VERIFY

2698 - ALERT - RPD EQUALS ZEROS

2699 - ALERT - RPD MATCHED TO NEW AND OLD RATE TABLES - VERIFY PENALTY PCT

2900 - SCREENING REPLY PENDING - DEATH MATCH SHOWS DOD

2901 - ANNUITY IN FORCE - DEATH MATCH SHOWS DOD

2902 - ACTIVE MIRTEL - DEATH MATCH SHOWS DOD

2903 - MIRTEL SHOWS CESSATION OF DIB - DEATH MATCH SHOWS DOD

2904 - MIRTEL SHOWS LOSS OF QRRB STATUS - DEATH MATCH SHOWS DOD

2001

MBR SCREENING ALERTS

REFERRAL CODE - REFERRAL MESSAGE

2801 - ALERT - REPLY CONVEEYING TERM - MIRTEL NOT UPDATED

2802 - ALERT - REPLY CONVEYING SBI ENROLLMENT - MIRTEL NOT UPDATED

2803 - ALERT - REPLY HAS YES OPTION - MIRTEL TERM - NOT UPDATED

2804 - ALERT - REPLY HAS 2ND ENROLLMENT - MIRTEL 1ST ENROLLMENT – NOT UPDATED

2805 - ALERT - REPLY HAS CONFLICTING DATA - MIRTEL INFO RETAINED

2806 - ALERT - REPLY RECEIVED HAS 1ST ENROLLMENT 2ND ENROLLMENT - MIRTEL NOT UPDATED

2807 - ALERT - REPLY RECEIVED - MIRTEL HAS DUAL ANNUITANT - NOT UPDATED

2808 - ALERT - REPLY RECEIVED ON INACTIVE CASE - REPLY NOT PROCESSED

2809 - ALERT - RESCREENING REPLY CONVEYING EARLIER SED - MIRTEL NOT UPDATED

2810 - ALERT - CHECK PAID THRU - POSSIBLE REFUND - MIRTEL NOT UPDATED

2811 - ALERT - POSSIBLE DUAL DEDUCTIONS - MIRTEL NOT UPDATE

MIRTEL FOLDER NOTICE

REFERRAL CODES - REFERRAL MESSAGE

3220 - PREMIUMS PAID AFTER SBI POSSIBLE REFUND DUE

3221 - PREMIUMS DUE FOR PERIOD PRIOR TO SBI

3222 - IEP OPTION CHANGE - POSSIBLE REFUND DUE

3223 - PREMIUMS PAID AFTER TERM DATE - POSSIBLE REFUND DUE

3224 - PREVIOUS ARREARAGE - CHECK ACCTS REC OR ARREARAGE AMT

3226 - PREVIOUS ARREARAGE - AMOUNT UNKNOWN - CHECK ACCT REC

3227 - REVERSE TERMINATION - PREVIOUS ARREARAGE

3228 - SMIB OPTION CHANGED - POSSIBLE REFUND DUE

3229 - ANNUITY IN FORCE W/DED - POSSIBLE REFUND DUE

3231 - LOSS OF QRRB - PREV ARREARAGE - CHECK ACCTS REC FOR AMT

3301 - MIRTEL DROPPED

3302 - SCREENING REPLY PENDING FOR 30 DAYS - TRACER SENT

3304 - TOB CHANGED TO 2 - AGE 65

3303 - CESSATION OF DIB - MIRTEL TERMINATED

3812 - RRB JURISDICTION - REPLY PROCESSED

DOD ALERT REFERRAL (MEDREF)

REFERRAL CODE - REFERRAL MESSAGE

4001 - DATE OF DEATH EXCHANGE REFERRAL

4002 - DATE OF DEATH DISCREPANCE REFERRAL

RR DISABILITY ATTAINMENT REFERRALS (MEDREF)

REFERRAL CODE - REFERRAL MESSAGE

7101 - DIS EMPLOYEE - NO MATCHING BP RECORD

7102 - DIS EMPLOYEE - BP RECORD TERM OR BEN SYM NOT 0

7103 - SUSP DIS EMPLOYEE - BEN SYM NOT 0

7104 - SUSP DIS EMPLOYEE - BP RECORD MATCHED

7105 - RECONSIDERED DIS EMPLOYEE 64-7 OR LESS - NO MATCHING BP RECORD

7106 - RECONSIDERED DIS EMPLOYEE 64-7 OR LESS - BP RECORD TERM OR BEN SYM NOT 0

7107 - RECONSIDERED DIS EMPLOYEE 64-7 OR LESS - BP RECORD MATCHED

7108 - SUSP RECONSIDERED DIS EMPLOYEE 64-7 OR LESS - BEN SYM NOT 0

7109 - SUSP RECONSIDERED DIS EMPLOYEE 64-7 OR LESS - BP RECORD
MATCHED

7110 - RECONSIDERED DIS EMPLOYEE OVER 64-7 - NO MATCHING BP RECORD

7111 - RECONSIDERED DIS EMPLOYEE OVER 64-7 - BP RECORD TERM OR BEN
SYM NOT 0

7112 - RECONSIDERED DIS EMPLOYEE OVER 64-7 - BP RECORD MATCHED

7113 - SUSP RECONSIDERED DIS EMPLOYEE OVER 64-7 - BEN SYM NOT 0

7114 - SUSP RECONSIDERED DIS EMPLOYEE OVER 64-7 - BP RECORD
MATCHED

7115 - DIS CHILD IPI - BP RECORD MATCHED

7116 - DIS EMPLOYEE - NO SMIB INDICATION - NO MATCHING BP RECORD

7117 - DIS EMPLOYEE - NO SMIB INDICATION - BP RECORD TERM OR BEN SYM
NOT 0

7118 - DIS EMPLOYEE - NO SMIB INDICATION - BP RECORD MATCHED

7119 - SUSP DIS EMPLOYEE - NO SMIB INDICATION - BEN SYM NOT 0

7120 - SUSP DIS EMPLOYEE - NO SMIB INDICATION - BY RECORD MATCHED

7121 - DIS CHILD IPI - NO SMIB INDICATION - BEN SYM NOT 0

7122 - DIS CHILD IPI - NO SMIB INDICATION - BP RECORD MATCHING

7201 - SURV DIS CHILD - SS RATING - NO MATCHING BP RECORD

7202 - SURV DIS CHILD - SS RATING - BP RECORD TERM

7203 - SURV DIS CHILD - SS RATING - BEN SYM NOT 3 OR 6

7204 - SUSP SURV DIS CHILD - SS RATING - BP RECORD MATCHED

7205 - SUSP SURV DIS CHILD - SS RATING - BEN SYM NOT 3 OR 6

7206 - SURV DIS CHILD - NO SS RATING - NO MATCHING BP RECORD

7207 - SURV DIS CHILD - NO SS RATING - BP RECORD TERM

7208 - SURV DIS CHILD - NO SS RATING - BP RECORD MATCHED

7209 - SURV DIS CHILD - NO SS RATING - BEN SYM NOT 3 OR 6

7210 - SUSP SURV DIS CHILD - NO SS RATING - BP RECORD MATCHED

7211 - SUSP SURV DIS CHILD - NO SS RATING - BEN SYM NOT 3 OR 6

7212 - DIS WIDOW - SS RATING - NO MATCHING BP RECORD

7213 - DIS WIDOW - SS RATING - BP RECORD TERM

7214 - DIS WIDOW - SS RATING - BEN SYM NOT 6

7215 - SUSP DIS WIDOW - SS RATING - BP RECORD MATCHED

7216 - SUSP DIS WIDOW - SS RATING - BEN SYM NOT 6

7217 - DIS WIDOW - NO SS RATING - NO MATCHING BP RECORD

7218 - DIS WIDOW - NO SS RATING - BP RECORD TERM

7219 - DIS WIDOW - NO SS DATE - RATING CODE IS 0 OR 1

7220 - DIS WIDOW - NO SS DATE - BEN SYM NOT 6

7221 - SUSP DIS WIDOW - NO SS DATE OR BP RECORD MATCHED

7222 - SUSP DIS WIDOW - NO SS DATE - BP RECORD MATCHED

7223 - SUSP DIS WIDOW - NO SS DATE - BEN SYM NOT 6

7224 - WIDOW - NO MATCHING BP RECORD

7225 - WIDOW - PB RECORD TERM

7226 - WIDOW - BEN SYM NOT 3 OR 6

7227 - SUSP WIDOW - BP RECORD MATCHED

7228 - SUSP WIDOW - BEN SYM NOT 3 OR 6

7229 - DIS SURV ELIGIBLE FOR MEDICARE PREV - NOT ENROLLED – NO MATCHING BP RECORD

7230 - DIS SURV ELIGIBLE FOR MEDICARE PREV - NOT ENROLLED - DP RECORD TERM

7231 - DIS SURV ELIGIBLE FOR MEDICARE PREV - NOT ENROLLED - BP RECORD MATCHED

7232 - DIS SURV ELIGIBLE FOR MEDICARE PREV - NOT ENROLLED - BEN SYM NOT 3 OR 6

7233 - SUSP DIS SURV ELIGIBLE FOR MEDICARE PREV - NOT ENROLLED - BP RECORD MATCHED

7234 - SUSP DIS SURV ELIGIBLE FOR MEDICARE PREV - NOT ENROLLED - BEN SYM NOT 3 OR 6

7301 - UNABLE TO DETERMINE NAME OF DIS CHILD

7302 - RETIREMENT - NO ABD IN RESEARCH RECORD

7303 - SURVIVOR - NO ABD IN RESEARCH RECORD

7901 - NOTIFY BA **** STEEL COMPANY RR OF DISABILITY ANNUITANT MEDICARE ENTITLEMENT

STATE BUY-IN/PARS REFERRALS (MEDREF)

REFERRAL CODE - REFERRAL MESSAGE

6301 - STATE BUY-IN ADJUSTMENT

6302 - STATE BUY-IN ADJUSTMENT WITH PARS

PAM REFORMAT REJECT (MEDREF)

REFERRAL CODE - REFERRAL MESSAGE

9970 - UNABLE TO PROCESS - HANDLE MANUALLY

SCREENING REJECT REFERRAL (MEDREF)

REFERRAL CODE - REFERRAL MESSAGE

5001 - NAME NOT UPDATED - OTHER FIELDS UPDATED

5002 - BENE NAME HAS OTHER THAN ALPHA OR BLANKS OR INCORRECTLY STRUCTURED

5003 - FIRST LINE OR LAST LINE OF ADDRESS INCORRECT

5004 - LAST LINE OR FIRST LINE OF ADDRESS INCORRECT

5005 - SEX CODE UNKNOWN

5006 - HI CARD CODE OTHER THAN 0, 1 OR 2

- 5007 - ALERT - CESSATION OF DIB UPDATED
- 5008 - REQUESTER IDENTITY UNKNOWN
- 5009 - SEX CODE OTHER THAN MALE OR FEMALE
- 5010 - BENE NAME HAS OTHER THAN ALPHA OR BLANKS OR INCORRECTLY STRUCTURED
- 5011 - 3RD PARTY PART B CODE OR DATE INCORRECT
- 5012 - URIC UNMATCHED ON HI CLAIM NUMBER
- 5013 - URIC MATCHED SKELETON RECORD
- 5014 - DUAL SURVIVORS - TRANSFER COMPLETED - PLEASE INVESTIGATE
- 5015 - UNMATCHED ON HI CLAIM NUMBER
- 5016 - URIC PROCESSING DATE EQUALS EDB PROCESSING DATE
- 5017 - DUPLICATE DATE BEING CONVEYED TO EDB
- 5018 - URIC MATCHED EDB ON NAME, DOB AND SEX - UNMATCHED ON BIC
- 5019 - URIC MATCHED EDB ON BIC - MATCHED ANOTHER EDB ON NAME, DOB AND SEX
- 5020 - URIC MATCHED ON HI CLAIM NUMBER - UNMATCHED ON NAME, DOB AND SEX
- 5021 - HI CLAIM NUMBER AND EQUATABLE BIC MATCHED MORE THAN ONE EDB
- 5022 - UNMATCHED ON HI CLAIM NUMBER
- 5023 - RIC G MATCHED OTHER THAN EDB
- 5024 - DUPLICATE DATA BEING CONVEYED TO EDB
- 5025 - HI CLAIM NUMBER INCORRECTLY STRUCTURED
- 5026 - BIC BEN SYM AND PREFIX NOT VALID
- 5027 - BIC AND SEX CODE INCONSISTENT
- 5028 - DATE OF BIRTH INCORRECTLY STRUCTURED
- 5029 - CURRENT OR PRIOR PART A EFF DATE INCORRECTLY STRUCTURED

5030 - PART A OR B OPTION CODE OR PART A OR B EFF DATE INCONSISTENT WITH OTHER DATA

5031 - CURRENT OR PRIOR PART B OPTION CODE NOT VALID OR INCONSISTENT WITH TYPE ACTION

5032 - CURRENT OR PRIOR PART B EFF DATE INCORRECTLY STRUCTURED

5033 - PART B EFF DATE INCONSISTENT WITH OTHER DATA

5034 - PART B TERM DATE INCORRECTLY STRUCTURED

5035 - PART B TERM DATE INCONSISTENT WITH PART B OPTION

5036 - EFF DATE INCORRECTLY STRUCTURED

5037 - URIC CODE NOT 1, 4, 5, 6 OR 9

5038 - EVENT CODE INCONSISTENT WITH URIC CODE - FORWARD TO SUPERVISOR

5039 - EFF DATE INCORRECT OR INCONSISTENT WITH OTHER DATA

5040 - REINSTATEMENT AND URIC CODE INCONSISTENT

5041 - XREF HI CLAIM NUMBER INCORRECTLY STRUCTURED

5042 - XREF BIC INCORRECT

5043 - KILL CREDIT OR XREF CODE NOT J OR INCONSISTENT WITH URIC

5044 - DATE OF DEATH NOT VALID

5045 - URIC PROCESSING DATE INCORRECT

5046 - RRB EDB WITH P-OPTION MATCHED TO RRB FLAG EDB

5047 - SSA URIC REJECT - SSA HI CLAIM NUMBER XREF TO RRB EDB

5048 - RRB URIC REJECT - RRB HI CLAIM NUMBER XREF TO SSA EDB

5049 - RRB URIC MATCHED ON BIC TO EDB SKELETON RECORD

5050 - RRB DIB URIC MATCHED AGED EDB

5051 - DIB CODE IS INCORRECT

5052 - PART A EFF DATE FOR DIB BENE INCORRECT

- 5053 - PART B EFF DATE FOR DIB BENE INCORRECT
- 5054 - RRB RECORD STATUS CODE INCORRECT
- 5055 - FIRST SSA HI CLAIM NUMBER MISSING
- 5056 - REASON FOR ENTITLEMENT CODE NOT AGED OR DIB
- 5057 - MBR CURRENT OR PREV PART A OPTION INCORRECT
- 5058 - FIRST PART A TERM DATE INCORRECT
- 5059 - CONFLICT BETWEEN MBR PART A OPTION, EFF DATE AND TERM DATE
- 5060 - ZIP CODE MISSING
- 5061 - SECOND PART A TERM DATE INCORRECT
- 5062 - UNMATCHED ON HI CLAIM NUMBER
- 5063 - DUPLICATE DATA BEING CONVEYED TO EDB
- 5064 - NO PART B EFF DATE ON EDB
- 5065 - TERM DATE NOT GREATER THAN PART B EFF DATE PLUS 1 MONTH
- 5066 - CANNOT TERM PART B BECAUSE 3RD PARTY INVOLVEMENT
- 5067 - DIB TERM BUT NO DIB INDICATION IN EDB
- 5068 - DIB TERM INCONSISTENT WITH EDB ENTITLEMENT DATES
- 5069 - MBR INCOMPATIBLE WITH RRB SYMBOL AND PREFIX
- 5070 - NO SSA MATCH ON IDENTITY OF BENE
- 5071 - SSA NUMBER INACTIVE
- 5072 - UNMATCHED ON HI CLAIM NUMBER
- 5073 - RIC G MATCHED OTHER THAN EDB
- 5074 - DUPLICATE DATA BEING CONVEYED TO EDB
- 5075 - PART B TERM ON EDB
- 5076 - EFF DATE UNEQUAL TO EDB PART B EFF DATE
- 5077 - REINSTATING PART B BUT NO TERM DATE ON EDB

5078 - DUPLICATE DATA BEING CONVEYED TO EDB

5079 - PART B EFF DATE INCORRECT

5080 - PART B EFF DATE PRIOR TO 7-73, ENTITLEMENT CODE DIB

5081 - PART A OR B EFF DATE INCORRECT

5082 - 2ND PART B TERM DATE INCONSISTENT WITH OTHER FIELDS

5083 - RRB URIC CONVEYING ADVERSE PART A OR B EFF DATE - NOT APPLIED

5084 - RRB URIC CONVEYING ADVERSE PART A OR B EFF DATE - APPLIED

5085 - URIC ENTITLEMENT DATE OUT OF SYNC WITH EDB

5086 - URIC WITH NO PART B EFF DATE MATCHED EDB WITH CURRENT AND PRIOR PART B

5087 - RRB URIC CONVEYING AN ADVERSE PART B EFF DATE - APPLIED

5088 - RRB URIC REINSTATING PART B ENTITLEMENT

5089 - TERM DATE NOT GREATER THAN PART B EFF DATE PLUS 1 MONTH

5090 - XREF ACTION REJECTED

5091 - ACTIVE RRB - MATCHED SKELETON - BAD LAF

5092 - ACCRETION BOAN POINTS TO MULTIPLE HI CLAIM NUMBERS

5093 - MATCHED ON NAME, DOB AND SEX - UNMATCHED ON BIC

5094 - FIRST INITIAL, LAST NAME AND DOB MATCHED ANOTHER EDB

5095 - HOC/SOC EQUAL P ON SSA URIC

5096 - DEL ENTITLEMENT FAILED - MATCHED HIC AND BIC - UNMATCHED ON NAME, DOB AND SEX

5097 - DENIAL CASE MATCHED ACTIVE EDB

5098 - EDB ENTITLEMENT REASON NOT UPDATED OR DELETED

5099 - SEQUENCE ERROR - DIB/ESRD AFTER AGED ENTITLEMENT

5100 - RRB XREF ACTION FAILED - EXCEPTION CODE UNKNOWN

5101 - UNMATCHED RRB SKELETON EDB ON ACCOUNT NUMBER AND BIC OR GIVEN NAME

5102 - RRB URIC UNMATCHED TO EDB BUT NOT ACCRETED TO EDB

5103 - RRB URIC MATCHED TO XREF EDB

5104 - XREF REJECT - ACTIVE AND INACTIVE BIC A

5105 - RRB EDB WITH P-OPTION MATCHED XREF CONTAINING ACTIVE SSA NUMBER

5106 - RRB XREF REJECT - ACTIVE OR INACTIVE HIC HAVE A BAD LAF

5107 - TEMPORARY EDB AT CMS

5108 - RRB URIC CONVEYING PART B EFF DATE PRIOR TO DIB ATTAINMENT AGE

5109 - SSA SYSTEMS LIMITATION

5110 - EDB AIF PROBLEM

5111 - URIC REQUEST - NO MBR FOR CLAIM NUMBER

5112 - URIC REQUEST - NO MBR FOR BIC

5113 - URIC REQUEST - NO DUAL ENTITLEMENT

5114 - URIC REQUEST - NO ENROLLMENT INFORMATION ON MBR

5301 - RRB NUMBER INCORRECT

5302 - RRB SYMBOL AND PREFIX INCORRECT

5303 - RRB PAYMENT STATUS INCORRECT

5304 - RRB BENE CODE INCORRECT

5305 - RRB XREF CODE INCORRECT

5306 - DUPLICATE SSA NUMBERS

5307 - RRB EXCHANGE JURISDICTION CODE INCORRECT

5401 - NO RECORD OF BIC IN SSA FILE

5402 - SSA RECORD HAS NO HI DATA

5403 - SSA BENEFIT TERM, BIC ALIVE

5404 - SSA RECORD SHOWS RRB HI IND

5405 - SSA BENEFIT TERM A/C DEATH

5406 - ENTITLEMENT UNDER ANOTHER SSA CLAIM NUMBER

5501 - DUAL ANNUITANT

5502 - INVESTIGATE SSA NUMBER

5503 - PROGRAM REJECT - EXCESS REPLY

5504 - PROGRAM REJECT - REPLIES NOT EQUAL TO REQUEST

5505 - DUPLICATE RECORD HAS JURISDICTION DISCREPANCY

5506 - INVESTIGATE SSA REPORT OF DEATH

5507 - JURISDICTION CODE DISCREPANCY

5508 - SSA SUFFIX MISSING

5509 - DUPLICATE SSA AND RRB TRANSFERS

5510 - RR ANNUITY IN SUSPENSE - VERIFY ADDRESS FOR ID CARD

5511 - SSA AND RRB SMIB OPTION DISCREPANCY

5512 - P-OPTION ENCOUNTERED IN MBR RECORD

5513 - INVESTIGATE DELINQUENT SMIB PREMIUMS

5514 - SMIB PAID THRU DATE ASSUMED PENDING SSA REPORT

5515 - SMIB PAID THRU DATE ASSUMED PENDING INVESTIGATION OF SSA PREMIUM AMOUNT

5516 - SMIB TERM REQUESTED - TAKE TERM ACTION ON DATE INDICATED

5517 - SMIB PREMIUMS DUE - SSA AND RRB BENEFITS IN SUSPENSE

5518 - HI AND SMIB TRANSFER COMPLETED

5519 - MANUAL TRANSFER REQUIRED - SSA TERM DATE AFTER RRB SMIB DATE

5520 - SSA REFUND FOR UNINSURED BIC INDICATED

5521 - TRANSFER MANUALLY - PAID THRU DATE UNDETERMINED DUE TO P-OPTIONS

5522 - POSSIBLE ENROLLMENT UNDER DIB PROVISIONS

5523 - INVESTIGATE DIB, HIB AND SMIB DATES BEFORE 7-73

5524 - RRB ENT DATE PRIOR TO SSA ENT DATE - CHECK FOR POSSIBLE ARREARAGE

5525 - DEEMED QRRB FROM SSA UNDER 1974 AMENDMENTS

5526 - MANUAL TRANSFER, CESSATION OF DISABILITY

5999 - UNABLE TO DETERMINE CAUSE OF REJECT

DUAL SURVIVORS - TRANSFER COMPLETED - PLEASE INVESTIGATE

UNABLE TO PROCESS ACTIVITY - SCREENING REPLY OUTSTANDING

CMS-EDB ALERT OR EXCEPTION (MEDREF)

REFERRAL CODE - REFERRAL MESSAGE

5001 - NAME NOT UPDATED - OTHER FIELDS UPDATED

5002 - BENE NAME HAS OTHER THAN ALPHA OR BLANKS OR INCORRECTLY STRUCTURED

5003 - FIRST LINE OR LAST LINE OF ADDRESS INCORRECT

5004 - LAST LINE OR FIRST LINE OF ADDRESS INCORRECT

5005 - SEX CODE UNKNOWN

5006 - HI CARD CODE OTHER THAN 0, 1 OR 2

5007 - ALERT - CESSATION OF DIB UPDATED

5008 - REQUESTER IDENTITY UNKNOWN

5009 - SEX CODE OTHER THAN MALE OR FEMALE

5010 - BENE NAME HAS OTHER THAN ALPHA OR BLANKS OR INCORRECTLY STRUCTURED

5011 - 3RD PARTY PART B CODE OR DATE INCORRECT

5012 - URIC UNMATCHED ON HI CLAIM NUMBER

- 5013 - URIC MATCHED SKELETON RECORD
- 5014 - DUAL SURVIVORS - TRANSFER COMPLETED - PLEASE INVESTIGATE
- 5015 - UNMATCHED ON HI CLAIM NUMBER
- 5016 - URIC PROCESSING DATE EQUALS EDB PROCESSING DATE
- 5017 - DUPLICATE DATE BEING CONVEYED TO EDB
- 5018 - URIC MATCHED EDB ON NAME, DOB AND SEX - UNMATCHED ON BIC
- 5019 - URIC MATCHED EDB ON BIC - MATCHED ANOTHER EDB ON NAME, DOB AND SEX
- 5020 - URIC MATCHED ON HI CLAIM NUMBER - UNMATCHED ON NAME, DOB AND SEX
- 5021 - HI CLAIM NUMBER AND EQUATABLE BIC MATCHED MORE THAN ONE EDB
- 5022 - UNMATCHED ON HI CLAIM NUMBER
- 5023 - RIC G MATCHED OTHER THAN EDB
- 5024 - DUPLICATE DATA BEING CONVEYED TO EDB
- 5025 - HI CLAIM NUMBER INCORRECTLY STRUCTURED
- 5026 - BIC BEN SYM AND PREFIX NOT VALID
- 5027 - BIC AND SEX CODE INCONSISTENT
- 5028 - DATE OF BIRTH INCORRECTLY STRUCTURED
- 5029 - CURRENT OR PRIOR PART A EFF DATE INCORRECTLY STRUCTURED
- 5030 - PART A OR B OPTION CODE OR PART A OR B EFF DATE INCONSISTENT WITH OTHER DATA
- 5031 - CURRENT OR PRIOR PART B OPTION CODE NOT VALID OR INCONSISTENT WITH TYPE ACTION
- 5032 - CURRENT OR PRIOR PART B EFF DATE INCORRECTLY STRUCTURED
- 5033 - PART B EFF DATE INCONSISTENT WITH OTHER DATA
- 5034 - PART B TERM DATE INCORRECTLY STRUCTURED
- 5035 - PART B TERM DATE INCONSISTENT WITH PART B OPTION

- 5036 - EFF DATE INCORRECTLY STRUCTURED
- 5037 - URIC CODE NOT 1, 4, 5, 6 OR 9
- 5038 - EVENT CODE INCONSISTENT WITH URIC CODE - FORWARD TO SUPERVISOR
- 5039 - EFF DATE INCORRECT OR INCONSISTENT WITH OTHER DATA
- 5040 - REINSTATEMENT AND URIC CODE INCONSISTENT
- 5041 - XREF HI CLAIM NUMBER INCORRECTLY STRUCTURED
- 5042 - XREF BIC INCORRECT
- 5043 - KILL CREDIT OR XREF CODE NOT J OR INCONSISTENT WITH URIC
- 5044 - DATE OF DEATH NOT VALID
- 5045 - URIC PROCESSING DATE INCORRECT
- 5046 - RRB EDB WITH P-OPTION MATCHED TO RRB FLAG EDB
- 5047 - SSA URIC REJECT - SSA HI CLAIM NUMBER XREF TO RRB EDB
- 5048 - RRB URIC REJECT - RRB HI CLAIM NUMBER XREF TO SSA EDB
- 5049 - RRB URIC MATCHED ON BIC TO EDB SKELETON RECORD
- 5050 - RRB DIB URIC MATCHED AGED EDB
- 5051 - DIB CODE IS INCORRECT
- 5052 - PART A EFF DATE FOR DIB BENE INCORRECT
- 5053 - PART B EFF DATE FOR DIB BENE INCORRECT
- 5054 - RRB RECORD STATUS CODE INCORRECT
- 5055 - FIRST SSA HI CLAIM NUMBER MISSING
- 5056 - REASON FOR ENTITLEMENT CODE NOT AGED OR DIB
- 5057 - MBR CURRENT OR PREV PART A OPTION INCORRECT
- 5058 - FIRST PART A TERM DATE INCORRECT
- 5059 - CONFLICT BETWEEN MBR PART A OPTION, EFF DATE AND TERM DATE

5060 - ZIP CODE MISSING

5061 - SECOND PART A TERM DATE INCORRECT

5062 - UNMATCHED ON HI CLAIM NUMBER

5063 - DUPLICATE DATA BEING CONVEYED TO EDB

5064 - NO PART B EFF DATE ON EDB

5065 - TERM DATE NOT GREATER THAN PART B EFF DATE PLUS 1 MONTH

5066 - CANNOT TERM PART B BECAUSE 3RD PARTY INVOLVEMENT

5067 - DIB TERM BUT NO DIB INDICATION IN EDB

5068 - DIB TERM INCONSISTENT WITH EDB ENTITLEMENT DATES

5069 - MBR INCOMPATIBLE WITH RRB SYMBOL AND PREFIX

5070 - NO SSA MATCH ON IDENTITY OF BENE

5071 - SSA NUMBER INACTIVE

5072 - UNMATCHED ON HI CLAIM NUMBER

5073 - RIC G MATCHED OTHER THAN EDB

5074 - DUPLICATE DATA BEING CONVEYED TO EDB

5075 - PART B TERM ON EDB

5076 - EFF DATE UNEQUAL TO EDB PART B EFF DATE

5077 - REINSTATING PART B BUT NO TERM DATE ON EDB

5078 - DUPLICATE DATA BEING CONVEYED TO EDB

5079 - PART B EFF DATE INCORRECT

5080 - PART B EFF DATE PRIOR TO 7-73, ENTITLEMENT CODE DIB

5081 - PART A OR B EFF DATE INCORRECT

5082 - 2ND PART B TERM DATE INCONSISTENT WITH OTHER FIELDS

5083 - RRB URIC CONVEYING ADVERSE PART A OR B EFF DATE - NOT APPLIED

5084 - RRB URIC CONVEYING ADVERSE PART A OR B EFF DATE - APPLIED

- 5085 - URIC ENTITLEMENT DATE OUT OF SYNC WITH EDB
- 5086 - URIC WITH NO PART B EFF DATE MATCHED EDB WITH CURRENT AND PRIOR PART B
- 5087 - RRB URIC CONVEYING AN ADVERSE PART B EFF DATE - APPLIED
- 5088 - RRB URIC REINSTATING PART B ENTITLEMENT
- 5089 - TERM DATE NOT GREATER THAN PART B EFF DATE PLUS 1 MONTH
- 5090 - XREF ACTION REJECTED
- 5091 - ACTIVE RRB - MATCHED SKELETON - BAD LAF
- 5092 - ACCRETION BOAN POINTS TO MULTIPLE HI CLAIM NUMBERS
- 5093 - MATCHED ON NAME, DOB AND SEX - UNMATCHED ON BIC
- 5094 - FIRST INITIAL, LAST NAME AND DOB MATCHED ANOTHER EDB
- 5095 - HOC/SOC EQUAL P ON SSA URIC
- 5096 - DEL ENTITLEMENT FAILED - MATCHED HIC AND BIC - UNMATCHED ON NAME, DOB AND SEX
- 5097 - DENIAL CASE MATCHED ACTIVE EDB
- 5098 - EDB ENTITLEMENT REASON NOT UPDATED OR DELETED
- 5099 - SEQUENCE ERROR - DIB/ESRD AFTER AGED ENTITLEMENT
- 5100 - RRB XREF ACTION FAILED - EXCEPTION CODE UNKNOWN
- 5101 - UNMATCHED RRB SKELETON EDB ON ACCOUNT NUMBER AND BIC OR GIVEN NAME
- 5102 - RRB URIC UNMATCHED TO EDB BUT NOT ACCRETED TO EDB
- 5103 - RRB URIC MATCHED TO XREF EDB
- 5104 - XREF REJECT - ACTIVE AND INACTIVE BIC A
- 5105 - RRB EDB WITH P-OPTION MATCHED XREF CONTAINING ACTIVE SSA NUMBER
- 5106 - RRB XREF REJECT - ACTIVE OR INACTIVE HIC HAVE A BAD LAF
- 5107 - TEMPORARY EDB AT CMS

5108 - RRB URIC CONVEYING PART B EFF DATE PRIOR TO DIB ATTAINMENT AGE

5109 - SSA SYSTEMS LIMITATION

5110 - EDB AIF PROBLEM

5111 - URIC REQUEST - NO MBR FOR CLAIM NUMBER

5112 - URIC REQUEST - NO MBR FOR BIC

5113 - URIC REQUEST - NO DUAL ENTITLEMENT

5114 - URIC REQUEST - NO ENROLLMENT INFORMATION ON MBR

5201 - RECORD COMBINED - MEDICARE STATUS QUESTIONABLE

5201 - INACTIVE DEATH DATA MOVED TO ACTIVE

5203 - DATE OF DEATH DISCREPANT - ACTIVE EDB RETAINED

5204 - PART A OR B COMBINED - INACTIVE MOST ADVANTAGEOUS APPLIED

DATABASE REFERRALS

REFERRAL CODE - REFERRAL MESSAGE

UNABLE TO LOAD, CHECK CLAIM, SSA NOS

PROCESSED AS UPDATE, CODED AS NEW RECORD

UNABLE TO LOAD, CHECK CLAIM, SSA NOS

PROCESSED AS NEW RECORD, CODED AS UPDATE

LOADED RECORD - DUPLICATE PSEUDO NUMBER

MONTHLY REFERRAL (MEDREF)

REFERRAL CODE - REFERRAL MESSAGE

8001 - MECHANICALLY ADJUSTED - ARREARAGE DUE

8002 - COMPUTATION ERROR - CHECK SMIB EFF DATE AND RPD

8003 - MECHANICALLY ADJUSTED - POSSIBLE REFUND DUE

8004 - IMPOSSIBLE CONDITION - REFER TO ESA

8100 - SMIB OPTION DISCREPANCY - ANNUITY WILL BE ADJUSTED NEXT MONTH

8200 - CASE SELECTED FOR ADJUSTMENT - REJECTED

8300 - CRITICAL CONVERSION REFERRAL ON MIRTEL

8301 - UNABLE TO ADJUST MIRTEL - REJECTED

8400 - MIRTEL SHOWS SBI WITHOUT ACC DATE - UPWARD ADJUSTMENT TO CHICO REQ

8500 - MIRTEL HAS TERM OPT - UPWARD ADJUSTMENT TO CHICO REQ - REFUND DUE

8600 - SMIB OPTION DISCREPANCY - CHECK BOTH FILES

8700 - RPD DISCREPANCY - ANNUITY ADJUSTED

8800 - TERMINATION - CHECK JURISDICTION

8900 - POSSIBLE REFUND DUE - CHECK PAID THRU DATE

8901 - MIRTEL PENDING - CHICO SUSPENDED WITH DED

8902 - MIRTEL SHOWS LOSS OF QRRB STATUS - CHICO IN FORCE

8903 - MIRTEL SHOWS CESSATION OF DIB - CHICO IN FORCE WITH DED

8904 - MIRTEL RSC SHOWS BENEFICIARY DECEASED - CHICO NOT TERMINATED

8905 - RPD AND PAID THRU DISCREPANCIES - ANNUITY ADJUSTED

8906 - NO MATCHING MIRTEL - CHICO HAS SMIB CODE

8907 - NO MATCHING CHICO - MIRTEL SHOWS ANNUITY

8908 - BEN SYM/TOB INCONSISTENT ON MIRTEL AND CHICO FILES

8909 - INVALID OR MISSING PAID THRU DATE

8910 - ALERT - TERM OF DIB - ELIGIBLE FOR HI ADDITIONAL 24 MONTHS

8911 - ALERT - ANNUITY ADJUSTED DURING MEDICARE EXTENSION PERIOD

Exhibit 2 - MIRF (MIRTEL Film)

HEALTH INSURANCE SYSTEMS

MIRF (MIRTEL Film)

This microfilm contains records of all Qualified Railroad Retirement Beneficiaries enrolled for either Part A or Part B or Medicare. Fourteen records are printed on each frame. This microfilm is produced each month.

Consult RCM 3.3 Exhibit 1 for detailed explanation of the terms and codes used on the MIRF.

LINE	CAPTION	DEFINITION OF FIELD	OPTIONAL INFO CONTAINED IN FIELD
A	CLAIM NO	Symbol, prefix, RRB claim number	
B	TYPE BEN/SX	Type of beneficiary, sex code	PC-payee code
C	RR DOB	Date of birth established by RRB	
D	HI DOB	Date of birth established by SSA	
E	PSEUDO NO	Pseudo number if any	
F	FIRST NAME	Beneficiary's first name, middle initial	
G	LAST NAME	Beneficiary's last name	
H	REC STAT	Record status code	DOD - date of death
I	ID ISS/GEP	ID-issue code, ID issue date GEP enrollment code	
J	REF CD/DT	Referral code, referral date	
K	SREQ CD/DT	Screening request code, screening request date	
L	SREP DT	Screening reply date	
M	LAP CD/DT	Last activity processing code, type of activity code, activity processing date	

N	VCHR NO/DT	Voucher number, voucher date	
O	SOC/SOF DT	SMI effective date, SMI option filing date	
P	SED/RPD	SMI effective date, SMI premium rate	
Q	SMI TERM CD	SMI termination code	DT - SMI termination date
R	HED/TERM DT	HI effective date, HI termination date	
S	ACC/DEL DT	Accretion date, deletion date	
T	SEQ DT	Sequential date	BTCH# - batch number
U	LST PYMT/DT	Amount of last payment, billing release date	
V	3 PTY CD	Third party code accretion - deletion code	A/D CD - third party
W	PD THRU DT	Paid thru date - Asterik (*) indicates assumed paid thru date	DQ - delinquency date
X	LST BILL CD	Type of last bill premium amount	EX PR - excess
Y	CAT DATA CD	Medicare Catastrophic Data Code is displayed in the first five positions of this line.	Previous Medicare Catastrophic Data Code, if applicable, appears in the final five positions of each record group.
		<p><u>NOTE:</u> This code is used to define the SMIB deduction amount. It consists of three components: the Rate Table Indicator (S = Standard Table, P = Puerto Rican Table, C = U.S. Commonwealth/Territories Table), the Variable Rate Indicator (N = non-variable, V = variable), and the Penalty Percentage Indicator (000 through 220).</p>	
Z	CAT EFF DT	Catastrophic Medicare Effective Date. The current date is displayed in the first	Previous Catastrophic Medicare Effective Date, if applicable, appears in the

		five positions of this line.	final five positions of each record group.
	CAT ACCT DT	Catastrophic Medicare Accounting Date. The current date is displayed in the first five positions of this line.	Previous Catastrophic Medicare Accounting Date, if applicable, appears in the final five positions of each record group.
	VAR BS/RPD	Variable Base Rate, if applicable, is displayed in the first half of this line.	Previous Variable Rate Paid, if applicable, appears in the final half of each record group.

Exhibit 3 - MMAC (Microfilm of MIRTEL activity)

MMAC (Microfilm of MIRTEL ACTIVITY)

This microfilm reflects weekly additions to, subtractions from, and changes in the MIRTEL record. The MIRTEL record is manipulated by certain activity codes entered on the G-810, G-811 or through the RASI or attainment systems. The MMAC will show what activity was attempted, the existing master record, and the subsequent master record following the adjustment. In the event that the attempted activity cannot be processed, the MMAC will show "REJECT". Sometimes an activity will process, but the MMAC will show "ALERT." This is not a REJECT. An alert means a particular part of the record should be checked for accuracy. It advises of additional information to be considered in handling the case.

Consult RCM 3.3 Exhibit 1 for detailed explanation of the terms and codes used on the MMAC.

ACTIVITY RECORD CAPTION	INFO CONTAINED IN FIELD
RRB CLAIM NO.	Symbol, prefix, and RRB claim number
TYPE BEN	Type of beneficiary
SEX	Sex code
RRB DOB	Date of birth established by RRB
HI DOB	Date of birth established by SSA
PSEUDO NO	Pseudo number, if any

BENE SSA	Beneficiary's SS number
EE SSA	Employee's SS number
RRB/SSA NO/SUF	Previous RR number or second SS number
ACCTG DT	Accounting date
ACTIVITY	Activity code, source of activity, "ALERT" or "REJECT" indication if applicable
REC STAT	Record status code
SOF DT	SMI option filing date
SOC	SMI option code
SED	SMI effective date
RPD	SMI premium rate
PD THRU DT	Paid thru date, asterisk (*) - assumed paid thru date indication
EXC PREM AMT	Excess premium amount
SMI TRM DT	SMI termination date
DELQ DT	Delinquency date
HED	HI effective date
HI TRM DT	HI termination date
DOD	Date of death
ID ISS	ID issue code
PC	Payee code
ABD	Annuity beginning date
ORB CNT	Orbit count
DIS FRZ DT	Disability freeze date
ACCR DT	State-buy-in accretion date

DEL DT	State-buy-in deletion date
EVENT CD/DT	Event code, event date
REP PAY	Rep payee code
3 PTY CD	Third party code
TYPE BILL	Type of bill
AMT PAID	SMI amount paid
A D CD	Accretion/deletion code
POSTMARK	Postmark date
DT LST PYMT	Date of last payment (sequential date & batch number)
REFUND	Possible refund amount
SEC UNIT	Section/unit code
RRB CLAIM NO.	Symbol, prefix, and RRB claim number
TYPE BEN	Type of beneficiary
SEX	Sex code
RRB DOB	Date of birth established by RRB
HI DOB	Date of birth established by SSA
PSEUDO NO	Pseudo number, if any
BENE NAME	Beneficiary's first name, middle initial, and last name
REP PAY	Rep payee code
BENE SSA	Beneficiary's SS number
EE SSA	Employee's SS number
MASTER	IN - existing master record
	OUT - master record subsequent to adjustment
	(C) - conversion referral indication

TYPE APPL	Type of application
SSA CLM NO/SUF	SS number on which beneficiary is entitled to SS benefits
REC STAT	Record status code
DOD	Date of death
ID ISS	ID issue code
G-44/GEP	G-44 GEP code
REF CD	Referral code
REF DT	Referral code date
SREQ CD	Screening request code
SREQ DT	Screening request date
SREP DT	Screening reply date
LAP CD	Last activity processing code
LAP DT	Last activity processing date
VCHR NO	Voucher number
VCHR DT	Voucher date
SOF DT	SMI option filing date
SOC	SMI option code
ABD	Annuity beginning date
DIS FRZ DT	Disability freeze date
SED	SMI effective date
RPD	SMI premium rate
DELQ DT	Delinquency date
SMI TRM CT/DT	SMI termination code, SMI termination date
HED	HI effective date

HI TRM DT	HI termination date
ACCR DT	Latest state-buy-in accretion date
DEL DT	Latest state-buy-in deletion date
DT LST PYMT	Date of last payment (sequential date, batch number)
AMT PAID	SMI amount paid
BILL REL DT	Bill release date
3 PTY CD	Third party code
A D CD	Accretion/deletion code
PD THRU DT	Paid thru date, asterisk (*) - assumed paid thru date indication
EXC PREM AMT	Excess premium amount
ARRG DUE/CD	Arrearage due amount, arrearage due code
YEC	Year end code
PC	Payee code
GEO CD	Geographic code
ACCTG DT	Accounting date
SEC/UNIT	Section/unit code

Exhibit 4 - MIRTEL Inquiry

MMAC Microfilm of MIRTEL Activity

MIRTEL INQUIRY

This folder record printout is generated by preparation of Form G-811 with Activity Code 98 or 99. The G-811 can be prepared to obtain a printout of one beneficiary or of all beneficiaries entitled on a certain claim number. Detailed instructions for the preparation of Form G-811 are contained in section 3.3 Appendix B.

The following is a detailed explanation of the terms and codes used on the INQUIRY printout.

MASTER RECORD CAPTION	DEFINITION OF FIELD
RRB CLAIM NO.	Symbol, prefix, and RRB claim number
TYPE BEN	Type of beneficiary
SEX	Sex code
RRB DOB	Date of birth established by RRB
HI DOB	Date of birth established by SSA
PSEUDO NO	Pseudo number , if any
BENE NAME	Beneficiary's first name, middle initial, and last name
REP PAY	Rep payee code
SEC/UNIT	Section/unit code
TYPE APPL	Type of application
BENE SSA	Beneficiary's SS number
EE SSA	Employee's SS number
SSA CLM NO/SUF	SS number on which beneficiary is entitled to SS benefits
REC STAT	Record status code
DOD	Date of death
ID ISS	ID issue code
G-44/GEP	G-44 GEP code
REF CD	Referral code
REF DT	Referral code date
ZIP CD	Zip code
SREQ CD	Screening request code

SREQ DT	Screening request date
SREP DT	Screening reply date
LAP CD	Last activity processing code
LAP DT	Last activity processing date
VCHR NO	Voucher number
VCHR DT	Voucher date
SOC	SMI option code
ABD	Annuity beginning date
DIS FRZ DT	Disability freeze date
SED	SMI effective date
RPD	SMI premium rate
PC	Payee code
DELQ DT	Delinquency date
SMI TRM CD/DT	SMI termination code, SMI termination date
HED	HI effective date
HI TRM DT	HI termination date
ACCR DT	Latest state-buy-in accretion date
DEL DT	Latest state-buy-in deletion date
DT LST PYMT	Date of last payment (sequential date, batch number)
AMT PAID	SMI amount paid
BILL REL DT	Bill release date
3 PTY CD	Third party code
A/D CD	Accretion/deletion code
PD THRU DT	Paid thru date, asterisk (*) - assumed paid thru date

	indication
EXC PREM	Excess premium amount
ARRG DUE/CD	Arrearage due amount, arrearage due code
YEC	Year end code
RIC REL DT	Date universal RIC sent

3.4.1 Scope Of Chapter

This chapter covers the establishment of Medicare records, the release of Medicare cards and enrollment cards, and the processing of enrollment cards. Included are instructions on establishing a record under a pseudo number when multiple beneficiaries are entitled to Medicare under the same claim number.

3.4.2 Attainment Cases

An attainment case is one involving an annuitant, pensioner, or IPI whose record is on PREH or a social security beneficiary on CHICO at the time of the monthly search for individuals becoming eligible for aged Medicare in the sixth succeeding month. The disability Medicare effective date is a month behind the aged Medicare effective date. The following chart indicates which cases will be included in the monthly search of PREH or the CHICO master. The files will be processed in MIRTEL on the first work day of the following month.

<u>AGED - MEDICARE EFF DATE</u>	<u>DISABILITY – MEDICARE EFF DATE</u>	<u>SEARCH MADE</u>	<u>PROCESSED IN MIRTEL</u>
January	December	July	August
February	January	August	September
March	February	September	October
April	March	October	November
May	April	November	December
June	May	December	January
July	June	January	February
August	July	February	March
September	August	March	April
October	September	April	May
November	October	May	June
December	November	June	July

There are four different attainment processes. They are:

1. MAP – RR Retirement Aged Individuals
2. SURVEA – RR Survivor Aged Individuals
3. DIB ATTAIN Selection – RR Disabled both Retirement and Survivor Individuals
4. SSATS – SS Aged and Disability Individuals

These cases are handled as follows:

- A. QRRB – A Medicare record is automatically set up in the MIRTEL file for an annuitant who is attaining age 65. This includes SS Only cases.
- B. DQRRB - A Medicare record is automatically set up for a RR survivor or retirement annuitant who has been granted a disability freeze. It is not necessary for the beneficiary to be receiving a disability annuity. This includes SS Only cases.

However, a record must be established manually for the following:

- A retirement disability annuitant with a deemed freeze.
- A pure SS case not on CHICO because of LAF code is S2 or S3.
- Disabled child whose Medicare effective date is based on actual or potential eligibility as an IPI child.
- Disabled widow whose waiting period includes SSI entitlement as part of the 24 month waiting period.
- A pure SS case paid by RRB and individual is entitled to Medicare based on chronic renal disease (CRD).
- An individual entitled to disability Medicare based on ALS.
- H&A grants a disability and DF simultaneously or just grants a DF.
- A DF is awarded and the case will not be in pay status six months before the Medicare effective date.
- A DF is awarded, case is in pay status, but the DF information will not be updated to PREH six months before the Medicare effective date.
- A DF is awarded to establish Medicare only for an age and service annuitant.

- An award for Medicare is made based on the 74 Act/Government Employment provisions.
- A second DF is awarded to a disabled annuitant.
- See RCM 3.4.3

Generally, MS receives information about the above cases from the disability examiner via Form G-405. If MS is not immediately creating a MEDCOR activity to enroll the individual, a call up will be established. If the call-up is established, release a Form RL-310 if the individual was not previously notified of their Medicare effective date or if they were notified but the Medicare effective date was incorrect. When the call-up expires, 5 months prior to the Medicare effective date, MS will review the case and if necessary, create a MEDCOR Activity 12L.

3.4.3 Accretion Cases

An accretion case involves an individual who has not filed for an annuity and whose record, therefore, is not on PREH or the CHICO master. He or she must file an application for an annuity or for Medicare only at an RRB office, or for SS benefits at SSA.

- A. Mechanical Handling - When a Medicare application filed 3 months before a beneficiary attains age 65 or older, or when a retirement annuity application which is filed or paid 5 months before the beneficiary attains age 65 or older, is certified mechanically, a record is automatically set up in the MIRTEL file. A MEDCOR Activity 12L is created by APPLE when a survivor annuity application is entered on APPLE.
- B. Manual Handling - A record must be established manually by creating a MEDCOR Activity for a QRRB whose Medicare record is not established by the mechanical processing of an application. Manual handling is required when:
 - A survivor application is entered on APPLE and there is current entitlement to Medicare claimed, and any survivor application that is paid manually.
 - A retirement annuity or Medicare application is removed from mechanical processing before Medicare clearance is requested.
 - An annuity is terminated erroneously in or after the month PREH is searched for attainments (see RCM 3.4.2); or
 - An annuity is terminated erroneously and is not reinstated before the search of PREH for attainments (see RCM 3.4.2).
 - A “deemed” QRRB, i.e. a person whose SS benefits are payable at RRB but who is not on CHICO, is in his or her IEP.

- A person whose SS benefits are payable at RRB and is entitled to Medicare based on CRD before the regular waiting period is up.
- An individual entitled to Medicare based on ALS.
- A Medicare only application if RASI is looking for information.
- See RCM 3.4.2B

There are a small number of cases in which more than one beneficiary is entitled to Medicare under the same RRB claim number when the prefix and beneficiary symbols are equal (e.g., M, X, W; or C and WC). Since the CMS Enrollment Database (EDB) requires every beneficiary to have a unique number, it is necessary to assign a "pseudo" number. When a second beneficiary with the same RRB claim number, symbol and prefix becomes eligible for Medicare, refer the case to MS for the assignment of a pseudo number. See RCM 3.4.20.

Cases should be sent to MS to enroll a QRRB who was not enrolled timely, has no Medicare entitlement on a LAF `C' benefit, and more than 5 months of premiums would need to be deducted. These cases are eligible for equitable relief. See RCM 3.2 for information on equitable relief.

If a beneficiary is entitled under two RRB claim numbers, the Medicare enrollment should be on the primary number (A or WA). See RCM 3.5.51 through 3.5.54.

3.4.10 Screening For Clearance

From the MIRTEL system, a screening request is sent to SSA to update SSA's Master Benefit Record (MBR) to show that RRB has jurisdiction of the individual's Medicare. The file sent to SSA is the PSRRB file. SSA processes this file, updates the RR JURIS line on the MBR with a start date, and stops premium deductions if premiums were being withheld from SS benefits. SSA will send a file back to RRB with the screening replies. This file is the ECRUT file. The ECRUT file contains the information that RRB sent to SSA and any SSA information that was picked up from the MBR, such as SSA's Medicare entitlement dates, SSA's premium amount, and the paid through date at SSA.

RRB will process the ECRUT file and MIRTEL will be updated with the most advantageous dates. A Medicare card will be released. A URIC will be sent to CMS on the HMRUNT file to establish a record on the Enrollment Database (EDB). When the record is transmitted to the EDB, a Medicare record is established in the RRB portion of the file and any SSA record previously established is automatically transferred from the SSA portion. CMS processes the HMRUNT file and sends back a file called the RBEX file, which contains the EDB Alert and Exceptions.

NOTE: For LAF `E' cases, because no information is picked up, the examiner should show Medicare effective dates from the MOR if they are more advantageous than the effective dates based on RRB entitlement.

3.4.11 Records Of Clearance

The following records will show whether or not clearance has been obtained:

- A. Printout Reply for RASI Cases - RASI produces messages showing the information that it furnished to the MIRTEL system,
- B. Printout Reply to Other Screening Requests - When clearance is received as a result of a MEDCOR Activity 12L, mechanical attainment or a PAM transaction, a "RRB Jurisdiction" printout is generated.
- C. Printout Reply to MEDCOR Activity 99s - The printout reply to a MIRTEL inquiry (MEDCOR Activity 99S) shows the current status of the MIRTEL file.
- D. MMAC File - The MMAC File (Microfilm of MIRTEL Activity) is a weekly record of processed MIRTEL activities and the MIRTEL master before and after processing of the activity. See RCM 3.3.4.
- E. Folder Record - IBM cards showing jurisdiction were computer printed for the initial cases cleared with SSA in May 1966. The cards were prepared for qualified annuitants (whether payments were in force or in suspense), IPI's, and non-retired employees and spouses. Subsequent records were shown on 8 1/2" x 11" computer referrals marked "HIB Clearance." Beginning June 1978, the clearance record is titled "RRB Jurisdiction - Reply Processed."

3.4.12 Handling Referrals

Computer rejects often occur during the clearance operation. Since manual handling is required to establish or correct the EDB, it is important that MS handles these as soon as possible. If paper referrals are matched with folder material you are handling, the paper referral should never be ignored, unless it is stamped, "Associate With Folder and File Down" or "File Only." MS will handle referrals according to current instructions.

There is a monthly MIRTEL referral with the message "No Matching CHICO, MIRTEL SHOWS ANNUITY". These referrals are normally produced when RASI or PAM sets up a Medicare record before a payment is made. Usually once the payment is made no further action is necessary. Therefore, if one of these referrals is matched to a folder, pay the annuity or SS benefit. Only refer the case to MS if the person will not be paid (e.g., zero annuity rate.)

NOTE: There is a monthly MIRTEL referral with the message "No Matching CHICO, MIRTEL SHOWS ANNUITY". These referrals are normally produced when RASI or PAM sets up a Medicare record before a payment is made. Usually once the payment is made, no further action is necessary. Therefore, if one of these referrals is matched to a folder, pay the annuity or SS benefit. Only refer the case to MS if the person will not be paid (e.g., zero annuity rate.)

3.4.20 Assignment Of Pseudo Claim Numbers

MS is responsible for assigning "Medicare pseudo" numbers to "extra" beneficiaries (IPs, disabled children, second wives, etc.). The six digit numbers used through November 1974 were in the 995001 through 999995 series. Effective December 1, 1974, the beneficiary's own SS number is assigned as the pseudo number. If the beneficiary does not have a SS number, a six digit pseudo number can still be assigned.

If a dual annuitant needs a pseudo number, assign one so that cross reference of the records can be done and to avoid generating referrals. It is not necessary to send a letter to the dual annuitant to advise of the pseudo number assignment. This is more for internal records.

If a pseudo number was assigned in error, do the following:

1. Create a MEDCOR Activity 05S to drop the MIRTEL record with the pseudo number.
2. Create a MEDCOR Activity 13L to reestablish the MIRTEL without the pseudo number.
3. If the EDB was set up as an "MA" on the RRB claim number and the individual is currently a "WA", create a MEDCOR Activity 22S to change the symbol on the EDB from an "M" to a "W".
4. Create a MEDCOR Activity 35S to kill credit and cross refer the EDB records.

Release a letter advising the beneficiary that his or her RRB claim number is the Medicare claim number, release a new Medicare card and advise the beneficiary to destroy the Medicare card with the pseudo number on it.

The following individuals will require pseudo numbers:

A. Retirement Cases

- Second or later disabled child (20 years of age or older) who is eligible under the O/M.
- Second or later wife of an employee, if a previous wife was enrolled for Medicare under an identical claim number and symbol.

B. Survivor Cases

- One dependent parent, if two are receiving benefits under the same claim number and symbol.
- Disabled child (20 years of age or older), if another disabled child was previously enrolled.

- The widow, if a previous wife was enrolled for Medicare.

3.4.21 Cross-Reference File

Although MIRTEL does carry a cross-reference of the pseudo number and actual claim number, MS also maintains a 3" x 5" index card file of all pseudo numbers indexed alphabetically according to employee's surname.

This file contains all identifying information: "pseudo" claim number (add an asterisk if the pseudo claim number is the beneficiary's own SS number), actual claim number, two files or duplicate code, the employee's name, the beneficiary's name, sex, and date of birth, and the type of beneficiary. Prior to 1992 these cards were prepared for all pseudo's. After 1991, new cards are only prepared for QRRB's who are given a six digit pseudo number because they have no SS number of their own. If an individual does not have a SS number, a six digit number is assigned.

3.4.22 Responsibility For Processing Claims

Because of the special coding and the cards required for assigning pseudo numbers, MS is responsible for establishing and if necessary screening these cases. The retirement, survivor and disability examiners will handle annuities in claims of this type as usual. However, any form they prepare must show the pseudo number.

3.4.23 Input Forms

If the need for a pseudo number is recognized before the initial screening, MS will enter the beneficiary's own SS number in "PSEUDO NUMBER" field on the MEDCOR Menu Screen and set up the cross-reference cards. Usually, however, a pseudo number case is identified by the receipt of an EDB reject. In this case, a MIRTEL record has already been established under the regular RRB number. In order to establish the pseudo number record in the MIRTEL file and the EDB, MS will take the following action:

- Create MEDCOR Activity 05S to drop the MIRTEL record,
- Create MEDCOR Activity 31L to establish the pseudo record on MIRTEL and the EDB and, which will also cross refer the SS number to the RRB pseudo number.

All future MEDCOR correction activity and Medicare forms for this record should contain the pseudo number.

3.4.24 Computer Output

The pseudo claim number will appear as the claim number on Medicare cards and records sent to and from SSA and CMS. The cross-reference records in the MIRTEL file will allow activity to process from SSA and CMS with only the pseudo number. On

all other output, the referrals, informational printouts and premium notices, the pseudo number will appear in body of the record.

3.4.25 Handling Correspondence

The mailroom sends all correspondence referring to Medicare to MS. If the claim number is a "pseudo" number, MS will convert it to the actual claim number so that the correspondence can be associated with the RRB claim number.

3.4.26 Notifying "Extra" Beneficiary

If a Medicare card showing the regular RRB claim number has been issued to a beneficiary who is assigned a "pseudo" number, MS will ask the beneficiary to destroy the Medicare card under the regular number. Use Form RL-362 for this purpose.

3.4.30 Automatic Enrollment

- A. General - Before October 1, 1972, an individual who was eligible for Part B had to take positive enrollment action in order to obtain coverage. As the result of changes in the law effective October 1, 1972, most persons who are entitled to Part A beginning July 1, 1973 or later are "automatically" enrolled for Part B when they first become entitled to Part A. Instead of having to enroll affirmatively, the vast majority of Medicare beneficiaries who want Part B do not have to take any action. Action must be taken only if a beneficiary does not want Part B.
- B. Applicants Who File For Annuities Preceding Or During Their IEP. - Under the law, beneficiaries who file an annuity application during their IEP are entitled to Part B. At the present time, Part B options are being obtained in most retirement and survivor cases. In order to be enrolled for Part B, the individual has to elect or check "yes" in the box by the "do you wish to enroll" question; otherwise, the Medicare record will be set up for Part A only.

In a manually processed case, the beneficiary should be enrolled for Part B by creating a MEDCOR Activity 12L.
- C. When Automatic Enrollment Does Not Apply - Automatic enrollment does not apply to:
 1. Persons Already Entitled to HI - Automatic enrollment applies only to persons not already entitled to Part A at RRB or SSA who become entitled after June 1973. Any person entitled to Medicare before July 1973 is not subject to automatic enrollment. If such an individual wants to enroll for Part B, he or she must file during a GEP. A non-annuitant who files a Medicare application, and subsequently files for monthly benefits, is also excluded from automatic enrollment.

2. Applicants Who File Part B Options During an IEP - In most cases an individual filing an annuity application during an IEP also files a "yes" or "no" Part B option. Automatic enrollment does not apply to such an individual.
3. Persons Whose Disability IEP Precedes or Overlaps With Their Age 65 IEP - In any given month some beneficiaries are in their IEP based on disability as well as on prospective attainment of age 65. Medicare records for other beneficiaries were previously established based on disability. The following general rules apply to these cases:
 - a. Part B Option in Record at Time of Prospective Age 65 Call-up - A disabled beneficiary will not be included with the age 65 attainment group, when his or her case is called up for attainment (at age 64 years and 6 months) if RRB records show that the beneficiary has Part B coverage. Do not notify the beneficiary of continuing entitlement unless there would be a reduction in his or her Part B premium at age 65.
 - b. Part B Option Received Between 64 Years and 6 Months and Age 65 - Any Part B option received for a disabled beneficiary between the ages of 64 years and 6 months and age 65 is a valid option for or rejection of Part B as an age 65 beneficiary.
 - c. Part B Refusal or HI and Part B or Part B Termination in Record at Time of Prospective Age 65 Call-Up - The attainment activity will reject because of the existing MIRTEL record. Manual action is necessary to enroll the beneficiary for Medicare based on age. The enrollment may include Part A and Part B or just Part B. A G-41 should be sent.
4. Persons Residing Outside the U.S. or in Puerto Rico - The law excludes persons living outside the U.S. (including residents of Puerto Rico) from automatic enrollment. High proportions of eligible individuals in Puerto Rico receive medical care without payment on the basis of need and do not enroll for Part B. For them and for persons living outside the U.S., automatic enrollment generally would not be advantageous.

3.4.31 Preparation of ID Cards

Medicare cards are produced from two separate data processing programs. One of the programs processes replacement Medicare card requests entered using the MEDCOR Activity 62 (Duplicate Medicare Card Request) screen. The other program, which is part of the MIRTEL processing, generates (1) Medicare cards for individuals on the rolls who attain Medicare eligibility, (2) initial Medicare cards for new enrollments during an Initial Enrollment Period (IEP), and (3) revised replacement cards for individuals whose coverage changes, e.g. the beneficiary declines Part B coverage, Part B coverage is

terminated due to non-payment of premiums, jurisdiction for Medicare is transferred from SSA to RRB, the beneficiary enrolls in Part B during a General Enrollment Period or Special Enrollment Period, or whose Health Insurance Claim Number changes, e.g. spouse-to-widow conversions.

Note: At one time mailing labels were generated along with the Medicare cards. The mailing labels were used to mail Medicare and You handbooks. Although Medicare and You handbooks are now mailed by the Centers for Medicare & Medicaid Services, information about the mailing labels continues to be displayed on program syslists and is used to track when a Medicare card is released. The labels originally carried alphabetic designations to distinguish the type of handbook to be released, and/or the type of enrollment, i.e. U.S. resident, Canadian resident, etc. The alpha designations are as follows:

A	<p>Attainment; U.S. residents (Form RL-861)</p> <p>Note: In a manually established attainment case, if the beneficiary's EDB record was not previously established at CMS, and if clearance is received early enough for the delivery of the Form G-41 at least 2 months before the Part A effective date, enter a "1" in the "ID ISSUE CODE" field on the MEDCOR Activity 12L, to release Form G-41.</p>
A or B	<p>Non-attainments (U.S. residents) and attainments with Part A only (residents of Puerto Rico)</p> <ol style="list-style-type: none"> 1. If it is necessary to secure Medicare clearance, create a MEDCOR Activity 12L, enter a "2" in the "ID ISSUE CODE" field on the MEDCOR Screen. 2. In an attainment case in which the Medicare entitlement was previously established at SSA, we must not provide a second opportunity to cancel Part B, since SSA previously picked up such a case for automatic enrollment. 3. In a case in which Medicare clearance is received too late to permit the delivery of a Form G-41 at least two months before the Part A effective date, Form G-868 is to be released with the Medicare card.

	4. In an accretion case, in which the individual has filed an application and elected Part B coverage.
C or D	Residents of Canada
E or F	Residents of foreign countries, other than Canada

Revisions to the two data processing programs were completed in November 2008, to allow printing of all Medicare cards on tear and water resistant paper affixed to the bottom center of a full page (8½ x 11) document. A Form RL-860 series letter is printed above the peel-off Medicare card. The revised forms are printed using a digital imaging system, rather than an impact printer. The revised format improves the print quality on the cards, safeguards personally identifiable information displayed on the cards, and streamlines the mailing process. The form number for all Medicare cards issued with a Form RL-860 series letter is Form G-41.

1. Medicare cards for beneficiaries who attain Medicare eligibility and that are mailed with IEP packages are printed with **Form RL-861**. Forms RL-861 are generally printed one or two months before the start of the beneficiaries' Initial Enrollment Period (IEP). The forms are held in the Medicare Section until the start of the IEP, and then delivered to the mailroom for release with Booklet RB-12 and a return envelope.
2. All other Medicare cards generated from the MIRTEL processing are printed with **Form RL-866**.
3. All replacement Medicare cards generated from the processing of MEDCOR 62 activities are printed with **Form RL-865**.

3.4.32 Handling Of Medicare Cards

The attainment Medicare cards with Form RL-861 are delivered to MS for further handling. Medicare cards are generally sent to MS sorted by ZIP code and number order. The following explains what enclosures are to be released with the various Form RL-860 series letters and Medicare cards.

A. Form RL-861 and Medicare card (Form G-41) to U.S. Residents (Attainments)

Forms RL-861 are generally dated three months prior to the Part B effective date, i.e. the first day of the beneficiary's IEP. MS will hold Forms RL-861 until that date, and then take the cards to the mailroom. The following material is inserted with Forms RL-861 by the mailroom:

1. RB-12, Welcome to Medicare.
2. Pre-Paid return envelope - P.O. Box 10794 (catalog #040385).

B. Form RL-866 and Medicare card (Form G-41) to U.S. Residents (Non-Attainment Cases)

After review for accuracy and quality, Forms RL-866 addressed to U.S. residents are mailed without enclosures. These are generally transmitting initial Medicare cards for new enrollments (not attainments) during an Initial Enrollment Period (IEP), and revised replacement cards for individuals whose coverage changes, e.g. the beneficiary declines Part B coverage, Part B coverage is terminated due to non-payment of premiums, jurisdiction for Medicare is transferred from SSA to RRB, the beneficiary enrolls in Part B during a General Enrollment Period or Special Enrollment Period, or whose Health Insurance Claim Number changes, e.g. spouse-to-widow conversions.

Note: Examiners should immediately notify Eileen Binkus by e-mail if a Form RL-866 and Medicare card were generated in error, or if the Form RL-866 needs to be pulled for special handling, e.g. a delayed Part B enrollment (RCM 3.4.33). Provide the Medicare claim number, the beneficiary's name, and the beneficiary's mailing address, including the ZIP Code. Also indicate the date when a MEDCOR activity was entered to generate the Medicare card.

C. Form RL-866 and Medicare card (Form G-41) to residents of Puerto Rico (Attainments)

Beneficiaries residing in Puerto Rico are not covered by the automatic enrollment procedures and will initially be enrolled for Part A only. Hand prepare a Form G-44B for each individual from information shown on Form G-41. Stuff the following into mailing envelopes and forward them to the mailroom for mailing.

1. G-41, Medicare card - Part A only coverage (printed with Form RL-866).
2. G-44B, Application for Part B.
3. Form G-864
4. RB-20, Medicare for Railroad Workers and Their Families.
5. Return envelope - P. O. Box 10794 (catalog #040385).

If a Medicare card for a resident of Puerto Rico shows both Part A and Part B, or is not an attainment case, i.e. the Part A effective date is not in the current or a future month, handle it like a regular U.S. resident with Part A and Part B coverage as shown in B above.

D. Form RL-866 and Medicare card (Form G-41) to residents of Canada (Attainments)

Canadians are not covered by automatic enrollment and must file applications for Part B. Hand prepare a Form G-44B for each resident of Canada for whom a Form G-41 is printed. Stuff the following into mailing envelopes and forward them to the mailroom:

1. G-41, Medicare card – Part A only coverage (printed with Form RL-866).
2. G-44B, Application for Part B.
3. G-862, Canadian transmittal.
4. RB-104, leaflet.
5. AA-104, claim form.
6. Return envelope - P.O. Box 10794 (catalog #040384).

If a Medicare card for a resident of Canada shows both Part A and Part B, or is not an attainment case, i.e. the Part A effective date is not in the current or a future month, enclose only Forms AA-104, and RB-104. Do not include Form G-44B, Form G-862, or a return envelope. Release the package to the mailroom for mailing.

E. Form RL-866 and Medicare card (Form G-41) to Residents of Other Foreign Countries (Attainments)

Hand prepare a Form G-44B for residents of foreign countries other than Canada. Stuff the following into mailing envelopes and forward them to the mailroom:

1. G-41, Medicare card – Part A only coverage (printed with Form RL-866).
2. G-44B, Application for Medical Insurance.
3. RB-20, Medicare for Railroad Workers and Their Families.
4. G-863, Foreign transmittal.
5. Return envelope - P. O. Box 10794 (catalog #040385).

If a Medicare card for a resident of a foreign country, other than Canada, shows both Part A and Part B, or is not an attainment case, i.e. the Part A effective date is not in the current or a future month, forward the Form RL-866 without enclosures to the mailroom for release.

F. Form RL-865 and replacement Medicare card (Form G-41)

After review for accuracy and quality, Forms RL-865 are mailed to the beneficiary. There are no enclosures.

3.4.33 Delayed Notices Of Part B Enrollment

Part B enrollment may be delayed for many reasons. An individual, not eligible to enroll at the time he or she files for a reduced annuity, may become eligible before all issues are fully developed and resolved. His or her initial annuity award may be vouchered after PREH is searched for attainments. Unless a MEDCOR activity is created in such a case, a Medicare record will not be established unless the beneficiary inquires about Medicare entitlement. There will also be cases in which an individual's first notice that he or she is, or may be, entitled to Part B will be released after the first month of Part B coverage. These individuals must have at least 2 full months in which to file refusals of Part B without incurring premium liability or jeopardizing future enrollment rights.

Delayed cases will be handled as follows:

- MS will create a MEDCOR activity, if necessary, showing Part A and Part B.
- In an age 65 case, MS will manually prepare and release a Medicare card with Form RL-866 and Forms RB-12 and G-868. Form G-868 provides the option for the beneficiary to decline Part B coverage.
- In delayed disability cases, a Medicare card with Form RL-866 is prepared and mailed with Forms G-868 and RB-12.

The provisions of this section do not cover any individuals who have made specific "yes" or "no" options. They will be handled under regular enrollment procedures.

3.4.34 Processing Refusals Of Automatic Enrollment

Individuals who do not want Part B are instructed to sign the "NO" block on the back of the Medicare card, i.e. versions of Form G-41 dated before December 2006, or the back of Form RL-861 and to return the Medicare card. Upon receipt of the "NO" cards, MS checks the cards to be sure they have been properly completed, signed and mailed within two months of the month of mailing, and then processes them as follows:

- A. Part B Refusal Received in Time to Prevent Premium Deductions - All Part B refusals processed up to the recent cut-off date of the 3rd month of the IEP can be recorded in the MIRTEL file with a MEDCOR Activity 25S with a "2" entered in the 'EVENT CODE' field and the date of filing entered in the "EVENT DATE" field. The MEDCOR Activity will prevent premium deductions, initiate the generation of a new Medicare card showing Part A only, print out Label B in the syslist and send a correction to the EDB. Form RL-331 will be released to the beneficiary.

NOTE: Between July and November 1973, ESA mechanically processed Part B refusals for several hundred DQRRB's. Form G-41 stamped "Associate With Folder File Down," is the folder record. G-701's were not prepared.

B. Part B Refusal Received Timely But Too Late to Prevent Premium Deduction - Part B refusals processed after the recent cut-off date of the 3rd month of the IEP are handled as follows:

1. Create a MEDCOR Activity 25S, enter a "2" in the EVENT CODE field and enter the 3rd month of the IEP as the filing date in the EVENT DATE field. If the 3rd month of the IEP is not entered, the activity will reject. This is also true when for an optional Part B effective date is established.
2. MAMMA will mechanically refund up to 6 months worth of premiums.
3. If necessary, refund the erroneously deducted premium(s) via the Medicare Payment System (MPS).

Show the following reason for refund:

"You notified us that you did not want Part B."

C. Part B Refusal Received After Start of Coverage Period - A Part B refusal postmarked on or after the date of coverage starts, or more than 2 calendar months after the month the enrollment package was released, is treated as a voluntary termination of Part B. The QRRB is charged with a termination, his or her Part B coverage does not end until the last day of the month following the month in which the refusal is received, and he or she is liable for Part B premiums for the period they had coverage.

Create a MEDCOR Activity 23S, enter a "3" in the EVENT CODE field and enter the date of the request in the EVENT DATE field to update the MIRTEL and the EDB records with the Part B termination. Release Form Letter RL-336 to inform the beneficiary when the coverage will be terminated and the effect this will have on future enrollments. If the letter is released early enough in a GEP to permit reenrollment, include Code Paragraph 997. In all cases, a copy of this letter should be forwarded to the appropriate field office.

3.4.40 Temporary Notice Of HI Eligibility

An applicant for Medicare will normally receive a Medicare card within 30 to 60 days after filing. If a person will need medical care before he can expect to receive his Medicare card, the F/O may issue a temporary notice of Medicare eligibility (RL-345) if all of the following criteria are met:

- A. An application has been filed. (It may be filed at the time the notice is issued.)
- B. The applicant's eligibility as a QRRB is apparent or has been determined.
- C. Medicare services are needed immediately or will be needed before a Medicare card can be issued in normal operations.

- D. MS has been notified of the F/O's intention to issue the notice or the F/O has been authorized by MS to do so.

Since the applicant will make early use of the temporary notice, we must immediately establish his or her HI record so that it is available when an intermediary queries SSA for eligibility information. To do this, MS will complete a MEDCOR Activity 12L based on data called in by the F/O or, if clearance has already been initiated but is pending, take any action needed to expedite or force clearance.

3.3.41 Action By F/O

- A. Determine Eligibility - Before issuing a temporary notice, the F/O establishes any basic eligibility requirements not already established as follows:
1. Need for Temporary Notice - The applicant must be able to give reasonable assurance that he or she will be using covered services in the immediate future and before he or she could normally receive the Medicare card.
 2. Proofs - The applicant must submit acceptable proof of age and other proofs required to substantiate the claim.
 3. 120 Months of RR Service or if Less than 120 months – 60 Months of RR Service After 1995 (Employee/Spouse Applicant) - The employee must submit documentary proof that he or she has 120 months or if less than 120 months, 60 service months after 1995, e.g., a BA-6 showing at least enough service months. If the applicant cannot furnish adequate proof of service, the F/O will ask MS (by phone) to verify the claimed service.
 4. Insured Status (Survivor Applicant) - The F/O will make an insured status determination of whether RRB has jurisdiction of the survivor claim.
 5. Jurisdiction - SSA has a similar procedure to provide temporary notices of HI eligibility. Therefore, the F/O will refer the applicant to SSA if:
 - a. SSA has jurisdiction of survivor benefits, or
 - b. The employee has less than 120 months of RR Service or less than 60 months of RR Service after 1995.
- B. Telephone Notice to MS - When it is determined that an apparently eligible applicant needs a temporary notice of Medicare eligibility, the F/O will call MS and furnish the data required to prepare the MEDCOR Activity as follows:
1. Item 1 - RRB Claim Number, Symbol, and Prefix - If there is no evidence that a 6-digit claim number was previously established, the F/O will furnish the employee's SS number with the appropriate symbol and prefix. If there is a known prior claim number, the F/O will furnish it.

2. Item 5 & 5a - Date of Birth
 3. Item 7 - Beneficiary SSA Number - If the applicant is other than an employee, his or her own SS number is required.
 4. Item 8 - Employee's SS Number - This is required for any type of beneficiary.
 5. Item 10 - Status of Annuity - The D/O will furnish the type of application filed, i.e., AA-1, AA-101, AA-17, etc. If the applicant is a survivor, the F/O will indicate if annuity payments cannot be made because of work deductions.
 6. Item 13 - Part B Effective Date - The F/O will furnish this date only if a timely election is made. No date will be furnished if the applicant is not in an enrollment period.
 7. Item 19 - Part A Effective Date - July 1966, or the earliest date the applicant became a QRRB, or six months prior to the filing date of a Medicare or annuity application, whichever is later.
- C. Temporary Notice of HI Eligibility - Form Letter RL-345 will be issued by the F/O to an employee, spouse or widow applicant as evidence of entitlement to Medicare. A copy of the notice will be forwarded to MS either with the application or by G-26 if the application was previously forwarded.

3.4.42 Action By MS

- A. Verifying 120 Service Months or 60 Service Months After 1995 - Occasionally, the F/O will require assistance in establishing the service months. In such cases check EDM. If prior service is involved, furnish the information to the F/O by return phone call. If lag service is needed, have the F/O secure proof. If military service is needed, have a supervisor walk down a "special" G-563.
- B. Establishing Medicare Record - Determine whether or not an application was previously filed and clearance was requested.
1. Clearance Requested - If clearance was requested but is pending, get MBR's on all claim numbers involved and force clearance.
 2. MEDCOR Activity Needed - If clearance was not previously requested, create a MEDCOR Activity 12L based on the information provided by the F/O.
- C. Continuing Review for HI Eligibility – Review for any condition that would result in a disallowance of the claim for Medicare benefits.

1. Disallowance - Notify the F/O immediately if it is finally determined that the applicant is not eligible for Medicare. The D/O will contact the applicant to prevent the use of the temporary notice and to refer the applicant to SSA. Create a MEDCOR Activity 06S promptly to delete the Medicare record. Formally deny the claim and transfer it to SSA if applicable.
2. Allowance - When all claims material has been received and eligibility has been established, handle the folder in the normal manner.

3.4.50 Release Of Enrollment Kits During GEP

Forms RL-44/G-44 are prepared mechanically in December of each year (for the next year's GEP) and sent to MS for review and forwarded to the mailroom along with the following material:

- G-712,
- G-860 (for U.S. residents),
- Return Envelope - P.O. Box 10794 (catalog #040385),
- Mailing Envelope (catalog 040380).

The enrollment kits are sent to QRRB's (including DQRRB's) who reside in the United States and who:

- Refused Part B enrollment in the previous year;
- Withdraw from Part B coverage in the previous year; or
- Terminated Part B coverage in the previous year by failing to pay premiums within the grace period.

Beneficiaries whose Part B coverage has been terminated twice before are excluded from this group.

The specific criteria for determining the QRRB's to be solicited in each GEP is determined each year by SSA.

NOTE: Some Forms RL-44/G-44 need manual corrections before they are released. If the premium rate is \$0.00, an examiner must calculate and enter the proper amount in red on the RL-44/G-44. When the G-44 comes back, a MEDCOR Activity 22L must be created to update the MIRTEL with the Part B entitlement date and the correct premium and to update the EDB.

3.4.51 Request For Enrollment Card

MS will handle requests for enrollment cards as follows:

- A. If a G-44 was mechanically prepared and:
 1. The incoming correspondence requires no further reply, mark the correspondence "GEP Kit Released - File Only," and send to claim files.
 2. A further reply is required, mark the correspondence "GEP Kit Released," and handle the balance of the letter as usual.
- B. If a G-44 was not prepared, a timely application is not on file, and the correspondence cannot be used as an application for Part B, send the material to the D/O to obtain a G-44b before the end of the enrollment period.
- C. If a G-44 was not prepared and the request clearly indicates an intent to enroll, create a MEDCOR Activity 27S, enter a "1" in the EVENT CODE field and enter January, February or March in the EVENT DATE field. Release RL-331.

3.4.60 Responsibility For Processing Enrollment Cards

Adjudication units will not handle Forms G-44 or G-44B. MS will handle all processing related to GEP or SEP enrollments.

3.4.61 Properly Completed Enrollment Application

Form G-44 - When MS receives Forms G-44 or G-44b from the mailroom, they are to separate incomplete, mutilated and miscellaneous cards from those which have been properly completed. MS examiners will handle GEP elections by creating a MEDCOR Activity 27 and enter a "1" for a `yes' election or enter a "2" for a `no' election in the EVENT CODE field and enter January, February or March in the EVENT DATE field. GEP election cards with the premium rate shown in red are effectuated by creating a MEDCOR Activity 22L. When the action is complete, stamp them "Folder Record - Associate and File Down," and send them to claim files.

G-44b or Correspondence Received Clearly Indicates Part B Option "Yes" - The Medicare examiner will check the MOLI for the current status and will:

- If there is no MIRTEL record, (no Medicare record has previously been established) create a MEDCOR Activity 12L.
- If there is a MIRTEL record, create a MEDCOR Activity 27 and enter a "1" for a `yes' election in the EVENT CODE field and enter January, February or March in the EVENT DATE field.
- MIRTEL will generate a new Medicare card showing the Part B effective date.

3.4.62 Establishing Filing Date For Part B

These instructions apply to any Part B election made with RRB or SSA, whether made on an enrollment card, a Medicare or annuity application, or on any signed statement expressing an intent to enroll.

Establish the filing date in accordance with the following instructions:

- A. Received During Enrollment Period - If an application is received in an RRB or SSA office during the applicant's initial enrollment period or during a general enrollment period, use the date of receipt as the filing date, see 3.2. If the application is postmarked in an enrollment period, use the postmark date as the filing date.
- B. Received After Enrollment Period - If the application was signed during the enrollment period or if the date signed is not known, the application is deemed to have been filed on the last day of the enrollment period provided it is received in an RRB or SSA office before the eighth day of the month following the end of the enrollment period or it is postmarked no later than the first day after the close of the enrollment period.

3.4.63 Duplicate Cards

Cards may be returned with a message indicating that the person has already signed up. If there is an indication that the person has Medicare under another RRB number, handle in accordance with 3.4.65.

In all other cases, determine whether a previous "Yes" election is on record at RRB or SSA. If so, mark the card "Duplicate" and file it down. If there is no previous "Yes" election and the card does not show one, advise the person of this and ask him or her to complete another card. If there is no previous election and the duplicate card is properly completed, have it processed as usual.

3.4.64 Beneficiary Entitled At SSA

If there is an indication of SSA enrollment or entitlement, MS will take the following action:

- A. If clearance has been received and jurisdiction has been transferred to RRB, inform the annuitant of that fact. If the card was not answered "Yes" or "No", handle as shown in sec. 3.4.68C.
- B. If clearance was requested but jurisdiction has not been transferred to RRB, get MBRs on all numbers. See your supervisor for instructions if the issue cannot be resolved.

- C. If the G-44 or correspondence indicates that the beneficiary has Medicare coverage under a social security number not previously shown in our file, create a MEDCOR Activity 21L and enter the social security number in the FORMER SS CL NO field.

NOTE: Check DATA-Q to see if the annuity has been offset for SSA entitlement. If not, forward case on G-26a to payment examiner indicating no offset present.

3.4.65 Dual RR Annuitant

If a beneficiary states that he or she is enrolled under another RRB claim number, check MOLI on that number. If two Medicare records have been set up, handle as shown in 3.5.50 through 3.5.54.

3.4.66 Beneficiary Deceased

- A. Deceased HI Enrollee - If the deceased beneficiary is a Medicare enrollee only, create a MEDCOR Activity 50S (enter a "6" in the EVENT CODE field and enter the date of death in the EVENT DATE field) to convey the death termination to the MIRTEL file and the EDB.
- B. Deceased Annuitant - If the deceased beneficiary is an annuitant send the G-44 to claim files on a G-26 marked "Notice of Death." The date of death will be picked up in the MAMMA Run.

3.4.67 Changes Of Address

- A. Beneficiary In Receipt of RRA Annuity (DATAQ Record Exists) If requests are made on enrollment cards for the addition or correction of a ZIP code, or for a complete address change, prepare a FAST change of address in accordance with 9.7 instructions. If a name change is required prepare a FAST transaction in accordance with 9.4 instructions for the correction. If the request is made in a separate communication, transcribe any pertinent information from the card to the correspondence and send the correspondence to the PSU for processing. If the correspondence is unsigned, mark it "Signature on G-44."
- B. Beneficiary Entitled to Medicare Only If the beneficiary is not receiving an RRA annuity, i.e. that is no DATAQ record, prepare a MEDCOR Activity 22L to change the beneficiary's address.

3.4.68 Improperly Completed Enrollment Cards

If an enrollment card cannot be processed in accordance with the preceding sections because it is not properly signed, the Part B option is not clearly indicated, the card is damaged, etc., handle it in accordance with the instructions below:

- A. Card Not Signed - If the card was not signed, send it to the F/O to have it properly completed. No file annotation is needed.
- B. Card Signed by Someone Other Than Payee - The enrollment card should be signed by the person to whom it was addressed. If it was signed by anyone else, handle according to instructions in RCM sec. 3.2.9.
- C. Option on Card Not Clear - If the choice of option is not clear, or if contradictory answers are given, request the F/O to assist the individual in completing the application.

NOTE: The action taken will depend on the circumstances in the case.

3.4.69 Correspondence

Correspondence accompanying enrollment cards will be handled as follows:

- Destroy correspondence that does not require a reply and does not contain information of value.
- When a reply is necessary and the enrollment card is being separated from the letter for processing, transcribe any pertinent information from the card to the letter. The correspondence should then be handled in accordance with regular procedures.

3.4.70 Undeliverable Mail

When a G-44 enrollment package is returned for a better address, check MOLI for Medicare only cases and in an annuity case, check DATAQ, if a better address is not available, send the material on Form G-831 to the field for development of the correct address and delivery of the package.

Appendices

Appendix A

A1. Non-Disability Retirement Applications

- A. Mechanical Processing - When an initial annuity application is processed mechanically in a retirement case, an HI record is automatically established or, if a SMI application was previously filed, premium billing is terminated and annuity deductions are initiated.
- B. Manual Handling - When an application is dumped from the computer before HI clearance has been requested, the HI record must be established manually by the use of a G-810 activity code 12. If SMI coverage was previously established,

G-811 activity code 60, must be submitted to stop the release of SMI premium billing notices.

In manual cases in which the annuity is awarded less than eight months before the HI effective date, check to see whether an HI record has been established. If not, and the beneficiary is 64 years and seven months of age or older, prepare a G-810 activity code 12. If the beneficiary is under 64 years and seven months of age, enter an "MPS" call-up for the first day of the month before the start of the IEP. If automatic enrollment applies (see sec. 3.4.30), enroll the beneficiary for HI-SMI rather than HI only.

If HI clearance is received before the annuity is awarded, SMI premium deductions should be made. HI clearance is indicated by a record status code other than 01, 02, 03, 04, or 05 on the MIRF by a referral marked "RRB Jurisdiction" or by a printout showing a cleared record status. Do not deduct premiums until clearance is received.

- C. Denials - When denying an application, if the applicant is at least 64 years and 9 months old but is not a QRRB, be sure to transfer HI data to SSA as shown in RCM Chapter 3.5, Exhibit 2.

A2. Non-Disability Survivor Applications

- A. General Handling - A G-810 activity code 12 must always be prepared in a non-disability survivor case, other than a spouse-to-widow conversion case, or a case in which a widow was entitled to SMI as a retirement spouse IPI.

If HI clearance is received in such a case before an initial survivor annuity is awarded, SMI premiums should be deducted from the SMI effective date or the SMI paid through date, if shown. HI clearance and the SMI paid through date are shown on the MIRF or on a referral marked "RRB Jurisdiction". Do not deduct SMI premiums until clearance has been received, unless jurisdiction was transferred from SSA on SSA-1233RR as shown in item B.

If a widow files for a non-disability annuity and Medicare based on disability (on AA-17b), pay the annuity with "No SMIB This Cert" and control. After the case is returned, prepare Form G-325 as shown in RCM Part 11 and send the case to DB. See RCM sec. 3.2 for handling a case in which the annuity is denied.

- B. Form SSA-1233RR - Form SSA-1233RR is used to indicate that activity code of survivor benefits and Medicare belongs to RRB. Always prepare a clearance G-810 transfer HI activity code from SSA to RRB. SMI premiums may be deducted before HI clearance is received if Form SSA-1233RR is received for a widow who was enrolled for SMI at SSA as the employee's spouse. If the widow was enrolled for SMI at SSA based on a wage record other than the employee's, HI clearance must be received before SMI deductions can be made.

- C. Spouse-to-Widow Conversion Cases - When a widow's annuity, in a spouse-to-widow conversion case, is awarded less than eight months before the HI effective date, check to see if an HI record has been established. If not, and the widow is 64 years and seven months of age or older, prepare a G-810 activity code 12. If the widow is under 64 years and seven months of age, enter an "MPS" call-up for the first day of the month before the start of her IEP.

No action is necessary in a spouse-to-widow conversion in which an HI record was established under the spouse claim number. However, if the spouse annuity is suspended, prepare a G-811 activity code 60 as shown in RCM Chapter 3.14 before paying the widow's annuity and deduct premiums based on the SMI paid through date. A G-811 activity code 60 with the widow's the claim number symbol should also be prepared when awarding an initial survivor's annuity to a widow who was entitled to SMI as a retirement spouse IPI. Deduct SMI premiums beginning with the month following the SMI paid through date.

- D. Denials - When denying an application, if the applicant is at least 64 years and 9 months old but is not a QRRB, be sure to transfer HI data to SSA as shown in RCM 3.5, Exhibit 2.

A3. Disability Applications

Occasionally, a non-disabled annuitant, i.e., young mother or reduced employee, may file an application for Medicare based on disability. Frequently, DB may rate the person disabled retroactively. If the person eligible or will be eligible within five months, prepare a g-810 activity code 12 (see section 3.2 for determining effective dates). This type of case will not be screened mechanically, therefore, failure to prepare the G-810 may affect the person's coverage.

When awarding a survivor annuity to a disabled child who was enrolled for SMI as a retirement IPI, prepare a G-811 activity code 60. Show "WC" in item 1 and 14 in item 4. This will change the MIRTEL record to agree with the new CHICO record and will initiate deductions from the paid through date.

A4. Dual Enrollments, Entitlement Under Two RRB Numbers, Multiple Beneficiaries Under One Claim Number

Send to MPS cases in which the beneficiary claims to be enrolled for SMI by both SSA and RRB. However, there is no need to refer to MPS cases in which SMI jurisdiction was transferred from SSA to RRB and Medicare information is shown on Form G-90. That is not an indication of dual SMI deductions.

If the beneficiary claims annuity entitlement under two different RRB numbers, obtain both folders and determine whether an HI record has been established under either claim number. If no HI record has been previously established, prepare a clearance G-810 for the primary claim number (A or JA) and enter code 9 into the benefit payment record for the secondary claim number (MA or WA), as shown in RCM sec. 3.5.6. If a

HI record has been previously established under both claim numbers, send the folders to MPS.

If the HI record of more than one beneficiary must be established under the same claim number and symbol, send the case to MPS for the assignment of a pseudo number.

A5. Preparation Of Form G-810

Before preparing any G-810, check the MIRF. If a record is on the MIRF do not release a G-810. A G-810 may be prepared in an age case when the beneficiary is 64 years and 7 months of age or older. A G-810 may be prepared in a disability case five months prior to the HI effective date (see sec. 3.2 for determining effective dates).

If a beneficiary is entitled to automatic enrollment (a U.S. resident is entitled to monthly benefits or filed for such benefits in his IEP, as shown in sec.3.4.50) and an HI record will not be established mechanically (see RCM Chapter 3.3, G-810 Instructions), prepare Form G-810 with code 1 (first enrollment) in item 12, the SMI effective date (based on the RRB application) in item 13, and the SMI premium rate in item 14. Do not deduct SMI premiums from the annuity award until HI clearance has been received except as shown in section A2, item B. Pay the annuity with "No SMI This Cert" shown on the award form. There usually is no need to control the file for further Medicare handling after the annuity is awarded. After clearance is received SMI premiums will be mechanically deducted from an annuity in pay status or MPS will receive a referral calling for manual deductions.

If the applicant files for SMI in a GEP, prepare a G-810 with an SMI effective date of 7-1 of the current year. Be sure to use the correct SMI premium rate for late enrollments.

If the applicant files for SMI in a GEP, prepare a G-810 with an SMI effective date of 7-1 of the current year. Be sure to use the correct SMI premium rate for late enrollments.

If the applications is filed outside an enrollment period or a "No" option is filed complete the G-810 without an SMI effective date and rate.

Note: If the SMI effective date is more than five months in the past, do not prepare a G-810. Control the file and forward to MPS after your action. Identify the case as "delayed enrollment" on the route slip.

A6. Reinstatements

Before reinstating an annuity, check the file and the MIRF to determine whether SMI premiums were deducted prior to suspension or paid direct for any period. If so, reinstate the premium deductions from the later of the month of suspension or the paid through date shown on the MIRF. When reinstating an annuity in a case in which HI clearance was received but SMI premiums were not previously deducted, begin deducting premiums from the SMI effective date.

A7. Recerts

If SMI premiums were not previously deducted but the MIRTEL file shows SMI entitlement, deduct SMI premiums from the recert award if the difference in the previous and current rates is at least \$5.00 a month more than the current SMI premium rate. If the difference in rates is less than \$5.00, suspend the annuity and reinstate it including the SMI premium deduction.

A8. Suspension

When a monthly benefit which had SMI deductions is suspended for return to LPS or RR employment include code paragraph 977 in the notification of suspense letter to the payee. This advises the beneficiary of the option of paying SMI premiums quarterly or being billed at the end of the year.

A9. Terminations

- A. Retirement - When a spouse who was entitled to HI coverage on her husband's earnings record is divorced, her HI jurisdiction of suspense letter to the payee. This advises the beneficiary of the option of paying SMI premiums quarterly or being billed at the end of the year.

A9. Terminations

- A. Retirement - When a spouse who was entitled to HI coverage on her husband's earnings record is divorced, her HI jurisdiction must be transferred to SSA unless she is entitled to a railroad retirement annuity on another earnings record. Prepare Form RR-80 (see RCM Chapter 3.5, Appendix A), Code Letter 852, and a G-811 activity code 52 to terminate the HI record. If a divorced spouse is entitled to an annuity on another earnings record, send the case to MPS for handling.

If a spouse who has HI entitlement but is not receiving an annuity (an AA-103 enrollee or IPI) is divorced or a disabled child IPI marries, prepare a G-811 activity code 52 to terminate the HI record, Code Letter 854, and Form RR-80.

- B. Survivors - If a deceased employee had HI entitlement (based on an AA-101) but was not receiving an annuity before his death, terminate his HI record by preparing Form G-811 activity code 50.

When terminating the annuity of a remarried widow, a disabled child who married, or a spouse whose deceased husband was not insured for the payment of survivor benefits at RRB, prepare Form RR-80, Code Letter 852, and a G-811 activity code 52 to terminate the HI record. If a beneficiary whose entitlement on one earnings record is terminated, is entitled to an annuity on another earnings record, send the case to MPS.

3.5.1 General

The term "jurisdiction" is used in the Medicare program to indicate whether RRB or SSA is responsible for enrolling a person, issuing his/her Medicare card and collecting Part B premiums. Agreements between SSA and RRB have divided the responsibility. RRB is solely responsible for payment of Medicare benefits to qualified railroad retirement beneficiaries (QRRB's) residing in Canada.

3.5.2 Jurisdiction When HI Record Established

RRB has jurisdiction of the Medicare of all QRRB's, see 3.2.9. Also under the 1974 Railroad Retirement Act, RRB assumes Medicare jurisdiction for all individuals whose SS benefits are paid by RRB, including those who do not meet the definition of a QRRB. All individuals who receive SS benefits from RRB are also QRRB's for Medicare purposes. However, since the categories of beneficiaries whose SS payments are under RRB jurisdiction include other than QRRB's, these individuals are "deemed" to be QRRB's for Medicare, see 3.2.12.

A Medicare record will not be established until a QRRB or a "deemed" QRRB files a railroad retirement or social security application. If SSA has jurisdiction when a Medicare record is initially established, that agency will continue to have jurisdiction until the QRRB files a railroad retirement application or an inquiry is received and jurisdiction clearance is requested by RRB. At that time, the Medicare jurisdiction is automatically transferred to RRB.

If the individual does not meet the definition of a QRRB and SS benefits are not payable at RRB, RRB does not have jurisdiction. However, once the Medicare is established at RRB, jurisdiction will not change as long as the person is a QRRB or SS benefits are payable at RRB.

EXAMPLE: SSA has jurisdiction over the Medicare of an employee with less than 120 months of service or less than 60 months of service after 1995 (except commuted value cases as shown in 3.2.164), a survivor whose annuity rate is zero and no other entitled at RRB, the disabled child of an employee who is under age 62 and not under a DF, or a survivor who elected a RLS.

3.5.10 Transfer From SSA To RRB

Medicare jurisdiction will ordinarily be transferred from SSA to RRB mechanically when:

- A. A QRRB who filed for and was entitled to Medicare coverage at SSA, files for and becomes entitled to an annuity or files a Medicare application at RRB.
- B. A spouse beneficiary receiving a LAF C DIB benefit and Medicare coverage at SSA attains age 65.

- C. An annuitant who had Medicare coverage at SSA based on one DOB, attains age 65 based on a later DOB established at RRB.
- D. An ESRD beneficiary at SSA becomes entitled to a LAF E SS benefit or qualifies for Medicare at RRB based on age or regular disability.

3.5.11 Mechanical Transfer When Clearance Requested

Jurisdiction is automatically transferred, as shown in 3.4.10, when clearance requests from RRB are processed against the Master Benefit Record (MBR) at SSA in Baltimore. Clearance requests are generated by the Monthly Attainment Program (MAP), the Survivor Electronic Attainments (SURVEA), the Disability Attainment Selection for RR (DIB Attainment Selection, the SS Attainment Selection (SSATA), Retirement Adjudication System Initial (RASI) processed applications, Post Adjudication Mechanical (PAM) transactions, survivor application put on Application Express (APPLE) and manual handling. Normally, the process will pick up the most advantageous dates from SSA and RRB will establish the Enrollment Database (EDB) record. If the SSA benefit is certified by RRB, RRB has to consider the SSA effective dates before screening.

3.5.12 Request For Transfer

If SSA, an annuitant, or an IPI requests the transfer of Medicare jurisdiction to RRB, the case should be routed to MS for handling.

MS will check MOLI and will take the following action, depending on the status of the case:

- If clearance has been received, MS will notify the annuitant or the IPI of that fact.
- If a QRRB and a MEDCOR Activity 12L was not created, MS will create the MEDCOR activity. If the beneficiary is not a QRRB, he/she will be told Medicare stays at SSA.
- If MOLI indicates that jurisdiction is pending (record status of 01, 02, 03, 04, or 05 or screening request code A, B, or D), MS will secure MBR's on all possible account numbers that the beneficiary may be entitled on. Using the information on the MBR, the on-line State buy-in master (SPACE), the on-line SSA direct bill master (SOBER) and phone calls to the appropriate SSA program service center (PSC), the MS specialist will finalize the screening.

3.5.13 SMI Premium Collections

After the transfer of jurisdiction from SSA to RRB, if the beneficiary elected Part B, the deduction of Part B premiums or the premium billing operation is initiated mechanically in most cases. If there is an arrearage, MS will set up PARS in accordance with 3.12.

3.5.20 Transfer From RRB To SSA

Medicare jurisdiction must be transferred from RRB to SSA if:

- A. A non-disabled applicant is at least 64 years and 9 months old but is not a QRRB or "deemed" QRRB;
- B. An annuitant, IPI, or AA-7 enrollee who is not a "deemed" QRRB loses QRRB status (included are cases in which the employee dies and SSA has jurisdiction of survivor benefits, a spouse is divorced, a widow remarries, or a disabled child marries);
- C. A "deemed" QRRB is no longer entitled to SSA benefits; or
- D. A "deemed" QRRB is no longer entitled or potentially entitled to a railroad retirement annuity (a widow remarries before age 50).

Cases in which a non-disabled applicant is younger than 64 years and 9 months old and is not a QRRB should not be transferred to SSA. Deny such a case and inform the applicant to apply for Medicare at SSA 3 months before the attainment of age 65. Also if a disabled adult child marries and is not 65 and is not receiving SS benefits, Medicare entitlement should be terminated. Route the case to MS so they can put termination information on EDB.

Be sure to create MEDCOR Activity 52S to terminate the MIRTEL record in any case in which a beneficiary loses QRRB or "deemed" QRRB status. Also an RR-3T or an RR-80 is prepared in every case in which the Medicare jurisdiction is being transferred to SSA. Normally, to transfer the Medicare, the survivor examiners prepares an RR-3T, the retirement examiners prepare a RR-80 and if necessary the Medicare examiner would prepare an RR-80. If an RR-3T or an RR-80 is not prepared or the preparation is delayed, the beneficiary can lose his Medicare coverage. The beneficiary should be notified, and Appeal rights should be given if annuity entitlement or Medicare entitlement is terminated.

When MS receives the RR-3T or RR-80, the Medicare examiner cross refers the EDB's using CMS's BERT system. MS will then pend the case to be sure SSA starts premium deductions.

3.5.21 Transfer Of Medicare Or Annuity Application

If an application is put on the system, close out and deny the application as shown in 3.2.170. When an AA-6 or AA-7 is denied and transferred, be sure to have the delayed claim card pulled. Refer to the Exhibit titled "RR-80-RRB Report of Health Insurance Information SSA Jurisdiction", at the end of this chapter.

- A. Retirement Case - If an employee's application is being denied because he has less than 120 months of service or less than 60 months of service after 1995,

make certain that lag, military service (M/S) and prior service (P/S) have been developed. If M/S or P/S has been claimed but not developed, send the case to the appropriate retirement examiner. Be sure to include any Part B election with material being transferred. If Medicare was erroneously set up, send the material to MS to ensure EDB record is cross referenced or terminated.

- B. Survivor Case - If SSA has jurisdiction for the payment of benefits in a survivor case, Form RR-3T is sent to MS separately from the regular transfer packet.
- C. PURE SSA CASES - If SS benefits were payable at RRB, send the case to CBS OR SPS.

3.5.22 Spouse Or Survivor Entitlement Terminates For A Reason Other Than Death

A spouse's status as a QRRB on her husband's wage record terminates when her husband dies, if he is not insured under the RR Act, and may terminate when she is divorced. A widow's QRRB status on her husband's wage record terminates when she remarries and a child's QRRB status terminates when he marries. Divorced spouses and remarried widows entitlement terminates if they become entitled to a RIB that is greater than the statutory share of the employee's PIA. Annuitants or IPI's do not lose QRRB status when their annuities are suspended or they are removed from the O/M because of excess earnings, etc.

NOTE: In certain cases in which an SS benefit is payable at RRB, SS benefits will continue to be payable and RRB will continue to have Medicare jurisdiction after a spouse is divorced or a disabled child or widow marries. Refer any case in which an SS benefit is being paid by RRB to the appropriate payment examiner for handling.

- A. Beneficiary Has QRRB Status On Another Wage Record - A spouse who is entitled to an annuity on her own wage record or a remarried widow who marries another railroad employee continues to be a QRRB. In such a case, transfer the Medicare record from one RRB number to the other. Refer to Section B of Exhibit titled "Correcting HI Record When an Annuity Terminates for a Reason Other Than Death", at the end of this chapter.
- B. Beneficiary Loses QRRB Status - When a beneficiary loses status as a QRRB, transfer jurisdiction to SSA. Assemble the material with the Form RR-80 on top. Refer to Section A of Exhibit titled "Correcting HI Record When an Annuity Terminates for a Reason Other Than Death" and Exhibit titled "RR-80-RRB Report of Health Insurance Information SSA Jurisdiction", at the end of this chapter.

If an in-force or suspended annuity is terminated, create a MEDCOR Activity 52S in addition to pressing PF-7 key to terminate the record on FAST. The MEDCOR Activity 52S will deactivate the MIRTEL record or change the record status to 98.

A Monthly Referral marked "Termination-Check Jurisdiction" will be issued after an annuity in current payment status is terminated with codes 44, 57, 59, or 61 if the MEDCOR Activity 52S is not created.

If an IPI or an AA-7 enrollee loses QRRB status (e.g., a spouse married less than 10 years is divorced), transfer jurisdiction to SSA using Form RR-80. Deactivate the MIRTEL record by creating a MEDCOR Activity 52S. Refer to Exhibit titled "RR-80 RRB Report of Health Insurance Information SSA Jurisdiction" at the end of this chapter, on instruction as to how to transfer Medicare jurisdiction - RRB to SSA

3.5.30 Correcting HI Record When Beneficiary Enrolled By Both Agencies

Cases arise in which both RRB and SSA have assumed Medicare jurisdiction for the same individual, despite the fact that jurisdiction should be with RRB.

These dual enrollments occur for various reasons, the wrong SS account number is on the records of either agency; the individual's entitlement at SSA is based on an account number other than her own or her spouse's account number; clearance is received at RRB just prior to the time that SSA updates its records with new benefit entitlement data; or the MBR does not have a start date in the RRB JURIS field.

Some of the indications of dual enrollments are as follows:

- A letter is received from the beneficiary alleging dual enrollment.
- Form G-44, was released to the beneficiary as a part of RRB's enrollment process. The form is returned with an indication that he/she was already signed up for Medicare at SSA.
- A notification is received from SSA indicating SSA Medicare enrollment.
- Unrounded MBC (gross SS rate) shown on the RR-1a, RR-1e or MOR.
- Cost of living listings

MS will handle these cases as shown in 3.5.31 and 3.5.32.

3.5.31 Initial Handling

- A. Referral From CMS - When SSA or RRB enrolls a beneficiary for Medicare, CMS receives a transaction to accrete the record. The EDB takes the transaction and compares it to the EDB records. If the last name, first initial or first name and date of birth are the same as another record, or the SSA claim number is a cross reference on a RRB claim number, or the beneficiary's own account number (BOAN) is a BOAN on another EDB record, CMS receives an alert.

CMS reviews these alerts and for cases with railroad retirement involvement that they cannot handle are referred to RRB. MS handles these cases by taking the following steps.

1. Checks BERT to see if there are two records.
2. If there are two EDB records, are they for the same person? If not, mark the referral "NAN File Only", initial and date.
3. If both EDB records are for the same person, get a MBR on the SSA claim number, and a MOLI ('GD' and 'SC') print (get two sets of MOLI prints if both EDB numbers are RRB numbers).
4. If the beneficiary is receiving a LAF 'C' SS benefit, check DATA-Q to see if RRA benefits are offset for social security.
 - a. If RR annuity is enforce or in suspense and the "SS ENT" field is not "YES" or SS payments are enforce with the same SSA claim number and suffix, notify CBS if a retirement case or SAPT if a survivor case.
 - b. If RR survivor annuity enforce and SS benefit is LAF 'C' or LAF 'E' is based on the employees SSA number, notify SAPT.
5. If the beneficiary is still a QRRB, take action to correct the MBR to show RRB has Medicare jurisdiction and consolidate EDB records.

B. Other Notice Of Dual Enrollment

Check EDB, MOLI and SSA's MBR as in section 'A' above. However, if notice is from a RRB field office or an adjudicative unit, DATA-Q does not need to be checked.

If SSA's MBR shows that SSA has jurisdiction of the Medicare, handle as shown in 3.5.32.

3.5.32 Rescreening

When an F-2 referral or other material reflects that SSA's MBR does not indicate that RRB has jurisdiction of the individual's Medicare, MS will create a MEDCOR Activity 21S, or if any part of the MIRTEL record must be changed, a MEDCOR Activity 21L should be created. The MEDCOR Activity 21 is used only if there is a MIRTEL record. If there is no MIRTEL record, a MEDCOR Activity 12L should be created.

A. When The Screening Reply Is Received - MIRTEL will be mechanically updated if there is no evidence of current or prior premium collection.

If premiums are or had been collected, the case will be referred out for manual handling of the dually collected premiums. MS will refund any excess premiums via the Medicare Payment System (MPS) or create a MEDCOR Activity 20L to advance the paid through date. The paid through date should only be advanced to six months in the future, any other excess premiums should be refunded. Also, paid through date cannot be updated past December of the current year, unless it is after October when the new rate for the next year are put in the system. If there is any overpayment to the annuity because of SSA entitlement, the refund should be offered to DRD to be used to lower the overpayment,

- B. Handling Cases With LAF `E' Code and E-Y Option for HOC and SOC - These specific records are pending because RRB is certified to pay the SS benefits and incorrect entries were made on the MBR. The MBR should be coded with an LAF `E' Code and RR Juris indicator that RRB has jurisdiction of the individual's Medicare. But in these cases, the MBR was coded with a LAF `E' Code and reflects that SSA has jurisdiction of the individual's Medicare. MS may receive the file for one or more of the following reasons:

- Referral - Unable to process activity-screening reply outstanding
- Referral - Folder Notice - Screening reply pending for 30 days - Tracer sent
- ALERT - Screening reject received-MIRTEL still pending
- CMS Exceptions
- Complaints about dual deductions or dual payments

Action: Check the MBR. If the MBR reveals there is a LAF `E' Code and SSA is deducting the Part B premium, refer the case to P&S – PAS, Attention Sharon Morris.

3.5.40 Change in SMI Elections

A change of election can be made on any RRB or SSA form or in a letter. The request for change of election must be properly signed by each beneficiary involved.

- A. When an Election Can Be Changed to "Yes" - A beneficiary can change a Part B election to "Yes" during any period in which he/she would be eligible to enroll. This includes the seven months of his/her initial enrollment period (IEP), the three months of any general enrollment period (GEP) in which he/she could enroll or under a special enrollment period (SEP) provision, enroll while still covered by an EGHP or during an eight month period beginning with the first day of the first month in which the individual is no longer enrolled in an employer group health plan (EGHP).

NOTE: If a SEP and GEP overlap, the individual who enrolls in January, February or March, can elect to have the GEP enrollment, rather than the SEP enrollment. If an individual chooses a GEP enrollment, a specific statement claiming premium surcharge should be secured so the months of EGHP coverage can be eliminated when the premium increase is calculated. An IEP and SEP cannot overlap; if the individual is in an IEP, SEP rules cannot apply.

- B. When a "Yes" Election Can Be Withdrawn or Canceled - A beneficiary may cancel an application for Part B made during his IEP by filing a request for withdrawal or cancellation during the first 3 months of his IEP. A beneficiary may cancel an application for Part B enrollment when the enrollment was delayed, as shown in 3.4.33, the beneficiary has two months after the notice of enrollment is received to file a refusal of Part B. Use the screening request and screening reply dates to determine approximately when the Medicare card was released.

If an application for Part B is withdrawn or canceled, it is as if no application has been filed. Part B coverage is not effective for any period and no Part B premiums are due.

Handle the timely cancellation of a Part B application according to 3.5.41 and 3.5.42. A refusal of automatic Part B enrollment which is received before the Part B effective date, is handled in a similar manner, as shown in 3.4.34.

- C. When a Change in Election is Treated as a Voluntary Termination - A request for withdrawal or cancellation of a Part B application, filed during the fourth through the seventh month of an IEP, outside an enrollment period, or more than 2 months after a notice of Part B enrollment is received, is treated as a voluntary termination. The beneficiary is, therefore, charged with a termination, his Part B coverage does not end until the last day of the month following the month in which the request for cancellation is received, and he is liable for the payment of Part B premiums for the period of coverage.
- D. Termination after State Buy-In Deletion - See 3.2.107

3.5.41 Changing Election - Application Pending On Computer

When the election was made on Forms AA-1, AA-3, AA-6 or AA-7, and the application is pending on the computer, the method of processing the IEP election change depends on the status of clearance (screening request).

If screening reply or clearance has not yet been received, check MBR and create a MEDCOR Activity 32 with the appropriate information. If the information on the MIRTEL record is not changing, use the short version. If the information on the MIRTEL record is changing, use the long version. If there is Part B entitlement on the MIRTEL record, after the Activity 32 has processed, create a MEDCOR Activity 25S.

If clearance has been received, create a MEDCOR Activity 25S.

The status of Medicare clearance is indicated on the MOLI `SC' screen and in the record status on screen `GD'.

3.5.42 Changing Elections In Other Cases

Apply the following procedures when an effective IEP change of election is received in a case in which an annuity is in force or in suspense, a Form AA-6 or a Form AA-7 has been certified on the computer, and in any other case not covered in the preceding section.

- A. Election Is Changed to "Yes" - Create a MEDCOR Activity 25S with a "1" in the EVENT CODE field and the date of filing entered in the EVENT DATE field. With this Activity 25, the date of filing has to be a month in the IEP.

If it is a good cause (equitable relief case), create a MEDCOR Activity 25S with a "1" in the EVENT CODE field and enter the Part B effective date in the EVENT DATE field.

B. Election Is Changed From "Yes" to "No" in Time to Prevent Premium Deductions

- An annuity is set up for mechanical adjustment on the cut-off date in the month before the month in which Part B is effective (generally, the 3rd month of the IEP). The MEDCOR Activity must be created and processed before or in the Last MIRTEL Run of the month before the Part B effective date. A change in election processed before that date will prevent premium deductions. Create a MEDCOR Activity 25S with a "2" entered in the EVENT CODE field and the date of filing entered in the EVENT DATE field to change the MIRTEL/MOLI and the EDB. The date of filing must be one of the first three months of an individual's IEP.

In a bill-direct case, check MOLI to determine the premium status. If no premiums have been paid, create the MEDCOR Activity 25S.

C. Timely Refusal Not Processed Timely - Although the change of election may have been filed in time to withdraw or cancel Part B, it may not be processed in time to prevent crediting of a cash premium or the deduction of a premium from the annuity.

If a Part B withdrawal, in a case in which an annuity is in pay status, is processed after the cut-off date in the month before the month in which Part B is effective (generally the 3rd month of the IEP) assume that the annuity has been set up for mechanical adjustment). If the MEDCOR Activity is processed in or later than the First MIRTEL Run of the month before the Part B effect date, deductions are likely to start. A change in election processed before that date can be recorded in and handle as follows:

1. Create the MEDCOR Activity 25S with a "2" entered in the EVENT CODE field and the date of filing entered in the EVENT DATE field. The date of filing must be one of the first three months of the individual's IEP.

2. Refer the case to the retirement or survivor examiner to stop premium deductions.
3. Refund the erroneously deducted premium, via the Medicare Payment System (MPS). Show the following reason for the refund:

"You notified us that you did not want medical insurance protection."

In a bill-direct case in which premiums have been collected, create the MEDCOR Activity 25S and refund the erroneously collected premiums via SURPASS.

3.5.43 Voluntary Termination

- A. Enrollee Contacts RRB Field Office - When the enrollee contacts the field, the contact representative will secure a signed statement from the enrollee. When the field has the signed statement in their hands, they will send an e-mail to MS so the termination request can be processed and forward a signed statement to confirm the call. MS should handle as follows:
 - When the e-mail is received, create MEDCOR Activity 23S, enter a "3" in the EVENT CODE field and enter the date of filing in the EVENT DATE field and release RL-336 to enrollee as notification that we have acted on his request. This also notifies him of the effect termination will have on future coverage.
 - Control for signed termination request from the field.
- B. Enrollee Contacts Headquarters Directly - If the enrollee sends a signed statement to headquarters clearly requesting a withdrawal from Medicare Part B. Create MEDCOR Activity 23S, enter a "3" in the EVENT CODE field and enter the date of filing in the EVENT DATE field and release RL-336.

If an ambiguous request is received, call the appropriate field office so that they can clarify the request.

3.5.44 "Yes" Election Outside Enrollment Period

If a "yes" election is filed outside of an enrollment period, deny the deletion with Form RL-394.

3.5.45 Acknowledging Effective Changes Of Election

Ordinarily, it will not be necessary to acknowledge effective requests for changes of election, since they are usually made through the field. However, if the individual requests acknowledgement, or it would be desirable to acknowledge the change of election for any other reason, release Form RL-331.

3.5.46 Effective Date Of Voluntary Termination

A. Request Filed After April 1, 1968 and Before July 1, 1987 -

Part B coverage terminated the last day of the calendar quarter after the calendar quarter in which the request was filed.

B. Request Filed After June 30, 1987

Part B coverage terminates as of the end of the calendar month after the calendar month in which the request is filed.

3.5.50 Establishment Of Dual HI Records

Every month the Research and CHICO files are used to select RR annuitants or SS beneficiaries who will be eligible for Medicare in the sixth succeeding month. A MIRTEL record is established and screening records are prepared for each SSA number that is available for the beneficiary (the employee's number, beneficiary's own SS number, and/or a SS claim number). The screening records are sorted to SSA number sequence before they are sent to SSA in Baltimore. A listing will be prepared whenever there is more than one screening record per SSA number and the RRB claim numbers differ. The screening request is still sent to SSA and the MIRTEL record is not changed.

The listing is forwarded to MS. Employees will be identified by a `10' preceding their name. Spouses will be identified by a `14' and widows will be identified by a `16'. It will be MS responsibility to ensure that:

- Only one enrollment package (G-41) or identification card (G-43) is released.
- The MIRTEL record (spouse or widow) is annotated with a dual annuitant indication (Part B Option of 9). This will prevent dual premium deductions.
- The EDB records are consolidated.
- Determine if the employee's annuity or social security benefit is large enough to sustain the monthly premium deduction. If it can, the beneficiary should be enrolled for Medicare on the employee claim number. If the employee's annuity is too small to sustain the deduction, the beneficiary's Medicare record should be established under the spouse's or widow's claim number.

A beneficiary should be enrolled for Medicare under only one record. However, in some cases, a beneficiary who is entitled to annuities under two RRB claim number may have records established under both claim numbers if:

- Form G-44 is returned with a "YES" option and the beneficiary does not state that he/she was previously enrolled for Medicare under another RRB claim number.

- An employee files Form AA-1 and a record is established under the retirement claim number. In later months this same employee files Form AA-3 for a spouse annuity. A second record is set up under the spouse's claim number 'MA'.

3.5.51 General Handling Of Dual HI Cases

If clearance has been requested (a clearance or MEDCOR Activity 12L was created or clearance was done mechanically) under either claim number in a dual case, the payment examiner should send both folders to MS, after any necessary vouchering action has been completed. MS will handle the case as shown in 3.5.51B and 3.5.52.

If clearance was not previously requested under either claim number, the payment examiner should handle the dual case as shown in item A, below.

The cost of living process generates a listing of dual annuitants where there is not Part B option code on the CHICO record. MS takes action to put a Part B option of 9 on the CHICO record..

- A. Medicare Clearance Not Requested Under Either RRB Claim Number - A payment examiner should request clearance under the primary claim number (A or JA) by creating a MEDCOR Activity 12L and enter a 9 in the Part B Option Code field for the secondary claim number (MA or WA) or by entering code 9 in the Part B option box on the award form being prepared or, if the annuity is in pay status, by preparing and submitting Form G-607. Prepare the Form G-607 in accordance with regular name change instructions but enter code 8 in col. 14 and 9SMIB in cols. 16-20. See 9.4, G-607 instructions. If the payment examiner does not take this action, the material should be referred to MS
- B. Medicare Clearance Previously Requested - If clearance has been requested but MOLI shows that clearance is pending, MS will pend the case until the screening reply is received. When the reply is received MS will determine if a record has been established on one or both numbers. If records have been established on both numbers, MS will handle in accordance with 3.5.52.

If a record has been established on only one number, MS will create a MEDCOR Activity 25S, enter a "9" in the EVENT CODE field and enter the current date in the EVENT DATE field, to enter a 9 Part B option code on the MIRTEL record of the other number and also enter a 9 in the CHICO record using Form G-607.

3.5.52 Consolidation Of Established Dual HI Records

- A. General - When the Medicare EDB records have been set up under both RRB claim numbers, determine under which claim number to consolidate the records as follows:
 - 1 If Part B premium deductions have not been made under either RRB claim numbers.

- Consolidate the Medicare records under the primary claim number by creating a MEDCOR Activity 34S, enter the secondary RRB claim number in the FORMER RR CL NO field. Primary claim number is the employee number, prefix "A".
2. If Part B premium deductions have been started under the primary claim number (A or JA).
 - Consolidate the Medicare records under that number.
 3. If Part B premium deductions have been started under the secondary claim number (MA or WA) and not under the primary claim number (A or JA).
 - Consolidate the Medicare records under the secondary claim number.
 - Changing the Medicare number after it has once been established would cause confusion.
- B. Consolidation - Check MOLI in each case to determine whether there is a record under either or both RRB claim numbers. Determine under which claim number to consolidate the Medicare records. Consolidate the records as follows:
1. For the Claim Number Under Which the Medicare Record Is Being Consolidated
 - a. If there is a record under that claim number, create a MEDCOR Activity 34S, enter the secondary RRB claim number in the FORMER RR CL NO field.
 - b. If there is no record under that claim number, create a MEDCOR Activity 31L, enter the secondary RRB claim number in the FORMER RR CL NO field.
 2. For the Claim Number From Which the Medicare Record Is Being Transferred
 - If there is a record under that claim number, create a MEDCOR Activity 25S, enter a "8" in the EVENT CODE field and enter the current date in the EVENT DATE field.
 - If Part B premium deductions are not being made, prepare Form G-607 as shown in 3.5.51.
 - If Part B premium deductions are being made, suspend the annuity on FAST-suspension/termination on DATA-Q by pressing PF-7 key and completing the necessary items. Reinstate payments with a Part B

option code 9 on the award form and refund any excess premiums via the Medicare Payment System (MPS).

3.5.53 Notice To Annuitant

MS will notify the annuitant that records have been consolidated and that the Medicare card under the RRB number from which the Medicare record was transferred should be destroyed. Prepare a letter to be released to the beneficiary. Select the paragraphs according to the type of correction made and whether or not an annuity adjustment and refund will be made:

1. Your health insurance coverage has been consolidated under _____.
2. Premium deductions will (not) (no longer) (continue to) be made under _____.
3. We will adjust your annuity payments under _____ and you will receive a refund for premiums deducted under that number as soon as possible.
4. If you are holding a health insurance card under _____ it should be destroyed.

Release the letter to the beneficiary and make any necessary annuity adjustment or refund.

3.5.54 Making Adjustments And Refunds.

When dual deductions of Part B premiums have been made under both RRB claim numbers, adjust payments and refund premiums due under the RRB claim number no longer having jurisdiction of Part B. Use a Part B option code 9 on the award form to indicate "dual annuitant". This will prevent solicitation in the future GEP's.

Make premium refunds via the Medicare Payment System (MPS). This will take care of the refund and the transfer of funds from the Part B account. When a refund is not being made (e.g., the premiums are used to offset an overpayment), the examiner will notify the premium collection clerk by memorandum (original only) of the amount of premiums to be transferred from the Part B account to the RR account. Show the period that the premiums covered. When transferring premiums by memorandum, send the folder and memorandum to the premium collection group for their action.

3.5.55 Request For Address And Name Changes

- A. **ADDRESS CHANGES** - A request that is received for a change of address must be signed by the annuitant/applicant. In representative payee cases, the change of address request must be signed by the representative payee, and **not** by the annuitant/applicant. Upon receipt of an address change request, take the following action:

1. If a Medicare only beneficiary, create a MEDCOR Activity 22L to change the beneficiary's address on MIRTEL/MOLI and the EDB.
2. If annuity payable, enter the address change via FAST-COA to update the CHICO/DATAQ.
3. Prepare Form RL-476 to advise the beneficiary that action has been taken to change the address of his/her record.

- B. **NAME CHANGES** - Documentary evidence in support of a name change is not required when the name change is based on court action. In such a case, the field office examination of the document submitted is sufficient. Take the following action when a request for a name change correction (incorrect spelling) is received:

Create a MEDCOR Activity 22L to update MIRTEL/MOLI and the EDB with the correct name. Also, be sure to enter a "2" in the ID ISSUE CODE field to release a new Medicare identification card.

After your action has been completed to change the beneficiary's name, attach a Form G-26 to the material and route to PSD.

Exhibits

Exhibit 1 - Correcting HI Record- Annuitant Terminates for Other than Death

When an annuity in current or suspended payment status is terminated for any of the reasons listed below, separate actions are necessary to correct the beneficiary's HI record.

G-96 Cause

Code	Reason
44	Beneficiary remarried
57	Spouse divorced
59	Annuitant or pensioner's benefit terminated
61	Cancellation of application

The HB or adjudication examiner in the section holding the folder should take the actions described below when an annuitant loses status as a QRRB. Cases in which the annuitant does not lose status as a QRRB should be sent to HB for handling. A referral

marked "Termination - Check Jurisdiction," is issued in these cases. However, do not wait for the referral to take the necessary action.

A. Annuitant Loses Status as QRRB - Jurisdiction will be transferred to SSA. Take the following action:

1. Prepare Form RR-80 with section B completed. Enter in item 14 the month and year in which the last check was issued and not returned for cancellation.
2. Release code letter 852 to the beneficiary to notify him of the transfer. Prepare a copy of the letter for SSA and attach it to the Form RR-80.
- 3 In addition to the termination Form G-96, prepare Form G-811 activity code 52 to deactivate the MIRTEL record and to alert SSA of the impending transfer.
4. If a not due check, from which a premium was deducted, has been cancelled, the examiner terminating the annuity will address a handwritten memo to the premium collection group in HB requesting a transfer of funds from the SMI account to the RRB account. Send the memo and the folder to the premium collection group so the transfer schedule number and date can be noted in the folder.
5. If a not due check, from which a SMI premium was deducted, is not cancelled, do not transfer funds from the SMI account to the RRB account. Instead, include the amount of the SMI premium in the annuity overpayment.

B. Annuitant Does Not Lose Status as QRRB - RRB retains jurisdiction if the annuitant does not lose his status as a QRRB. For example, RRB retains jurisdiction when a widow marries another RR employee and goes from a WA to MA. To transfer the annuitant's record from one RRB number to another, HB will take the following actions:

1. Prepare Form G-811, activity code 52 to deactivate the old RR number.
2. If there is an MIRTEL record under the new claim number, prepare Form G-810 or Form G-811, activity code 34.
3. If there is no MIRTEL record under the new claim number, prepare a activity code 33. This will establish a MIRTEL record under the new number and transfer utilization from the former RR number to the new RR number.

B. Beneficiary Withdraws Annuity Application - RRB will retain jurisdiction if he is a QRRB or a potential QRRB. If he is a QRRB, prepare a Form G-810, activity

code 20, to change the record status to bill direct (22) and enter a delinquency date.

If the beneficiary is not a potential QRRB, prepare a Form G-811, activity code 52, to deactivate the record and a Form RR-80 to transfer jurisdiction to SSA.

Exhibit 2 - HI Jurisdiction Transfer - RRB to SSA

RR-80-RRB Report of Health Insurance Information SSA Jurisdiction

Prepare original and one copy.

Use

Section A - Used to transfer Medicare data from RRB to SSA for persons not on the EDB under a RR claim number because they are non-QRRB's.

Section B - Used to transfer Medicare jurisdiction from RRB to SSA for persons on the EDB under a RR claim number who have ceased to be QRRB's.

Completion

Complete items 1 through 5 and item 17 regardless of which section will be completed; also complete items 6 through 8 if Section A is applicable, or items 9 through 15 if Section B is applicable.

Item	Entry
1	Enter the beneficiary's RRB claim number.
2	Enter the beneficiary's Medicare claim number established on the RRB record. The symbol, if any, prefix and claim number must be shown to enable SSA to transfer any information on the EDB to the beneficiary's SSA claim number. If the beneficiary has been assigned a pseudo number, enter the pseudo number.
3	Enter the RR employee's SS account number.
4	Enter the SSA account number of the beneficiary for whom Medicare data or Medicare jurisdiction is being transferred. If none, enter "NONE".
5	Enter the beneficiary's complete name and address. Enter the beneficiary's telephone number if it is available in the folder.

Section A

6	Enter the official filing date of the application. (If the application is an SS Medicare application, change "RRB" to "SSA.")
7	Enter the reason the beneficiary is not a QRRB, e.g., "Less than 120 months or less than 60 months after 1995", "Does not meet definition of spouse." If reason is long, enter "See Attachment" and attach an explanation.
8	Check box to indicate the Part B election shown on the application. If the application is an SS Medicare application, change "RRB" to "SSA".

Section B

9	Enter the effective date of Part A coverage.
10	Check the appropriate box and enter the date of the event that ended RRB Medicare jurisdiction. If the event was other than one of the printed reasons, describe the event.
11	Enter the effective date of the first Part B coverage period. Enter a termination date if the beneficiary's Part B coverage was terminated for non-payment of premiums or a voluntary cancellation of Part B coverage. The date in this item is not to be confused with the date jurisdiction ended, as shown in item 10.
12	Enter the effective date and termination date of the second Part B coverage period, if any.
13	Enter the premium rate for the last month the premium was paid (the month entered in item 14.)
14	<p>Enter the last month and year for which the premiums were paid. Check the MOLI `GD' screen for this date. For spouse no survivor insured status cases, the premium paid through date will be the employee's date of death unless SBI or bill direct involvement. If premiums were deducted from an annuity, determine the correct premium paid through date as follows:</p> <ul style="list-style-type: none"> • If a "not due" payment has been cancelled, do <u>not</u> consider the premium paid for that month. • If a refund has been received or has been requested for the <u>net</u> amount of a "not due" payment after Part B deduction, do <u>not</u> consider the premium paid for that month.
15	Check the appropriate box to indicate the method of payment in use when QRRB status was terminated.

16	Enter any other explanation which may be necessary.
17	Enter the preparer's signature, the current date and the preparer's telephone number.

Section C -For Field Office use only.

Section D - For SSA use only.

Preparation Of Related Transfer Material

Organize RR-80 with all related transfer materials which might expedite SSA's completion of the transfer action. Examples of materials which might be included are:

If Section A is Completed:

- The RRB or SSA Medicare application, or xerox copy if original must be retained.
- The annuity application, or xerox copy if original must be retained.
- Copy of denial letter when Section A is completed.

Disposition

No Transfer Of Credits Involved:

Attach any related transfer material to the RR-80. Letters on tissue paper should not be attached to the RR-80. Attach a good quality photocopy.

NOTE: DO NOT ATTACH ANY COPIES OF RR-80 TO G-73a

Transfer of Credits Involved:

Release G-73a with related transfer material to BIS. Release the RR-80 separately.

Examiners in larger units where central control areas are established should put the completed forms into the tray designated for RR-80's. These forms will be delivered daily to the MS. Personnel in other units may send the RR-80 to MS.

NOTE: DO NOT MAIL THE RR-80 TO CMS

MS will send all RR-80 forms to CMS through the facsimile process. This is done on a daily basis.

3.6.1 Scope Of Chapter

This chapter covers the various edit programs in MIRTEL and the HIM and the reject, alert and folder notices messages produced in these programs. Included are instructions for handling these referrals and other processing problems.

3.6.2 MIRTEL

The MIRTEL system has an elaborate system of edits to validate input, check the consistency of input to the existing record and verify the Medicare information on the CHICO file. All input both manual and mechanical is edited for completeness, validity and consistency of data in a series of edit programs.

3.6.3 OCR Scan Program

The program that scans the G-811 checks that entries have been made in items 3 and 4. Therefore the G-811 will reject if the scanner is unable to read the form or if either or both items 3 and 4 are blank.

3.6.4 G-811 Reformat Program

The scanned material is reformatted to change the data to the correct MIRTEL codes. The reformat program also checks that all entries are valid (numeric). Reject referrals from this program are self-explanatory. A new G-811 with correct entries must be prepared. The referral messages are listed in Exhibit 1.

3.6.5 Pre-Edit

All input is taken into the pre-edit program to check that data is valid (i.e., the codes are proper, the claim number and SSA numbers are established numbers, etc.); all mandatory fields are checked for entries (in addition to the general mandatory fields, each activity has its own set of required fields) and certain fields are checked against each other to assure that they are consistent. Activity that does not meet the edit criteria will be rejected. The messages on the reject referrals are self-explanatory. A corrected input must be prepared. The reject messages are listed in Exhibit 2.

In some cases certain data on the input may be questionable but does not prevent further processing. Alerts are produced in these cases. These alerts specify the questionable field(s). The field(s) should be verified. If the input was correct, no further action is necessary. If the input was erroneous, a correction must be prepared. These alert messages are listed in Exhibit 3.

3.6.6 Update Edits

Input can either establish or change an existing record. An activity designated to establish a record should not match an existing record and a change activity must match an existing record. The update program uses the following fields to match:

1. claim number (six or less digit number must also match on prefix)
2. pseudo number, if present
3. beneficiary symbol within certain tolerance, i.e., MA-WA, CA-WCA.

In addition, G-810 change activity (codes 20,21,22,32 and 34 and all G-811 activity except 62, 98 and 99 must match on year of birth or if the year of birth is changing, the name must match.

Mechanical input, RASI and attainments, must match on criteria 1 and 3 listed above and the beneficiary's first name.

An activity to establish a record (codes 12, 13,31 and 33) will reject if it matches an existing record. If an activity to establish a record makes a total match (same beneficiary) or partial match (same claim number symbol and pseudo number, if present) it will reject with the referral message "Activity To Establish Record Matched Existing MIRTEL." See Exhibit 2.

Mechanical input, RASI and attainments, although primarily designed to establish a record may match an existing record and act as a change activity. Therefore, this activity will not reject solely because it matches an existing record. It will, however, reject if it matches an existing record on claim number, prefix and symbol but not on name.

Once matched, all change activity is edited against the existing record to verify that the changes are acceptable for the activity and the record. For example, activity code 20 will reject if it is conveying an option change other than the changes that are acceptable for the activity and the record. For example, activity code 20 will reject if it is conveying an option change other than to or from SBI. Any option change option will reject if the record status is not changed to agree with the new option. The reject messages generated in the update are shown in Exhibit 2. Included in Exhibit 2 are referral messages generated in the update but not directly caused by an activity, i.e., a screening reply is still outstanding 30 days after the tracer request.

As in the pre-edit program, certain questionable change activity will process. However, an alert referral will be produced in these cases. These messages are shown in Exhibit 3.

Folder notices are produced as a record of action that has been taken. The messages for these notices are listed in Exhibit 5.

3.6.20 Rejects From The MBR

Screening records can reject because of conflicting information is SSA's MBR. The most common causes of these rejects are that the personal characteristics do not match, the SS benefit is terminated for a reason other than death or a SMI option of "P" prevents us from determining the paid through date. These rejects should be handled in accordance with current procedure.

3.6.21 Screening Replies

Screening replies from SSA are used to update MIRTEL. Generally, the most advantageous entitlement data from the reply or MIRTEL is retained in the updated record, i.e., a "yes" option is retained over a "no" option and the earliest HI-SMI effective dates. Occasionally the entitlement data from SSA conflicts with the data in MIRTEL and the reply cannot be processed mechanically. These cases will be referred out for manual handling and determination of correct entitlement information. These rejects will occur more frequently on rescreenings when jurisdiction cleared on the initial screening. Some reject messages are listed in Exhibit 3. These rejects are produced on regular yellow MIRTEL referral pages. Other rejects are produced on white computer paper and are listed in Appendix A. Determine the correct entitlement information and, if the record must be changed, prepare Form G-810 to correct the necessary data.

If the screening reply processes, a folder notice entitled "RRB Jurisdiction Reply Processed" will be produced as record of correct entitlement information.

3.6.30 Health Insurance Master (HIM)

All input to the HIM is edited in CMS's pre-edit and update programs. RRB input that is identified as an exception (reject) or an alert is returned to RRB. When this referral file is received at the Board, an 805 referral is produced.

Exceptions (rejects) occur when the error condition prevents processing of the transaction. When this occurs, a reject indicator is entered on the HIM Alerts are produced when the input has been accepted but contains a questionable condition which should be investigated. There is no indicator entered on the HIM when alerts are produced.

Three items are matched when input is sent to the HIM: sex, date of birth and name. An alert is produced when only two match. A reject is produced when one or non match. When all three match, the input is accepted.

3.6.31 Exception Format

All input to the HIM is edited in CMS's pre-edit and update programs. RRB input that is identified as an exception (reject) or an alert is returned to RRB. When this referral file is received at the Board, an 805 referral is produced.

Exceptions (rejects) occur when the error condition prevents processing of the transaction. When this occurs, a reject indicator is entered on the HIM. Alerts are produced when the input has been accepted but contains a questionable condition which should be investigated. There is no indicator entered on the HIM when alerts are produced.

Three items are matched when input is sent to the HIM: sex, date of birth and name. An alert is produced when only two match. A reject is produced when one or none match. When all three match, the input is accepted.

One of the following general captions and date the 805 is produced are printed at the top of the referral:

SSA-HIM Jurisdiction Reject

SSA-HIM Entitlement Transfer Reject

SSA-HIM Correction Reject

The next printed line contains the RRB claim number, date of birth, sex and name, followed by the date the activity was processed.

The last printed line contains the reason for the reject. See Appendix B for common exception codes and descriptions.

If "unable to determine the cause of the reject" is printed, check the exception code listing to determine why the referral was produced. See example 1 in Appendix C.

3.6.32 Resolving Exceptions

Prior to resolving any reject or alert condition, it will be necessary to first verify:

- The beneficiary's QRRB and Medicare status, and
- The Health Insurance Utilization Master and MIRTEL are consistent and contain the latest information.

In order for a correction to process, all three of the following must match: sex, date of birth and name.

In many cases the beneficiary is now deceased. However, a record correction is required. Some referrals are meaningless because corrective action had been taken or the condition was identified incorrectly. If one of the three matching criteria is being changed, an alert will always be produced but no action is necessary in these cases. See Appendix C for the types of conditions which result in these referrals.

3.6.40 Monthly MIRTEL

The MIRTEL monthly system validates the Medicare information on CHICO records any change in pay status or name and/or address, and adjusts the annuity to a start or stop SMI deductions or enters the SMI option if no adjustment is necessary. Any discrepancies between the two files are referred out for manual handling. The referral messages are explained in Exhibit 6.

Appendices

Appendix A - Master Benefit Record (MBR) Screening Rejects

Background

Screening records can reject because of conflicting information in SSA's MBR and what is being furnished by the RRB. The most common causes of these rejects are that the personal characteristics differ, the social security benefit is terminated for a reason other than death or a SMIB option "P" prevents determining a valid paid through date. Referrals are also printed when the MBR is coded with a SMIB option "P" and an "E" LAF code, or to acknowledge that jurisdiction has been transferred from SSA to RRB.

There should be a separate reply for each social security number screened. Each reply will show the reason for the reject or alert, or that no MBR is established for the social security number (NO RECORD OF BIC IN SSA FILE).

Referral Format

Each reject referral may have more than one reject cause identified. There will be one general caption printed on the top of the referral as well as the date the referral was printed. These captions will be:

- SSA HIM Jurisdiction Reject Referral
- Transfer of Jurisdiction - SSA to RRB
- SSA HIB Jurisdiction Alert Referral
- SSA HIB Jurisdiction Reject Referral

The next line of printing identifies the cause of the reject. A message will precede each screening record. Following are the various reject messages that will have to be investigated. Explanations and samples of each are included with this procedure.

REJECT MESSAGES - The grade level of the examiner who handles the reject is shown in () following the messages:

- 1) No Record of BIC in SSA File (GS-5 thru GS-8)

- 2) Transfer Manually - Paid thru date undetermined due to "P" option (GS-7)
- 3) SSA Benefit Term A/C Death (GS-7)
- 4) SSA Benefit Term BIC Alive (GS-7)
- 5) No SSA Match on Identity of Beneficiary's (GS-8)
- 6) Dual Survivors - Transfer Completed - Please Investigate (GS-8)
- 7) Program Reject - Replies Not Equal to Request (GS-5)
- 8) Jurisdiction Code Discrepancy (GS-8)
- 9) MBR Incompatible W/RRB Symbol - Prefix (GS-5)
- 10) Entitlement Under Another SSA Claim Number (GS-7)
- 11) SSA Record Has No HI Data (GS-7)
- 12) Duplicate SSA/RRB Transfers (GS-7)
- 13) Manual Transfer - Cessation of Disability (GS-8)
- 14) Dual Annuitant (GS-5)
- 15) SSA Refund for Uninsured BIC Indicated (GS-8)
- 16) SMIB paid thru Date Assumed Pending Investigation of SSA Premium Amt. (GS-7)
- 17) Manual Transfer Required. SSA Term Date After RRB SMI Date (GS-7)
- 18) RR Annuity in Suspense - Verify Address for ID Card (GS-5)
- 19) Check for Possible Arrearage - RRB ENT Date Prior to SSA ENT Date (GS-7)
- 20) Deemed QRRB From SSA Under 1974 Amendments (GS-5)
- 21) Unable to Process Activity - Screening Reply Outstanding (GS-8)
- 22) P-option Encountered in MBR Record (GS-7)
- 23) Investigate Delinquent SMI Premiums (GS-7)

The line following the reject message will contain the RRB claim number, the social security number being screened (if matched to a MBR, SSA's suffix will also be printed), the RRB date of birth and option, and the type of screening record (ENT = employee's

social security number, XREF = beneficiary's own social security number or the number of the wage earner whose earnings may entitle the beneficiary to SSA benefits).

The second line contains the RRB HI/SMI dates and the type of payment (annuity deduction, bill direct, etc.).

The third line identifies SSA's HI/SMI dates and option for the MBR record. The beneficiary's RRB name/address is printed to the right of the second and third lines. SSA's date of birth from MBR record is printed to the far right and between the third and fourth lines.

The fourth line identifies the RRB beneficiary (spouse, widow(er), etc.), record status and the jurisdiction code (RRB, NIF = no MBR established, SSA benefit terminated, etc.). If a MBR was matched and enrolled for SMI, SSA's SMIB rate will also be printed.

The last line of information will show SSA's effective date of suspension or termination, if applicable.

1) NO RECORD OF BIC IN SSA FILE

Reason - This message occurs when there is no MBR for the corresponding SSN. It is usually printed on the same page with another screening record that rejected for other reasons.

Action - None. The reject situation for the other screening reject should be resolved.

Disabled child's name is different on SSA's records: RAFAEL GALLEGOS
Submit a G-810(21) with all necessary information and show name and address. However, show her name as RAFAEL GALLEGOS. When clearance is received, correct MIRTEL with a G-810(22) and have the machine release a card if necessary.

Employee - screening record sent with spouse's SSN.

Release HMO teletype under SSN. If no record, force clearance with a G-811(32).

If necessary, take action to rescreen with a G-811(21) or G-810(21).

Dual annuitant receiving annuities under MA-123-45-6789 and A-999-99-9999.

Clearance was received under A-999-99-9999 but not under MA-123-45-6789.

Drop MA record with a G-811(05). Re-establish as HIB ONLY. A few days later, submit a G-811(34) under primary number and a G-811(25) under the MA or secondary number. Release a letter to beneficiary.

Spouse enrolled at SSA as uninsured BIC. Filed at RRB for annuity. She did not pay premium because of the annuity application filed at RRB and SMIB coverage terminated.

Call SSA PSC in reference to the premium status. Clear MIRTEL with G-810(32), using the most advantageous information.

Disability entitlement is questionable. Before any corrective action can be taken, the file should be sent to the disability program section to determine the freeze status. When the file is returned, either delete the MIRTEL using G-811(05) or, if necessary, clear the MIRTEL using G-811(32) if our information is correct or a G-810(32) if our information needs to be corrected. Then terminate Medicare coverage using current procedure if necessary.

If you have a pure SS case, file should be routed to the OSR instead of to the disability program section.

Spouse enrolled at SSA as uninsured BIC. Filed at RRB for annuity. She did not pay premiums because of the annuity application filed at RRB and SMIB coverage terminated.

Call SSA PSC in reference to the premium status. Clear MIRTEL with G-810(32), using the most advantageous information.

Disability entitlement is questionable. Before any corrective action can be taken, the file should be sent to the disability program section to determine the freeze status. When the file is returned, either delete the MIRTEL using G-811(05) or, if necessary, clear the MIRTEL using G-811(32) if our information is correct or a G-810(32) if our information needs to be corrected. Then, terminate Medicare coverage using current procedure if necessary.

If you have a pure SS case, file should be routed to the OSR instead of to the disability program section.

Female employee initially receiving SS survivor benefits under her husband's SSN (999-99-9999D4). She remarried, the D4 benefit was terminated, and payment history transferred to the new SSN. In this situation, RRB is paying the SS benefit and clearance was previously received under the D4 number. Therefore, the MIRTEL should be cleared with G-811(32).

2) TRANSFER MANUALLY - PAID THRU DATE UNDETERMINED DUE TO "P" OPTION

Reason - This message occurs when "P" options were previously put on the MBR. Screening action will not mechanically clear. SSA's HIB and SMIB dates are shown; however, a paid through date cannot be computed.

Action - Call the SSA-PSC for a paid through date and any other clarifying data. The MIRTEL should then be cleared using the most advantageous information.

If it is necessary to correct the HIB and/or SMIB date or to enter a paid through date, use a G-810(32) to clear MIRTEL. If the information on MIRTEL is correct and it is not necessary to enter a paid through date, use a G-811(32) to clear MIRTEL. Depending on the information provided by SSA and the information in RRB's file, there may be a refund or an arrearage due. Also if an option letter was released, in addition to clearing MIRTEL, a corrected card and letter of explanation should be released.

Sometimes this referral is reduced when an examiner submits a G-811(21). He/she think clearance was not received and submits another G-811(21). In these cases it may not be necessary to call the SSA-PSC if you can find the referral or the necessary information on the MMAC is dated after the first G-811(21) was submitted. MIRTEL can then be cleared using this information. When this type of referral is produced, MIRTEL has to be cleared, whether we are screening initially or rescreening. If MIRTEL is not cleared, any input will reject because a screening reply is outstanding.

This referral was produced because SSA's entitlement dates are more advantageous.

Call SSA-PSC to verify entitlement and to obtain a paid through date. Clear MIRTEL with a G-810(32). An arrearage is very probable.

This referral was produced because there may be a duplication in collection of SMIB premiums. If there was, a referral may be due. There is no change in entitlement dates.

Clear MIRTEL using a G-811(32). Call SSA-PSC to obtain a paid through date.

3) SSA BENEFIT TERM A/C DEATH

Reason - This message occurs when the MBR under the SSN indicates that the SSA beneficiary is deceased.

Action - Verify the DOD of the beneficiary. Then take one of the following actions:

- 1) If the DOD is prior to the effect date, drop MIRTEL with a G-811(05). Refer to Example 9.
- 2) If SSA was paying SS benefits and SSA's HIB and SMIB dates are more advantageous, drop the MIRTEL record with a G-811(05). Refer to Example 10.

- 3) If RRB is certified to pay SS benefits and a good HIM should be established, take one of the following actions:
- If the MIRTEL record is established for HIB only and there is no election for SMIB, clear MIRTEL with a G-811(32), and then submit G-811(50). If the HIB date is not correct, use a G-810(32), then submit the G-811(50).
 - If the MIRTEL record is established for HIB only and there is an indication that SMIB was elected, clear MIRTEL as Part A only. If the HIB date is correct use a G-811(32). If the HIB date should be corrected, use a G-810(32). Then submit a G-811(50).
 - If the MIRTEL record is established for HIB and SMIB, drop the MIRTEL record using a G-811(05), re-establish using a G-810(31) as Part A only, then submit a G-811(50).
- 4) If an examiner was trying to establish a HIM based on a phone call or correspondence, a G-811(32) should be used to clear MIRTEL, then a G-811(50). If a premium arrearage exists, refer to RCM 3.7.42.

The DOD has been determined to be 1/81. Drop MIRTEL using a G-811(05).

SSA was paying benefits. SSA's entitlement dates are more advantageous.

Drop MIRTEL with a G-811(05). Assume that SSA collected premiums and a HIM record was properly established.

4) SSA BENEFIT TERM - BIC ALIVE

This message occurs when the MBR for the SSN has terminated for a reason other than death.

Reason - 1 A spouse or disabled child was enrolled on employee's SSN before his death.

Action - 1 Check the file for a SSA-1233R. This form should have some information concerning Medicare. Verify death of RR employee. This should be the same as the SSA DATE OF SUSP/TERM. If so, this would be the SMIB paid through date. SSA's HIB and SMIB dates are on the referral. Clear MIRTEL with a G-810(32) using the most advantageous information. If there is conflicting information, a call to SSA - PSC should be made before clearing MIRTEL. Refer to examples 11 and 12.

Reason - 2 An individual was enrolled as an uninsured beneficiary at SSA. Coverage terminated because he/she filed at RRB.

Action - 2 Call appropriate SSA-PSC for uninsured beneficiaries for correct information regarding their Medicare. Then, clear MIRTEL with a G-810(32) using the most advantageous information.

Reason - 3 Previous entitlement at SSA based on disability. Beneficiary is now recovered and the MBR has been coded accordingly. Beneficiary is now eligible for Medicare at RRB.

Action - 3 In most cases, RRB's dates will be correct and MIRTEL should be cleared with a G-811(32). However, if there is a discrepancy for an employee, disabled child, or widow (RR CASE), file should be routed to the disability section to determine disability status before clearing MIRTEL. If there is a discrepancy in a pure SS case, file should be routed to the OSR.

Reason - 4 Previous entitlement at SSA on another SSN. Beneficiary now files at SSA on another wage earner. The first entitlement is terminated because the information has been transferred to the second number.

Action - 4 Check RRB file for information regarding entitlement at SSA. If you are unable to determine the SSN, release a teletype under the SSN which was terminated; there should be a cross reference number. It may be necessary to rescreen using a G-811(21). If an individual's Medicare terminated because she filed at SSA under the RRB employee's SSN and RRB is certified to pay the SS benefits, a call to SSA PSC should be made to verify the HIB and SMIB dates and paid through date before clearing the MIRTEL with a G-810(32).

Regardless of the reason that prevents the mechanical screening record from not clearing, you will have to clear MIRTEL, most likely with a G-810(32), using the most advantageous information. In some cases, a letter of explanation should be released to the beneficiary. There may be an arrearage or a refund due.

If it is necessary to put "P" options on the MBR, file should be routed to the appropriate GS-9 examiner, who in turn will call SSA.

Before the employee died, disabled child was enrolled at SSA under employee's SSN. When he died, the MBR was terminated.

All the information on the referral appears to be correct. Clear MIRTEL with a G-810(32), showing HIB 2-74, SMIB 2-74, and paid - through date of 7-76.

Before the employee died, spouse was enrolled at SSA under employee's SSN. When he died, the MBR was terminated.

There is a discrepancy: DOB is 1902. HIB DATE is 12-69, SMIB DATE is 6-78, and the SMIB rate is 9.60. A call to SSA PSC should be made. When reply is received from SSA PSC, MIRTEL should be cleared with a G-810(32) with the correct information.

5) NO SSA MATCH ON IDENTITY OF BENEFICIARY

Reason - This reject occurs when the personal characteristics from the screening request do not match the personal characteristics on SSA's MBR or as a result of the following:

- 1) RRB error
- 2) Prior wife
- 3) Employee screened against spouse's SSN
- 4) Dual annuitants - beneficiary receiving annuities as an employee and as a spouse/widow(er)
- 5) An employee and spouse born the same month and year; one screening record clears and the other one does not.

Action - Verify the SSN. If the SSN is not correct, drop MIRTEL with a G-811(05) and, a few days later, submit a G-810(12) with correct SSN.

If the SSN is correct, release a HMQ teletype. When replies are received:

- 1) If no record exists, clear MIRTEL with a G-811(32).
- 2) If the personal characteristics do not match, rescreen using a G-810(321). Correct the NAME, DOB or SEX, whichever one is preventing the screening request from clearing. Also, code the G-810 so that a card is not released. When clearance is received, correct MIRTEL with a G-810(22). If the given name or initial needs correcting, prepare a HCFA-1664 and have a card released.

If there is a second wife involved, drop MIRTEL, assign a pseudo number, and re-screen.

In the case of dual annuitants, drop the pending MIRTEL record with a G-811(05). Reestablish with a G-810(13) as HIB ONLY. Then a few days later, submit a G-811(34) under primary number and a G-811(25) under a secondary number. A short letter should be sent to the beneficiary. Also prepare G-607 for secondary number to enter SMIB option code 9 on CHICO.

6) DUAL SURVIVORS - TRANSFER COMPLETED - PLEASE INVESTIGATE

Reason - This message occurs when a screening record with a survivor prefix (WA or WCD) matches a survivor MBR (BIC D or C) which would indicate that both RRB and SSA are paying survivor benefits.

Action - Transfer has been completed. A HMQ teletype should be released to investigate the possibility of dual payment of survivor benefits.

If RRB is the only agency paying the survivor benefits, no further action is necessary.

If RRB is paying a survivor benefit and there is an indication on the MBR that SSA is also paying a survivor benefit, the file should be routed to the MOD. The MOD will determine which agency should pay survivor benefits. If it is determined that SSA should pay the survivor benefits, it may be necessary to transfer Medicare to SSA. That requires an RR-80 to remove "P" options from the MBR, G-811(52) and a letter to beneficiary. The MOD will determine the overpayment in these cases.

In most cases, this type of reject is produced when there is a disabled child, employee is still living and RRB is certified to pay the disabled child's SS benefits (LAF Code E). To avoid this type of reject, when screening is necessary, the prefix should be CA, type bene 16, and record status 02.

Refer to R.C.M. 7.4 Appendix C for a breakdown of LAF codes on the MBR. Refer to examples 13, 14 and 15.

RR employee living. RRB is certified to pay SS benefits for disabled child. Release a HMQ teletype. If the LAF CODE reveals that SSA is also paying a survivor benefit, file should be routed to the MOD.

RR employee is deceased. RRB has jurisdiction of survivor benefits. Release a HMQ teletype. If there is a termination in the LAF CODE on the MBR, no action is necessary/

In this situation, MIRTEL needs a record correction (G-810 Code 22) because of the name.

RR employee is deceased. RRB has jurisdiction of survivor benefits. Release a HMQ teletype. If there is a termination in the LAF CODE on the MBR, no action is necessary.

If the LAF CODE reveals that SSA is still paying benefits, the file should be routed to the MOD.

This file should be referred to MOD because the LAF CODE on the MBR is a "C".

Screening record sent with two SSN's, 123-45-6789 and 999-99-9999. We only received a reply under 123-45-6789. Rescreen using a G-811(21). Enter 999-99-9999 in item 9.

8) JURISDICTION CODE DISCREPANCY

Reason - This message also occurs when the MBR for the SSN has terminated for reasons other than death.

Action - Clearance will to be processed mechanically. MIRTEL has to be cleared with a G-811(32) if the information on the MIRTEL is correct or a G-810(32) if the information on MIRTEL needs to be corrected. The reason why the MER terminated is not as clear as with the SSA Benefit Term - BIC Alive reject. A call should be made to the SSA PSC if you are unable to determine why the reject was produced before clearing the record. Refer to Examples 17, 18, and 19.

Information in file disclosed that individual was previously entitled to Medicare based on disability. He recovered and subsequently a new period of disability was established and entitlement dates determined accordingly. The information in file was consistent and the information on MIRTEL was correct. Therefore, MIRTEL can be cleared with a G-811(32).

It was determined that the beneficiary filed at SSA and SSA paid benefits. However, SSA subsequently determined that payments were erroneous and terminated the MBR.

In this situation, MIRTEL should be cleared with a G-810(32), HIB effective 4-80. SMIB would be an option because, based on his filing at SSA, he could have had 4-80 and we have not yet cleared our MIRTEL. Option letter and related material should be released.

No information was conveyed from SSA. A call to the SSA PSC is necessary. Clear MIRTEL with the most advantageous information.

9) MBR INCOMPATIBLE W/RRB SYMBOL - PREFIX

This reject occurs when RRB screens with a prefix that is not compatible with the BIC that is on SSA's MBR.

Reason - 1. RRB is certified to pay SS benefits to a divorced wife. Screening record was sent as a WCA and SSA's BIC is a B6 or B9.

Action - 1. Drop WCA record with G-811(05), assign a pseudo number, and resubmit a G-810(12).

Reason - 2. Screening record was sent as a MA. Before clearance was received, the employee died and spouse is now WA. No change was made to the MIRTEL record.

Action - 2. Drop MA record with G-811(05) and submit G-810(12) as WA if RRB has jurisdiction of survivor payments. If SSA has jurisdiction of survivor payments, drop MIRF with a G-811(05) and release a HMQ teletype. If "options" are on the MBR, an RR-80 should be prepared.

This reject also results when we are paying an employee a SS B2 benefit as a WCA. The WCA record should be dropped with a G-811(05) and if the employee's Medicare has not been established under the A claim number, a G-810(12) should be submitted. A SMIB SSA option code of 9 should be entered for the WCA CHICO record using a G-607. Refer to Example 22.

Divorced wife's SS benefits were certified to RRB for payment.

Drop WCA record with a G-811(05). Assign a pseudo number and screen with G-810(12). If not processed timely, it may be necessary to offer an option.

Screening record processed as MA but the employee is now deceased. Record should be WA.

Drop MA record with G-811(05). submit G-810(12) as WA. If not handled timely, it may be necessary to offer an option.

Beneficiary is receiving an RR annuity as well as SSA benefits under his own SSN. He is also entitled to a SSA BI benefit which RRB is paying under RR claim number WCA-999-99-9999. Drop WCA record with a G-811(05). If Medicare has not been established as A, submit a G-810(12).

Prepare G-607 for SCA SSN to enter SMIB option code 9.

10) ENTITLEMENT UNDER ANOTHER SSA CLAIM NUMBER

Reason - This reject occurs when a beneficiary was previously entitled to SS benefits under one SSN. However, that benefit was terminated because of entitlement to SS benefits under another SSN.

Action - Check file for another SSN. If you cannot determine the other number, release a HMO teletype under the terminated SSN. The reply should show a cross reference number. Release a second HMO teletype under the cross reference SSN. Upon reply, either force clearance or rescreen. In some cases it may be necessary to call the SSA PSC.

11) SSA RECORD HAS NO HI DATA

Reason - This reject occurs when the MBR for the corresponding SSN has no HI information. However, there is an indication of SS entitlement under another SSN.

Action - Check the file for the other SSN. If you cannot obtain from information in file, a HMO teletype should be released under the SSN printed on the referral to see if there is a cross reference SSN. A second HMO teletype should then be released under the cross reference SSN. Depending on the second reply, either rescreen with a G-811(21), clear MIRTEL with a G-811(32), or, if MIRTEL has to be corrected, use a G-810(32).

In this situation, the beneficiary has been enrolled at RRB since 7066. Initial screening was made under his own SSN. His wife has now died and he filed for benefits under her SSN. RRB is paying the SS benefit.

After reviewing the file, it was established that RRB's HIB and SMIB are more advantageous, and that we previously screened under employee's SSN. Therefore, MIRTEL was cleared with a G-811(32).

12) DUPLICATE SSA/RRB TRANSFERS

Reason - This message occurs when there is a possibility that SSA transferred jurisdiction to RRB under two different SSN's.

Action - Release HMO teletypes under all SSN's involved. When replies are received either rescreen or force clearance. It may be necessary to call the SSA-PSC for Medicare information and notify SSA that they have a dual annuitant.

In this situation, it was determined that spouse had two SSA claim numbers 123-45-6789A and 999-99-9999B2. HMO teletypes were released and MIRTEL cleared accordingly.

13) MANUAL TRANSFER - CESSATION OF DISABILITY

Reason - This message occurs when a beneficiary was previously enrolled for Medicare at SSA based on disability. However, the MBR has been terminated for cessation of disability. RRB is now enrolling the beneficiary for Medicare.

Action - Reconcile effective dates and clear the MIRTEL with a G-810(32) or a G-811(32). Usually, RRB is trying to establish entitlement based on age.

In this situation, it was determined that MIRTEL can be cleared with a G-811(32) because RRB's HIB and SMIB dates are correct based on age. His previous entitlement based on disability was terminated correctly at SSA.

14) DUAL ANNUITANT

Reason - This message occurs when we receive two clearances for one SSN, and the RRB claim numbers are different. Refer to Examples 26 and 27.

Action - Instructions for consolidating the dual annuitant's records should be followed. See RCM 3.5.50.

Primary Number

Prepare G-811(34) and a letter to beneficiary.

Secondary Number

Prepare G-811(25) and, if necessary, an annuity adjustment

15) SSA REFUND FOR UNINSURED BIC INDICATED

Reason - This condition occurs when a screening record matches an MBR that is established for an uninsured SSA annuitant who is paying HIB and/or SMIB premiums directly.

Action - Transfer has been completed. Verify QRRB status. Compare RRB's HIB date to SSA's HIB date. Check the paid through date. If you determine that a refund of HIB premiums is due, file should be routed to the GS-11 supervisory claims specialist. If no refund is due, no other action is necessary.

Spouse paid HIB premiums to SSA for the period 7-1-78 thru 2-28-81. Spouse attained QRRB status 9-1-79. Therefore, a refund of HIB premiums is due for the period 9-1-79 thru 2-28-81. File should be routed to the GS-11 supervisory claims specialist who will make the necessary arrangements with CMS for refunding HIB premiums.

16) SMIB PAID THRU DATE ASSUMED PENDING INVESTIGATION OF SSA PREMIUM AMT.

Reason - There is a difference in SSA's and RRB's SMIB election and/or SMIB effective dates.

Action - Call SSA-PSC regarding SMIB premiums and election. Correct MIRTEL with a G-810(22), if necessary. If record has not cleared, use a G-810(32) to correct MIRTEL. There may be a refund due or an arrearage. Refer to Examples 29 and 30.

The paid through date on the referral is SSA's operating month when transfer action was taken. It must be verified.

RRB enrolling beneficiary based on age; previously enrolled at SSA based on disability. However, SSA's SMIB coverage was terminated. MIRTEL should be cleared with G-810(32); use SSA's HIB date, RRB's SMIB date. Option should be first enrollment with basic premium rate.

This situation resulted from rescreening. RRB and SSA's HIB and SMIB dates differ. SSA's PSC was called to verify the paid through date and a refund was prepared through the Medicare Payment System (MPS).

RRB's HIB and SMIB dates are more advantageous and premiums were being paid timely. In some situations the paid through date can be advanced instead of the MPS refund.

17) MANUAL TRANSFER REQUIRED -SSA TERM DATE AFTER RRB SMI DATE

Reason - This reject occurs when SSA's SMIB option is a termination or a withdrawal and RRB's SMIB option is a "YES."

Action - Verify enrollment and clear MIRTEL with the most advantageous information. If a correction is necessary, use a G-810(32). If MIRTEL contains correct information, use a G-811(32). In addition, a refund of SMIB premiums may be due. Call SSA PSC for the correct paid through date.

In this particular case, we screened using HIB and SMIB dates based on SSA's enrollment. There was no indication in our file that SMIB coverage was desired. Therefore, MIRTEL was cleared with a G-810(32), showing first termination, termination dates of 12-79, and a paid through date of 12-79.

18) RR ANNUITY IN SUSPENSE - VERIFY ADDRESS FOR ID CARD

Reason - The reject occurs whenever a screening record is sent to SSA and the beneficiary's monthly benefit is in suspense status.

Action - Determine QRRB status. If beneficiary is a QRRB and the address on the MIRTEL record is the current address, no further action is necessary. If the address on MIRTEL is incorrect or not shown, submit a G-810(22) to correct the address and to release a new identification card.

If the beneficiary is not a QRRB, Medicare should be transferred to SSA which is a G-811(52), RR-80 and letter to beneficiary should be completed.

Review disclosed that beneficiary is a QRRB and the address on MIRTEL is correct. Therefore, no further action was necessary.

19) CHECK FOR POSSIBLE ARREARAGE -RRB ENT DATE PRIOR TO SSA ENT DATE

Reason - This message occurs when RRB's SMIB date is prior to SSA's SMIB date, RRB has a refusal for SMIB, or RRB has a termination for SMIB coverage.

Action - Verify enrollment. Clearance was processed, however, it may be necessary to update or correct the MIRTEL with a G-810(22). In some cases a refund may be due or an arrearage may exist. It may be necessary to call the SSA-PSC for premium information.

In some cases you may have to reverse the termination with a G-811(26), then correct MIRTEL with a G-810(22).

In this case, a disabled child was enrolled at RRB with HIB 7-73, SMIB 7-73. However, the SMIB terminated 12-74. Child was enrolled at SSA with HIB 7-73 and SMIB 11-78. MIRTEL should be corrected to show second enrollment for SMIB.

20) DEEMED QRRB FROM SSA UNDER 1974 AMENDMENTS

Reason - This message occurs when a screening record matches a MBR with an "E" LAF code and "P" option SSA's HIB and SMIB dates are shown on the referral; however, RRB's HIB and SMIB dates are used to establish Medicare records.

Action - At one time this type of referral was informational. However, since we are not paying more SS benefits, a thorough check of the file should be made to determine the most advantageous dates for the beneficiary. The HIB effective date should always be corrected because, usually, there are no premiums involved. Depending on the circumstances, it may also be necessary to correct the SMIB effective date. Refer to RCM 3.2.90 for more specific instructions. The screening process has been completed and MIRTEL cleared. If MIRTEL should be corrected, use a G-810(22).

In some cases, it may also be necessary to call the SSA-PSC because of entitlement on another SSN. In addition, SSA may have deducted for a few months on the SSN on which we received clearance. You can determine this by checking the SSA award forms, the entitlement dates to benefits, when RRB started paying the benefits, and the G-90's. If a call is necessary, route file to a GS-7 examiner. This referral also identifies DOB discrepancies. If the DOB discrepancy has been resolved, correct MIRTEL accordingly. If not, forward file to the MOD.

If the beneficiary has lost QRRB status, it may be necessary to correct the MIRTEL record with a G-810(22) before submitting your G-811(52), RR-80 and letter to beneficiary.

DOB is the same at SSA and RRB. HIB and SMIB entitlement dates are the same. No further action necessary.

RRB's HIB and SMIB dates are more advantageous. Date of birth agrees. No further action necessary.

MIRTEL record is correct. However, if necessary, a G-607 should be submitted to correct the SS DOB on CHICO.

Medicare has been established based on RRB's DOB of 7-25-16. SSA's DOB is 7-25-14. Check the file. If DOB discrepancy has not been resolved, refer file to the MOD.

When correct DOB has been determined, if MIRTEL record needs correction, use a G-810(22). Correct according to RCM 3.2.46. If DOB on CHICO needs correcting use a G-607, according to RCM 9.4.

SSA's and RRB's HIB dates are the same. However, the MBR indicates an election for SMIB. Check the file. If there is no refusal, A G-811(25) should be

submitted to enter SMIB election on MIRTEL. If not processed timely, an option letter may be required and a G-810(22) prepared to enter SMIB election on MIRTEL.

SSA's HIB and SMIB dates are more advantageous than RRB's. If file review indicates that SMIB coverage is desired, the earlier HIB date and SMIB data can be put on MIRTEL with a G-810(22) and a new identification card should be released. If not processed timely, an option letter may also be required.

If SMIB coverage is not desired, correct HIB date with G-810(22) and release a new identification card.

RRB's and SSA's HIB dates are the same. However, SSA's SMIB effective date is more advantageous. Take one of the following actions:

- 1) If premium deductions have been initiated based on the earlier SMIB date and premium rate, correct MIRTEL SMIB date with a G-810(22) and release a new identification card.
- 2) If premium deductions have been initiated based on the later SMIB date and the premium rate is not correct adjust the annuity, refund excess premiums and correct the MIRTEL SMIB rate with a G-810(20).
- 3) If premium deductions have not been initiated, MIRTEL should be corrected with a G-810(22) to reflect earlier SMIB data and a new identification card released. In some situations, an option letter may be required.

This case concerns entitlement based on disability. SSA's dates are earlier because SSA has a earlier annuity beginning date.

Always correct HIB date. If deductions have started, do not change our SMIB date. If deductions did not start, correct the SMIB data and release a new identification card using G-810(22).

Sometimes, SSA's entitlement is based on CRD. This can be determined by checking the file thoroughly. If it is a CRD enrollment, release a teletype (HMO). If reply verifies that entitlement is established based on CRD, a G-810 should be submitted to correct the MIRTEL and there would be a premium arrearage. It may be necessary to call SSA for further verification.

21) UNABLE TO PROCESS ACTIVITY - SCREENING REPLY OUTSTANDING

This referral is produced when an activity matches a MIRTEL that has a screening reply outstanding. The activity will not process.

Check file and determine if there is a MER reject in file that was not processed. If there is no MER reject, release HMO teletypes and clear MIRTEL record accordingly, or rescreen if necessary.

22) P-OPTIONS ENCOUNTERED IN MBR RECORD

Reason - This message occurs when a previously established P-option is in MBR.

Action - Call PSC to verify paid through date. Then, prepare G-810(32) to correct MIRTEL and HIM.

After the paid through date is known, correct MIRTEL and HIM.

23) INVESTIGATE DELINQUENT SMI PREMIUMS

Reason - This message occurs when there is a SMI arrearage from SSA.

Action - Verify arrearage by calling PSC and handle according to RCM 3.2.

After the arrearage is verified, follow procedure for equitable relief.

Appendix B - Common HIM Exception Codes And Descriptions

Exception Code	Description
CK	Part B third party code.
ED	Date of birth.
EF	Part A entitlement date is not consistent with other fields in the transaction.
EG	Part B option is invalid or is not consistent with other fields in the transaction.
EH	Part B entitlement date.
EI	Part B entitlement date is not consistent with other fields in the transaction.
EK	First Part B termination date is not consistent with other fields in the transaction.
EU	Cross-reference claim number.

EV	Cross-reference BIC.
FB	Date of death.
FZ	Address line (address should start in the first position of the address line.)
HB	Part A entitlement date (disability case).
HN	Part A termination date is not consistent with other fields in the transaction.
L1	The transaction contains an adverse Part A entitlement date without a corresponding change in the date of birth or date of entitlement to disability. The adverse Part A entitlement date has not been applied.
L9	A transaction containing a Part B option of T or W is attempting to terminate a recently entitled master record. The termination date in the transaction is not greater than the month of Part B entitlement contained in the HI master plus one month.

- RRB record matched on BIC to HI master skeleton record (reject)
- RRB record matched on BIC unmatched on personal characteristics filming and investigation at SSA (alert).

Appendix C - HIM Exception Conditions

(Examples at end of Appendix)

- Type RRB record matched on BIC to HI master skeleton record

Condition A screening record is entered and a record under that number was previously established.

Action Drop existing record G-811(05). Assign a pseudo number in the appropriate manner G-810(31/33) GRADE 5

Condition Date of death was entered. Master record has not been deactivated. The beneficiary is alive (Refer to example 2).

Action Reactivate HIM (HCFA-1365). Allow 6 to 8 weeks to elapse. Enter a universal RIC to complete the correction. GRADE 8

2. Type RRB record conveying adverse Part A date (not applied. Refer to example 5).
 - Condition A HIB date has been established on HIM. A later date is on MIRTEL.
 - Action Determine the correct date. If HIM is incorrect, correct (HCFA-1364). If MIRTEL is incorrect, correct G-810(22). GRADE 7

3. Type Part A date inconsistent with other data.
 - Condition Date is missing or correct on MIRTEL. A date has been established on HIM.
 - Action Determine the correct entitlement date. If HIM is correct, correct MIRTEL G-810(22). If information on HIM is incorrect, correct (HCFA-1364). Allow at least 6 weeks to elapse and correct MIRTEL. GRADE 7.

4. Type Part A date for beneficiary is invalid.
 - Condition Sex code is missing or beneficiary code is incorrect.
 - Action Verify beneficiary status. If sex code is missing, correct with G-811(22). If beneficiary and sex codes are incorrect, use G-810(22). GRADE 5.

5. Type First Part A termination date is not consistent.
 - Condition Termination date is prior to the entitlement date on HIM.
 - Action Verify the correct entitlement and termination dates. Correct HIM (HCFA-1364). Follow this action with an appropriate universal RIC. GRADE 8.

6. Type RRB record matched on BIC, unmatched on personal characteristics.
 - Condition Sex code is incorrect or absent. Name on MIRTEL and HIM are different.
 - Action If the sex code is missing on MIRTEL but shown correctly on HIM, correct MIRTEL with a universal RIC G-811(22). (Refer to example 3). GRADE 5.

If sex code is correct on MIRTEL, but incorrect on HIM, correct with a HCFA-1664.

If sex code is incorrect on both records, correct each record.
GRADE 7.

If the sex code is correct but name differs on HIM and MIRTEL, determine correct name and correct with either G-810(22) or HCFA-1664.

- | | | |
|-----|-----------|---|
| 7. | Type | <u>RRB record conveying an adverse Part B date (applied). Refer to Example 4.</u> |
| | Condition | An earlier date is on the HIM. Correction record contains a later date. |
| | Action | Verify entitlement. If HIM is correct, change MIRTEL to agree G-810(20/22). If MIRTEL is correct, change HIM (HCFA-1363). Follow with universal RIC. |
| 8. | Type | <u>Part B entitlement date.</u> |
| | Condition | Part B date missing from MIRTEL. |
| | Action | Verify HIM. If coverage has terminated, check entitlement and termination dates. Make corrections (HCFA-1364). After the correction has processed, complete a universal RIC. GRADE 7. |
| 9. | Type | <u>RRB record attempting to terminate recently entitled master.</u>
(Term date not greater than Part B date plus 1 month) |
| | Condition | Self-explanatory. |
| | Action | Reverse erroneous termination G-811(26). Write an explanatory letter to beneficiary. GRADE 8. |
| 10. | Type | <u>Part B third party code.</u> |
| | Condition | There is a discrepancy between MIRTEL and the trailer code on the HIM. |
| | Action | Determine correct information. Make necessary correction on a universal RIC. GRADE 5. |

EXAMPLE 1 - Employee died April 4, 1979. Universal RIC changed his name erroneously. Correct HIM (HCFA-1664). Remove reject indicator G-810(22).

08/07/81

SSA-HIM CORRECTION REJECT

PREFIX	CLAIM NR	DOB	SEX	NAME
A	999999	09-06-15	UNK	J W DOE

SSA PROCESS DATE - 07-21-81

UNABLE TO DETERMINE CAUSE OF REJECT - (FB

AFBB00038296110AMS BW8 12028120296&151

EXAMPLE 2 - D.O.D. entered erroneously. Re-activate record (HCFA-1365). Follow up Universal RIC G-811(22).

10/12/82

SSA-HIM CORRECTION REJECT

PREFIX	CLAIM NR	DOB	SEX	NAME
A	999999	08-06-85	MALE	J M DOE

SSA PROCESS DATE - 09-28-81

RRB Record Matched On BIC To HI Master Skeleton Record

EXAMPLE 3 - Sex code missing. Correct with Universal RIC G-811(22)

09/08/81

SSA-HIM Correction Reject

PREFIX	CLAIM NR	DOB	SEX	NAME
WA	999999	09-08-90	UNK	J R DOE

SSA PROCESS DATE - 08-19-81

RRB RECORD MATCHED ON BIC, UNMATCHED ON PERSONAL CHARACTERISTICS - FILMING AND INVESTIGATION AT SSA

EXAMPLE 4 -10/19/81

SSA-HIM JURISDICTION REJECT

PREFIX	CLAIM NR	DOB	SEX	NAME
CA	999-99-9999	07-22-48	MALE	J DOE
WA	999999	09-08-90	UNK	J R DOE

SSA PROCESS DATE - 10-15-81

RRB RECORD CONVEYING AN ADVERSE PART B DATE (APPLIED)

EXAMPLE 5

10/19/81

SSA-HIM CORRECTION REJECT

PREFIX	CLAIM NR	DOB	SEX	NAME
WD	999-99-9999	01-21-15	FEMALE	J E DOE

SSA PROCESS DATE - 10-09-81

RRB RECORD CONVEYING ADVERSE PART A DATE (NOT APPLIED)

Exhibits**Exhibit 1 - G-811 Reformatting Rejects**

BOX 1 - ALL PREFIX INDICATOR BOXES ARE BLANK

ACTION: Determine and code correct prefix of claim number and resubmit G-811.

BOX 1 - MORE THAN ONE PREFIX INDICATOR HAS BEEN MARKED

BOX 1 - MORE THAN ONE SYMBOL INDICATOR HAS BEEN MARKED

BOX 1 - WRONG COMBINATION OF SYMBOL INDICATORS HAS BEEN MARKED

BOX 2 - CLAIM NUMBER CONTAINS INVALID DATA

BOX 3 - ACTIVITY CODE CONTAINS INVALID DATA

BOX 4 - TYPE BENEFICIARY CONTAINS INVALID DATA

BOX 5 - DATE OF BIRTH CONTAINS INVALID DATA

BOX 6 - SEX CODE CONTAINS INVALID DATA

BOX 7 - PSEUDO NUMBER CONTAINS INVALID DATA

ACTION: Determine correct entry for the box indicated on reject and submit another G-811.

BOX 8 - EVENT CODE CONTAINS INVALID DATA

BOX 8 - DATE CONTAINS INVALID DATA

ACTION: Determine correct event code or event date. Activity code, event code, and event date must be consistent. Submit another G-811.

BOX 9 - FORMER SSA OR RRB NO. CONTAINS INVALID DATA

ACTION: Verify that the former number is correct as well as the converted SSA claims suffix or numeric BIC for the RRB symbol and prefix. Submit another G-811 with corrected former RRB or SSA number.

BOX 10 - UNIT DESIGNATION CONTAINS INVALID DATA

ACTION: Correct and submit another G-811.

Exhibit 2 - Daily MIRTEL Referrals

ACTIVITY INVALID AGAINST DUAL ANNUITANTS-1225

CAUSE: This occurs when an activity is prepared for a record with a SMI option 9, dual annuitant.

ACTION: If the SMI option 9 is valid, the activity is unnecessary. If this record is becoming the primary record, prepare a Form G-811 activity code 05 to drop the record and a G-810 activity code 33 to establish the record and send a RIC to cross refer and transfer utilization from the former RRB number.

ACTIVITY INVALID FOR INACTIVE MIRTEL-1222

CAUSE: This will occur when an activity is processed for a record with record status 98, Inactive - No Longer QRRB. It can also occur with record status 90 or 99 if the activity does not reflect the termination.

ACTION: If the beneficiary has regained QRRB status or the death termination was erroneous and MIRTEL shows record status 90 or 99, correct the record with a G-810 activity code 22.

If the beneficiary has regained QRRB status and MIRTEL shows the record status 98, prepare a G-811 activity code 05 to drop the record, and

establish record with a G-810 activity code 13 if MBR shows a "P" option (G-811 activity code 22 is needed if there is a change in the surname.) or

establish record and screen with a G-810 activity code 12 if MBR shows "E" "Y" option.

NOTE: Beneficiary's terminated record must be removed from CHICO.

ACTIVITY MATCH CROSS REFERENCE RECORD-1304

CAUSE: An activity other than an ID request or inquiry matched a pseudo number cross-reference record.

ACTION: Prepare new input showing the RRB claim number in item 1 of Form G-810 or item 2 of Form G-811, also show the pseudo number in the appropriate area.

ACTIVITY MATCHED MIRTEL CODED FOR DROP-1309

CAUSE: Most activity is dropped immediately when activity 06 is processed, however, if the address is not in the MIRTEL record the record cannot be dropped until the address is received from CHICO. Any activity processed during this interim period will reject.

ACTION: If the action is valid it should be reentered.

ACTIVITY/MIRTEL - SSA NUMBERS NOT EQUAL-1207

CAUSE: This occurs when a mechanical activity matches MIRTEL but the SSA numbers are not the same.

ACTION: If the MIRTEL record is correct, mark the referral NAN.

If the SSA number on the MIRTEL record is incorrect, drop the record with a G-811 activity code 05 and reestablish the record with a G-810 activity code 13 (use activity code 12 if screening is required).

ACTIVITY TO ESTABLISH RECORD MATCHED EXISTING MIRTEL-1301, 1003

CAUSE: This reject occurs when the activity matched an existing record. This can be a complete match or partial match i.e., same symbol and pseudo number, if present.

ACTION: If the activity matched a record for a different beneficiary, and if the claim symbol is correct for both beneficiaries, establish a pseudo.

If the activity matched a record for the same beneficiary, check the entitlement data. If this data is the same, mark the referral NAN and file it down. If the entitlement data is different, determine which is correct. If the existing record is correct, mark the referral

NAN and file it down. IF the data on the activity is incorrect, prepare Form G-810 activity code 22 to correct the erroneous data.

ADDRESS DOES NOT MATCH RESIDENCY TABLE-1507

CAUSE: The SMI rate table indicator of S, P, or C does not agree with the address shown.

ACTION: If the sex code is missing, prepare Form G-810 activity 22, including the sex code and appropriate ID issue code.

If the address is required, prepare Form G-810 activity code 22 including the address and the appropriate ID issue code.

ADDRESS UNAVAILABLE - MIRTEL DROPPED - NO RIC SENT-1310

CAUSE: Activity code 06 was processed for a record without an address and the address was unavailable from CHICO.

ACTION: If it is necessary to send a RIC to delete the record, prepare Form G-810 activity 13 then five days later reenter the 06 activity.

ATTAINMENT MATCHED EXISTING MIRTEL - PROCESS MANUALLY-1237

CAUSE: This occurs when an attainment activity to establish a record and screen matched an existing record. This can be a complete match or partial match.

ACTION: If the activity matched a record for a different beneficiary, a G-810 activity code 12 should be submitted. If the claim symbol is correct for both beneficiaries, assign a pseudo number.

If the activity matched a record for the same beneficiary, check the entitlement data on both the existing record and the activity. If the data is the same, mark the referral NAN and file it down. If the data is different, determine which is correct. If the existing record is correct, mark the referral NAN and file it down. If the data on the activity is correct, submit either a G-810 activity code 22 or G-811 activity code 25.

NOTE: When a disabled beneficiary attains age 65, he/she has another opportunity to enroll in AML at the regular non penalty premium rate.

If a variable rate was established in January and the enrollment based on age 65 is in the same year; the variable rate still applies.

ATTAINMENT TOO OLD TO PROCESS-1056

CAUSE: SMI effective date is 6 or more months before the processing date of G-810.

ACTION: MPS examiner should prepare G-810 to enroll individual according to instructions in RCM 3.2.89A.

CATASTROPHIC EFFECTIVE DATE BEFORE SMI EFFECTIVE DATE-1509

CAUSE: catastrophic effective date must be equal to or later than SMI effective date.

ACTION: Determine correct SMI effective date and/or catastrophic effective date and submit corrected G-810.]

CATASTROPHIC EFFECTIVE DATE LESS THAN MASTER DATE-ACTIVITY 17 REJECTED-1517

CAUSE: The COL update established a variable rate, mechanical activity code 17 matched MIRTEL showing prior manual activity 17 with conflicting information.

ACTION: Verify catastrophic data and submit a G-810, if MIRTEL is incorrect.

CATASTROPHIC EFFECTIVE DATE LESS THAN HI EFFECTIVE DATE-MASTER NOT UPDATED-1551

CAUSE: The catastrophic effective date is prior to HI effective date.

ACTION: Verify information and submit corrected G-810, if necessary.]

CHANGE ACTIVITY NOT MATCHED TO MIRTEL-1300

CAUSE: A change activity did not match an existing record on claim number, pseudo number, if present, beneficiary symbol, year of birth or if the year of birth is changed, the name.

ACTION: Check the matching fields on the MIRTEL and activity. If the activity is incorrect, prepare a corrected input. If there is no MIRTEL determine if the activity is valid. If it is, establish a MIRTEL record.

COL VARIABLE-MIRTEL DOES NOT HAVE DEDUCTION STATUS-1515

CAUSE: The COL update established a variable rate. Mechanical activity code 17 matched MIRTEL showing no deductions.

ACTION: Verify SMI entitlement. If SMI deductions are proper, correct MIRTEL. If not, stop deductions. If beneficiary is no longer a QRRB or is deceased, prepare a G-96 and send the case to the MOD.

COL VARIABLE-MIRTEL SMI OPTION OTHER THAN 1 OR 5-1514

CAUSE: The COL update established a variable rate and mechanical activity code 17 matched a MIRTEL record with a SMI option other than 1 or 5.

ACTION: Verify SMI enrollment. If SMI enrollment is valid, correct MIRTEL. If MIRTEL is correct, deductions should be stopped. Check for possible refund.

COL VARIABLE-NO MATCHING MIRTEL RECORD-1513

CAUSE: The COL update established a variable rate and mechanical activity 17 did not match a MIRTEL record.

ACTION: Verify Medicare coverage and identifying data. If valid, establish a MIRTEL record or correct matching data. If invalid, deductions should be stopped.

COL VARIABLE-VERIFY SMI EFFECTIVE DATE-1516

CAUSE: The COL update established a variable rate, mechanical activity code 17 showed deductions prior to SMI effective date on MIRTEL.

ACTION: Verify effective date. If MIRTEL is correct, deductions should stop if still prior to effective date. Refund premiums. If deductions are proper, correct MIRTEL.

CROSS REFERENCE RECORD MATCHED EXISTING ENTITLEMENT RECORD-1302

CAUSE: The mechanical activity to establish the pseudo number cross-reference record matched an entitlement record.

ACTION: Determine which record is correct, the pseudo number or the entitlement. Take appropriate action to drop the erroneous record.

DOM APPLIES TO AUTOMATIC ENROLLMENT-1053

EE'S AGE OR D/F AFFECTS SPOUSE ENROLLMENT-1055

CAUSE: The RASI system is furnishing the MIRTEL system data that can not be verified mechanically.

ACTION: Determine spouse's Medicare eligibility and initiate necessary enrollment action (possible pseudo number).

ENROLLMENT DATA MISSING OR INVALID FOR THIS MIRTEL-1227

CAUSE: This occurs when activity 22 has a 5 SMI option with SMI effective dates prior to the SMI termination date.

ACTION: Determine the correct entitlement data. If MIRTEL must be corrected, prepare Form G-810 activity code 22 with the correct information.

IMPROPER USE OF RESERVED AREA-1041

CAUSE: Entry made in G-811 item 11.

ACTION: Determine if coding in item 11 is applicable to another entry. Submit new G-811.

INCONSISTENT DATA ON MECHANICAL INPUT-1042

CAUSE: RASI or SS application processed. Entitlement data, identifying information, SSA number, etc. are inconsistent.

ACTION: Determine the QRRB or deemed QRRB who is or will be eligible for Medicare and initiate necessary enrollment action.

IDENTIFYING DATA INCONSISTENT-1040

CAUSE: Beneficiary symbol, type of beneficiary code and DOB entries are inconsistent.

ACTION: Determine what you were trying to do and for whom. Resubmit activity with corrected entries.

INVALID OR INCORRECT ACTIVITY CODE-100

CAUSE: Activity code shown on form G-811 or G-810 is not a valid code.

ACTION: Enter correct activity code and resubmit G-810 or G-811.

INVALID OR INCORRECT ANN. BEGINNING DATE-1035

CAUSE: ABD must be consistent with record status. If coded, must be equal to or less than processing date plus 3 months.

ACTION: Verify record status code, correct date and resubmit G-810.

INVALID OR INCORRECT BEN SSA NUMBER-1016

CAUSE: Must be a valid 9 digit SSA number. If the activity is for an employee and this item is coded, it must be as the employee's SSA's number. If beneficiary has no SSA number, item should be blank.

ACTION: Determine correct number and resubmit G-810.

INVALID OR INCORRECT BEN SYMBOL-1004

CAUSE: Symbol unequal to M, W, WC, C, J, P, T, TC, K, KC, X or inconsistent with prefix.

ACTION: Determine correct symbol and resubmit G-810.

INVALID OR INCORRECT CATASTROPHIC DATA EFFECTIVE DATE-1505

CAUSE: The catastrophic data effective date is either prior to 12088 or contains a month unequal to 01-12, or a year unequal to 88 or later.

ACTION: Determine the correct catastrophic effective date and submit corrected G-810.

INVALID OR INCORRECT CHANGE INDICATOR-1501

CAUSE: The catastrophic data code change indicator (Item 9, 1st position) on G-810 is other than X.

ACTION: Submit correct G-810.]

INVALID OR INCORRECT CITY NAME-1046

CAUSE: A G-810 was prepared with a name and address. However, the system detected erroneous information or was unable to develop information from coded data.

ACTION: Verify address and submit corrected G-810.

INVALID OR INCORRECT CLAIM NUMBER-1003

CAUSE: Prefix A, six digit claim number is greater than 991273; prefix D, six digit claim number is greater than 415935; prefix H, claim number greater than 049159. The system will only accept a pseudo number in the claim number entry for G-811 activity codes 62, 98, or 99.

ACTION: Determine correct claim number and resubmit activity.

INVALID OR INCORRECT DATE OF BIRTH-1006

CAUSE: Month must be 01-12, day 00-31, year 00-99.

ACTION: Determine correct DOB and resubmit G-811.

INVALID OR INCORRECT DATE OF DEATH-1031

CAUSE: Should only be coded with activity code 13 or 22. DOD must be equal to or greater than SMI effective date, if coded. If no SMI effective date shown, must be greater than 6/66 for aged beneficiary or greater than 6/73 for disabled beneficiary.

ACTION: Verify activity code and if entry is applicable, resubmit corrected G-810.

INVALID OR INCORRECT DELINQUENCY DATE-1028

CAUSE: Entry is only allowed for record status codes 22-24. If record status is 22, the date should be greater than or equal to:

SMI effective date plus 2 months, or

the paid through date plus 3 months, or

the processing date plus 4 months.

If record status is 23 or 24, month should always be **April**. If no paid through date entered, the year should be the following year. If a paid through date is shown and is prior to December of the current year, enter the following year. If paid through date is December of the current year, enter current year plus 2.

ACTION: Determine correct date and resubmit G-810.

INVALID OR INCORRECT DIS FREEZE DATE-1036

CAUSE: DF date cannot be coded if Medicare entitlement was based on age. If coded, must be less than or equal to the processing date less 23 months.

ACTION: Verify the type of beneficiary. Enter correct date if required. Resubmit G-810.

INVALID OR INCORRECT EE SSA NUMBER-1017

CAUSE: This item must always be completed. If unknown, enter nines. Must be a valid 9 digit SSA number. Should be the same as the 9 digit RRB claim number.

ACTION: Determine correct number and resubmit G-810.

INVALID OR INCORRECT ENTRY MADE-1506

CAUSE: G-810, Item 9, last box, not blank.

ACTION: Submit corrected G-810.

INVALID OR INCORRECT EVENT CODE-1009

CAUSE: Unequal to 1-8 or not shown with activity codes 23-25, 27, 50 and 51.

ACTION: Determine correct event code and resubmit G-811.

INVALID OR INCORRECT EVENT DATE-1010

CAUSE: Event code entered without event date, month no 01-12, or year not 66-current.

ACTION: Determine current date based on event code, and resubmit G-811.

INVALID OR INCORRECT EXCESS PREMIUM-1026

CAUSE: Cannot be entered with activity codes 12 or 21. Cannot be greater than SMI premium rate. When removing excess (xxxx), option cannot be 2, 3, or 8.

ACTION: Determine correct amount, resubmit G-810.

INVALID OR INCORRECT FOREIGN COUNTRY NAME-1045

CAUSE: G-810 was prepared with a name and address. However, the system detected erroneous information or was unable to develop information from the coded data.

ACTION: Verify address and resubmit corrected G-810.

INVALID OR INCORRECT FORMER NUMBER-1011

CAUSE: If activity 34 or 35, must be valid 6 or 9 digit RRB claim number or a valid pseudo number. If activity is 30, 32 or 36, must be a valid 9 digit SSA number.

ACTION: Determine correct former number and resubmit G-811.

INVALID OR INCORRECT GEO CODE-1050

CAUSE: Geographic code is a mechanically produced code which refers to the region of the beneficiary's address. G-810 was prepared with a name and address. However, the system detected erroneous information or was unable to develop information from the coded data.

ACTION: Verify address and resubmit corrected G-810.

INVALID OR INCORRECT HI DATE OF BIRTH-1015

CAUSE: Month 01-12, day 01-31, year 00-99. Mandatory item.

ACTION: Enter correct DOB and resubmit G-810.

INVALID OR INCORRECT HIB EFF DATE-1029

CAUSE: Has to be consistent with identifying information. If age beneficiary, should be 7/66 or later and agree with age 65 and/or filing date. If a disabled beneficiary, must be 20 or older and date 7/73 or later.

ACTION: Determine correct date, resubmit G-810.

INVALID OR INCORRECT HIB TERM DATE-1030

CAUSE: Must be consistent with record status. Should be equal or greater than SMI effective date plus one month and less than processing date plus six months.

ACTION: Determine if entry is required and correct date. Resubmit G-810.

INVALID OR INCORRECT ID ISSUE CODE-1032

CAUSE: Must be coded 1-5 when a required entry. If the activity code is 20 and the SMI option is 8, the ID issue code must be coded 2 or 5. If the ID issue code is coded 1, the processing date must be 2 or more months before the SMI effective date and the SMI option must be code 1.

ACTION: Determine correct code and resubmit G-810.

INVALID OR INCORRECT NAME AND ADDRESS-1048

CAUSE: G-810 was prepared with a name and address. However, the system detected erroneous information or was unable to develop information from the coded data.

ACTION: Verify address and resubmit corrected G-810.

INVALID OR INCORRECT PAID THRU DATE-1025

CAUSE: Must be consistent with activity code, record status and SMI option. Has to be greater than 6/66 for age cases or 6/73 for DIB cases. Must be equal or greater than SMI effective date.

ACTION: Determine correct date, if applicable, resubmit G-810.

INVALID OR INCORRECT PAYEE CODE-1033

CAUSE: Should only be coded when beneficiary is in current pay or suspense status (RR or SS)> Do not enter payee code for IPI spouse.

ACTION: Determine status of and code correct payee code, if applicable.

INVALID OR INCORRECT PREFIX-1002

CAUSE: Prefix was omitted or not A, D or H.

ACTION: Determine correct prefix and resubmit activity.

INVALID OR INCORRECT PSEUDO NUMBER-1008

CAUSE: When coded, must be 995001 - 997999, of if a SSA No., must be the same as beneficiary's own number. Cannot be coded for an employee or JA.

ACTION: Determine pseudo no. and resubmit activity.

INVALID OR INCORRECT RECORD STATUS-1020

CAUSE: Required entry and should be consistent with activity code.

ACTION: Determine correct code and resubmit G-810.

INVALID OR INCORRECT REP PAYEE CODE-1034

CAUSE: Should only be coded when a name and address is shown. Acceptable codes are 1-3.

ACTION: Determine if entry is required and enter code that is consistent with name and address.

INVALID OR INCORRECT RRB DATE OF BIRTH-1014

CAUSE: Month 01-12, day 01-31, year 00-99. Mandatory item.

ACTION: Enter correct DOB and resubmit G-810.

INVALID OR INCORRECT SBI ACC DATE-1037

INVALID OR INCORRECT SBI DEL DATE-1038

CAUSE: SBI accretion date must be shown if activity code is coded 12, 13, 31 or 33 and SMI option coded 8. Accretion/deletion dates can both be coded if SMI option is 1 or 5, will be rejected if option coded 4 or 6.

ACTION: Verify option and if applicable, enter correct accretion and/or deletion date. Resubmit G-810.

INVALID OR INCORRECT SEX CODE-1007

CAUSE: Mandatory entry M or F, 1 or 2, blank only accepted on inquiries.

ACTION: Determine correct sex code and resubmit G-810 or G-811.

INVALID OR INCORRECT SMI EFF DATE-1023

CAUSE: If entitlement is based on age, must be 7/66 or later. Will be verified when possible, with DOB and filing date.

If entitlement is based on disability, must be 7/73 or later. Will be verified when possible, with freeze date and ABD.

Can never be later than current date plus 6 months. Must be consistent with SMI option.

ACTION: Determine correct date and resubmit G-810.

INVALID OR INCORRECT SMI OPTION-1022

CAUSE: Must be consistent with record status.

ACTION: Determine correct SMI option code, resubmit G-810.

INVALID OR INCORRECT SMI OPTION-1511

CAUSE: Entry in catastrophic data, G-810 Item 9, indicates SMI coverage, but SMI options code unequal to 1, 4, 5, 6, or 8.

ACTION: Verify SMI option and catastrophic data and submit corrected G-810.]

INVALID OR INCORRECT SMI OPTION FILING DATE-1021

CAUSE: Must be a valid IEP or GEP date.

REASON: Verify SMI option and catastrophic data and submit corrected G-810.]

INVALID OR INCORRECT SMI PENALTY PERCENTAGE INDICATOR-1504

CAUSE: Penalty percentage indicator unequal to 000, 010, 020 through 220.

ACTION: Determine correct penalty percentage indicator and submit corrected G-810.

INVALID OR INCORRECT SMI PREMIUM RATE-1024

CAUSE: G-810 activity code other than 17 submitted.

For state buy-in cases, must be the current basic rate from the applicable SMI table.

For options 1 or 5, if establishing a SMI premium rate, must be one of the three SMI table rates and must agree with the enrollee's residence, otherwise, must be a table rate and be consistent with the catastrophic data on the MIRTEL master.

For options 4 or 6, must be a table rate and must be the SMI premium rate that was in effect when SMI terminated.

ACTION: Enter correct rate and resubmit G-810. Items 12, 13, and 14 must be completed. If the SMI rate is variable, use activity code 17.

INVALID OR INCORRECT SMI RATE TABLE INDICATOR-1502

CAUSE: Rate table indicator unequal to S, P, or C.

ACTION: Determine the correct entry and submit corrected G-810.0

INVALID OR INCORRECT SMI TERM DATE-1027

CAUSE: Must be consistent with record status and option. If consistent, must be greater than SMI effective date and equal to or less than processing date plus 6 months.

ACTION: Determine correct date, resubmit G-810.

INVALID OR INCORRECT SMI VARIABLE RATE INDICATOR-1503

CAUSE: Variable rate indicator unequal to N or V.

ACTION: Determine the correct entry and submit corrected G-810]

INVALID OR INCORRECT SSA CLAIM NUMBER-1018

CAUSE: When coded, must be a valid 9 digit SSA No. If SSA suffix is "A" and activity is for an employee, it must be the same as employee's SSA number (item 8). If SSA suffix is "A" and activity is not for an employee, must be the same as beneficiary's SSA number (item 7).

ACTION: Determine correct number and resubmit G-810.

INVALID OR INCORRECT SSA SUFFIX/SYMBOL-1019

CAUSE: If the activity code indicates SSA - RRB transfer (30-32 OR 35) must be a valid SSA suffix. If activity code indicates RRB - RRB transfer 33-35), must be a valid RRB symbol.

ACTION: Determine correct Suffix/Symbol, resubmit G-810

INVALID OR INCORRECT STATE ABBREVIATION-1044

INVALID OR INCORRECT STATE FOR APO - FPO-1051

CAUSE: A G-810 was prepared with a name and address. However, the system detected erroneous information or was unable to develop information from the coded data.

ACTION: Verify state abbreviation by checking RCM 8.1 Appendix B. Verify address for APO-FPO. Correct address and resubmit G-810.

INVALID OR INCORRECT SUFFIX SYMBOL-1012

CAUSE: If activity code is 30, 32, 36 - must be 01-26. If activity code is 34 or 35 - must be 10-11, 13-17, 43, 45-46, 80, 83-86.

ACTION: Refer to conversion chart on G-811. Enter correct **numeric** code and resubmit activity.

INVALID OR INCORRECT 3RD PARTY CODE-1039

CAUSE: Can only be coded if record status coded 22. Must be acceptable 3rd Party Code 01, 51-58, 60-62, 69-70, 98-99.

ACTION: Verify record status, enter correct record status and 3rd Party Code, if applicable. Resubmit G-810.

INVALID OR INCORRECT TYPE BENEFICIARY-1005

CAUSE: Type beneficiary cannot be blank. Entry must be an acceptable code and must be consistent with the beneficiary symbol.

ACTION: Determine correct type beneficiary code and resubmit activity.]

INVALID OR INCORRECT UNIT DESIGNATION-1013

CAUSE: Missing, zero, or unequal to acceptable numeric or alpha/numeric unit designation.

ACTION: Correct unit designation and resubmit G-810 or G-811.

INVALID OR INCORRECT ZIP CODE-1049

CAUSE: System detected erroneous information.

ACTION: Verify address and resubmit corrected G-810.

MIRTEL HAS NO ADDRESS - ACTIVITY MUST SUPPLY-1220

CAUSE: This occurs if the activity has a record status of no annuity application filed (12,22) and MIRTEL has either to be adjusted or deductions in force. (21 or 31).

ACTION: Prepare G-810 including the name and address.

MIRTEL SHOWS CHICO IN FORCE WITH DED-ACTIVITY HAS NO PAID THRU DATE-1229

CAUSE: This occurs when the activity is changing the record status from 31 to 21, 22, 23, or 24.

ACTION: Prepare G-810 showing the paid thru date.

MIRTEL SHOWS CHICO IN FORCE WITH DED-ACTIVITY INVALID-1234

CAUSE: This occurs when activity code 20 is used to enter a SMI termination date in the past.

ACTION: Prepare G-810 activity code 22 to take this action.

NAME AND ADDRESS NOT COMPLETED-1512

CAUSE: Activity code 17 requires that the name and address be entered.

ACTION: Resubmit G-810 with the name and address.]

NAME AND DOB IN ACTIVITY AND MIRTEL NOT EQUAL-1233

CAUSE: This occurs when both a name and date of birth change are conveyed on the same activity. It may also occur if an activity matched the wrong MIRTEL record.

ACTION: Prepare a G-810 to change the name. A few days later, prepare a second Form G-810 to change the date of birth. If the activity matched an incorrect record, determine whether or not a pseudo number is required.

NO ADDRESS IN MIRTEL OR ACTIVITY, UNABLE TO OBTAIN FROM CHICO-1306

CAUSE: This will occur if CHICO is unable to furnish an address.

ACTION: Prepare G-810 including the name and address.

NO REPLY TO SCREENING TRACER-1312

CAUSE: The system generates this 30 days after the tracer if no reply is received.

ACTION: Query SSA's MBR using G-780b and handle in accordance with current instructions.

NO VALID SSA NUMBERS PRESENT-1054

CAUSE: Employee and beneficiary SSA number are blank, activity requires that at least one should be coded.

ACTION: Determine employee and/or beneficiary's number and resubmit G-810.

PAID THRU DATE AFTER SMI TERM-POSSIBLE REFUND DUE-1313

CAUSE: The system generates this when premiums have been paid after the SMI termination date.

ACTION: If a refund is due, refund the excess premiums through the Medicare Payment System (MPS).

PAYEE CODE REQUIRED FOR CHICO ADDRESS INQUIRY-1326

CAUSE: This will occur if the activity does not contain a payee code and there is no payee code in the MIRTEL record.

ACTION: Prepare a G-810 to take the desired action, include the payee code.

RPD ON ACTIVITY AND MIRTEL NOT EQUAL-SUBMIT G-810 ACTIVITY CODE 17-1518

CAUSE: SMI premium rate on activity does not match rate on MIRTEL and catastrophic data indicators not provided.

ACTION: Verify rate, if catastrophic data applies, submit G-810 activity code 17.]

REP PAYEE DATA INCONSISTENT-1052

CAUSE: A G-810 was prepared with a name and address which indicates a REP PAYEE is involved (contains "FOR" "AND FOR") and REP PAYEE CODE is not 1-3, or REP PAYEE is coded and no REP PAYEE in NAME/ADDRESS.

ACTION: Verify REP/PAYEE and resubmit G-810 with corrected code or NAME/ADDRESS.

SBI ACTIVITY CONVEYING DEATH-MIRTEL NOT UPDATED-1231

CAUSE: This occurs when a mechanical SBI activity indicates death.

ACTION: Determine whether or not the beneficiary is dead. If he is not, request a corrected SBI card from SSA. If he is dead, take appropriate action to terminate the record, if it has not been terminated.

SBI ACTIVITY CONVEYING DEATH-MIRTEL NOT UPDATED-1224

CAUSE: This occurs when a G-810 activity is attempting to change the SMI option to or from SBI (8) without the accretion or deletion date.

ACTION: Prepare a corrected G-810 including the accretion or deletion date.

SEX CODE ON ACTIVITY AND MIRTEL NOT EQUAL-1235

CAUSE: This occurs when the sex code on G-810 activity code 20 does not match the sex code on MIRTEL.

ACTION: If the sex code on MIRTEL is correct, prepare a corrected G-810. If the sex code is incorrect on MIRTEL, prepare a G-810 activity code 22 to take the desired action and change the sex code.

SMI EFFECTIVE DATE IN ACTIVITY AND MIRTEL NOT EQUAL-1210

CAUSE: This occurs when the SMI effective date in a mechanical activity is earlier than the effective date in MIRTEL.

ACTION: Determine the correct effective date and prepare G-810 activity 22 to correct the date if necessary.

SMI OPTION INVALID FOR THIS MIRTEL-1221

CAUSE: This occurs when activity 20 conveys a SMI option (other than state buy-in) which is different than the option on MIRTEL. It will also occur if activity 22 conveys an option change without a corresponding change in record status, or conveys an illogical option change, i.e., MIRTEL has an 8 option and the activity has a 2 option.

ACTION: If a logical option change is required, prepare G-810 activity 22 to change the option and record status. If the option on MIRTEL is wrong and the change cannot be made with activity code 22, drop the record and reestablish it correctly.

SMI PREMIUM RATE NOT CONSISTENT WITH INDICATORS-1510

CAUSE: The SMI rate is not consistent with either the residency, variable or penalty percentage indicator. For example, indicators show standard table, non-variable, zero penalty percent and the SMI rate is less than the standard table rate.

ACTION: Verify SMI rate and indicators and submit corrected G-810]

SMI TERM DATA INVALID FOR THIS MIRTEL-1226

CAUSE: This occurs when an activity attempts to enter a SMI termination for a MIRTEL having a SMI option other than 1 or 5. It will occur if the termination data is incomplete, i.e., option 4 or 6 and no term date. Activity 20 will reject if it conveys a current or past termination or a change in termination date.

ACTION: Determine the proper enrollment information. If MIRTEL is incorrect, prepare a Form G-810 activity 22 to correct the record.

TOB INVALID FOR THIS MIRTEL-1223

CAUSE: This occurs when an activity with a type beneficiary, disabled now age 65, (2) matches a MIRTEL with a record status 90, Cessation of Disability.

ACTION: If a previously disabled beneficiary becomes reentitled based on attainment of age 65, the type beneficiary should be 0_, (age 65).

UNABLE TO CHANGE ENTITLEMENT DATES OR DOB WITH THIS ACTIVITY-1228

CAUSE: This occurs when activity 20 contains either entitlement dates or a date of birth which is different from the MIRTEL record.

ACTION: If the dates need to be changed, prepare Form G-810 activity code 22 to correct the record. If the dates on the activity were incorrect, prepare Form G-810 activity code 20 with the correct dates.

UNABLE TO ISOLATE NAME-1043

CAUSE: Pre-edit program has a very comprehensive routine for isolating the QRRB's Name. However, if the group mark (1) does not precede the first line of address or the name contains NON-ALPHABETIC characters, this reject will occur.

ACTION: Verify NAME/ADDRESS, resubmit G-810.

UNABLE TO PROCESS ACTIVITY-SCREENING REPLY OUTSTANDING-1308

CAUSE: All activity, except activity 05, 21, 32 and 34 will try to process for ten days before it rejects. This referral will be generated on the tenth day if the screening reply still has not been received.

ACTION: Query SSA's MBR had handle in accordance with current instructions.

UNABLE TO PROCESS ACTIVITY WITH THIS MIRTEL-1205, 1232

CAUSE: This occurs when the activity cannot be processed and none of the reasons listed above applies.

ACTION: MPS examiners give referral to supervisors; MOD examiners refer case to M&P-A.

ZIP CODE IS MISSING-1047

CAUSE: G-810 was prepared with a name and address but no zip code.

ACTION: Enter zip code and resubmit G-810.

Exhibit 3 - MIRTEL Daily Referral - Alert

ALERT – ANN ADJUSTED – ARREARAGE DUE -2226

CAUSE: This occurs when a beneficiary has Part B coverage and premiums have not been paid, either by deductions, direct bill, or by the state.

ACTION: Follow the steps outlined below to process an arrearage.

1. Check the date of the MEDREF referral. The arrearage period should be around that time. Use MOLI to determine what months the beneficiary had entitlement to Part B and to determine the correct premium rate. The MOLI CP screen will have detailed information about the premium rate, including information on IRMAA, Part B Reduction, variable rate and penalty rate.
2. Use PREH screen 3277 to determine what months premiums were deducted from the recurring RR or SS payments. The PYMT-BEG-DT field indicates the month the RRB paid out the benefit check. The SMI-PREM-AMT (NOTE: This amount could include Part C and/or D premiums. Check the MOLI CP screen for the Part B amount) field indicates how much was taken for the monthly premium. If there are entries in the TERM-SUSP-CAUSE-CODE field, the check for that month was not released, and therefore premiums were not deducted from the RR benefit for that month. If there is an entry in the SS-BENF-TERM-SUSP-CAUS-CD field, the SS benefit was not released for that month. Note any Medicare vouchers that appear in field RR-VCHR-NO. (TAX screen PF 21 will show recurring deductions from an RR benefit, but not always from an SSA benefit.) NOTE: See RCM 16.2 for further instructions on reading PREH screens.

3. Use PREH screen 3275 to determine which months had premiums deducted from non-recurring payments. The voucher number appears in the VCHR-NO-1 field and the VCHR-DT field has the date of the voucher. Premiums deducted from vouchers or refunded from vouchers appear in the SMI-ACCRU-OP-AMT field on page 3 of the voucher. Deducted amounts will have a minus sign before the amount. Refunded premiums will not have a minus sign. Only premium refunds created in MAMMA (example 003 voucher) appear here. (NOTE: This amount could include Part C and/or D premiums. Check the CH or DH screens.) Premium deductions from an RBD/SBD manual voucher could appear here as well as the multiple month deduction vouchers (example 004 voucher) that are created in MAMMA.

Example 1: PREH screen 3275 indicates an 004 voucher took place on July 1, 2009. Page 3 of the voucher indicates \$192.80 was deducted. The \$192.80 is two months of premiums at \$96.40 per month for the months of June 2009 and July 2009. The premium deduction for multiple month premium deduction vouchers goes through the month of the voucher.

Example 2: PREH screen 3275 indicates an 003 voucher took place on June 22, 2009. Page 3 indicates \$289.20 was refunded. The \$289.20 is three months of premiums at \$96.40 per month for the months of April 2009 through June 2009. The refund of premiums goes through the month of the voucher.

(TAX screen PF 23 will show non-recurring deductions from RR benefits, but not always from SS benefits. Deductions from non-recurring payments can also be seen on the imaged ROC, SURPASS or SOLAR award.)

4. Check the MOLI (DB) screen (FOM 1 1540.15.3) to determine what months, if any, were paid by direct bill.

5. Check BERT (TP) screen for the months premiums were paid by the state (RCM 19.4.15). MOLI (SB) screen (FOM 1 1540.15.4) has state-buy-in information as well, but BERT (TP) is the official record.

6. Use the PHUS (RCM 19.2.15 e) to determine what months SSA deducted premiums. The BERT (DB) screen, PF 6, will give you the amount paid by direct bill at SSA (RCM 19.4.15).

Check the imaging system for refunds issued through the Medicare Payment System (MPS).

8. Are there any months of coverage that did not have deductions made? Are there any months collected at a lower premium rate?

If yes, an arrearage is due. Write up the months and the premium amounts due on the G-363M. Be sure to use the correct premium rate. NOTE:

Beware of erroneous refunds that typically happen when a SBI refund voucher gives back too much money.

9. If six or more consecutive months of premiums are owed, check Palmetto's records for utilization and BERT for HMO coverage. If the beneficiary did not use Part B nor was in an HMO for the arrearage period, the beneficiary has the option to cancel Part B for those months and have Part B effective with the month we resumed deducting premiums (RCM 3.2.105).
10. If the beneficiary is deceased, we can collect the debt from a survivor who is in pay status at the RRB and who lived with the deceased beneficiary at the time the debt was incurred. If no such survivor exists, send an email to the field to develop for an estate. If there is no estate, send the debt directly to uncollectible.
11. Use PAR to set up the arrearage record and to release the letter with the appropriate payment options (RCM 3.7.51).
12. Set up an ASTRO record per RCM 16.5 to start the collection process if there is an RR annuity in current pay status that is large enough to collect the debt in 36 months and there is no SS benefit, or the SS benefit is also too small to collect the debt in 36 months.
 - Do not use ASTRO if we are collecting from an SS benefit. Send the folder to dorm for 30 days to see which repayment option is chosen. Send RBD or SBD a G-812 on a G-26a to start full or partial withholding. When the worksheet is returned, set up a RECR table (RCM 3.12.18).
13. Send the case to authorization.

ALERT - BENEFICIARY DECEASED - ARREARAGE DUE-2228

CAUSE: This occurs when the paid through date is prior to the date of death.

ACTION: If premiums are due, handle in accordance with RCM 3.7.

ALERT - CATASTROPHIC DATA DEVELOPED - INVALID RPD - ASSUME VARIABLE-2696

ALERT - CATASTROPHIC DATA DEVELOPED - RPD ASSUMED VARIABLE - VERIFY-2694

ALERT - CATASTROPHIC DATA DEVELOPED - RPD NONVARIABLE - VERIFY-2695

CAUSE: MIRTEL validation of the recurring premium deduction (RPD) found an RPD other than standard table, nonvariable rate with catastrophic data. MIRTEL developed the catastrophic data.

ACTION: Verify RPD and other information. If MIRTEL is correct, check for refund or arrearage. If MIRTEL is incorrect, prepare a G-810 to correct MIRTEL and check for refund or arrearage.

ALERT - CATASTROPHIC EFFECTIVE DATE EARLIER THAN PREVIOUS - ADJUST DATES-2605

CAUSE: MIRTEL validation of the catastrophic data found that the current catastrophic data effective date is earlier than the previous catastrophic data effective date on the MIRTEL master.

ACTION: Send to M&P-A for referral to RCA.]

ALERT - CATASTROPHIC HISTORY OUT OF SEQUENCE - ADJUST MANUALLY-2606

CAUSE: The validation process developed catastrophic data and the new catastrophic data effective date is prior to the one currently on the MIRTEL master.

ACTION: Send to M&P-A for referral to RCA.

ALERT - CESSATION OF DIB - ARREARAGE DUE-2227

CAUSE: This occurs when the paid through date is prior to the termination date due to cessation of disability.

ACTION: If premiums are due, handle in accordance with RCM 3.7.

ALERT - CHECK EFFECTIVE DATES WITH DATE OF MARRIAGE-2114

CAUSE: RASI system is furnishing MIRTEL system data that cannot be verified mechanically.

ACTION: MIRTEL will use the dates furnished by the RASI system. However, these dates must be verified and corrected if erroneous. In some cases, a pseudo number is required.

ALERT - CHECK PAID THRU INFO - POSSIBLE REFUND DUE - MIRTEL NOT UPDATED-2810

CAUSE: MIRTEL record indicates possible dual payment of SMI premiums.

ACTION: MIRTEL will use the dates furnished by the RASI system. However, these dates must be verified and corrected if erroneous. In some cases, a pseudo number is required.

ALERT - CHECK ZIP CODE - UNABLE TO VERIFY IN ZIP MASTER-2113

CAUSE: System accepted ZIP code but it was unverified.

ACTION: Determine correct address for QRRB and correct address, if necessary.

ALERT - COL VARIABLE - MIRTEL'S PERCENT RETAINED POSSIBLE REFUND OR ARREARAGE-2518

CAUSE: The COL update established a variable rate. The CHICO and MIRTEL penalty percentages were not equal. The variable rate was established based on MIRTEL's penalty percentage.

ACTION: Verify rate. If the rate is correct, check for refund or arrearage. If the rate is incorrect, prepare a G-810 activity code 17 to correct MIRTEL and check for refund or arrearage.

ALERT - COL VARIABLE - POSSIBLE REFUND OR ARREARAGE-2519

CAUSE: The COL update established a theoretical variable rate for an enrollee in billing status.

ACTION: Verify rate. If necessary, adjust the paid through date on MIRTEL with a G-810 or collect the arrearage.

ALERT - COL VARIABLE RESIDENCY CHANGED - VERIFY SMI RATE-2517

CAUSE: The COL update established a variable rate. The CHICO and MIRTEL rate tables are not equal. The variable rate was established based on CHICO's rate table.

ACTION: Verify SMI rate. If it is correct, no action is necessary. If incorrect, prepare G-810 activity code 17 to correct MIRTEL and either refund excess premiums or collect arrearage.]

ALERT - DATA IN ZIP CODE AREA INCONSISTENT WITH FOREIGN ADDRESS-2104

CAUSE: System attempting to validate ZIP code. It accepted what was entered but is unverified.

ACTION: Determine correct address for QRRB and correct address, if necessary.

ALERT - EE'S AGE OF D/F USED TO DETERMINE SPOUSE EFF DATE-2116

CAUSE: RASI system is furnishing MIRTEL system data that cannot be verified mechanically.

ACTION: MIRTEL will use the dates furnished by RASI. However, these dates must be verified and corrected if erroneous. In some cases, a pseudo number is required.

ALERT - INCORRECT HI DATE CHANGED TO AGREE WITH OTHER DATA-2101

ALERT - INCORRECT SMI DATE CHANGED TO AGREE WITH OTHER DATA-2102

CAUSE: HI and/or SMI date changed to agree with option, DOB, filing date, etc. The changed date, which is the MIRTEL DATE(S), will be shown as well as the original date.

ACTION: Determine correct entitlement date and initiate corrective action, if necessary.

ALERT – PAID THRU DATE AFTER DOD – CHECK FOR POSSIBLE REFUND-2224

CAUSE: Premiums are paid directly or collected from the annuity after the month a beneficiary dies. Beneficiaries on direct bill usually pay in advance, so it is possible they will pass away and premiums will have already been paid for months after the DOD. The RRB will take action to refund the premiums collected for months after the DOD.

Sometimes the RRB is not notified timely of a beneficiary's death and not due checks with premium deductions are issued in months after the DOD. The premiums sent to the Part B trust fund in these cases need to be returned to the SSEB account or the SSA account, depending on whether the RRB deducted the premium from the RR or SS benefit. The Death Transfer Listing identifies most of these cases. UPSD completes SF 1081's to transfer the premiums back to the SSEB or SSA account.

If monthly payments with deductions were issued after the DOD and PREH screen (3277) indicates the payments were suspended or terminated (with a code other than a death code) immediately before the death code was put on the record, a manual transfer will be needed.

EX: An EE passed away in May 2009. PREH's 3277 screen indicates a check with a \$96.40 premium deduction from the RR benefit was released in June 2009. The death code termination was entered on PREH 6-2-02 (from TERM-SUSP-ACCT –DT field) stopping payments. Since the death code termination initially stopped the payments, this claim number will appear on the Death Transfer listing and UPSD will take action to transfer the premiums from the Part B trust fund to the SSEB account. A manual transfer would not be needed.

ACTION: Follow the steps below in handling 2224 referrals.

1. Check to make sure the date of death (DOD) on the referral and MOLI are the same. If not ,verify the correct DOD. NOTE: If the beneficiary is alive, delete the referral.

2. Use the MOLI DB screen and/or the PREH 3277 screen to determine how premiums were collected around the time of death.

Move to step 3 if premiums were collected by direct bill. Move to step 4 if deducted from the annuity.

3. If the MOLI (DB) screen (FOM 1 1540.15.3) shows a paid through date after the month of death, a refund is due. For procedure on Priority of Payment, see RCM 3.7.70. According to HI 01001.325, we do not develop for eligible survivors unless the amount due is 3 or more months of premiums. If less than 3 months is due, no further action is required. Send a G-363M to imaging, in case a survivor benefit becomes payable or a claim is made by an eligible survivor. If we receive a claim for a refund of less than 3 months, we would still pay it if the claimant were an eligible survivor. Use the Medicare Payment System (MPS) to pay any refund. (RCM 3.13.89).

4. Verify that there was a previous termination or suspension immediately prior to the DOD termination. Look at the "TERM-SUSP-CAUSE-CODE" line to verify that the code is a death code, most commonly a "1" for the EE, a "51" for an MA and a "41" for a WA or WCA. Hit PF12 to see if there is a previous termination or suspension code on the same line immediately before the death code.

If there is no previous code, no action is needed. If there is a previous code, move to step 5.

5. Complete a G-240 to transfer the Part B premiums deducted from the not due checks. Transfer the premiums from the appropriate Part B trust fund (Aged/Disabled and IRMAA/Regular) to the RRB's SSEB account (8010) if deductions were from a RR benefit; to 8011.6 if deductions were from an SSA aged (OASI) benefit; or to 8011.7 if deductions were from an SSA disability benefit (DI). Move to step 6 if the deduction was from SSA benefits.

6. In addition to the G-240 transferring premiums from CMS to 8011.6 or 8011.7, complete another G-240 to transfer the premiums from either 8011.6 or 8011.7 to the appropriate SSA account (OASI or DI).

NOTE: Always delete the referral on MEDREF after all actions are taken or if it is determined that no action needs to be taken. In addition, this procedure is only for Part B premiums.

ALERT - PAYEE CODE MISSING - RECORD STATUS SHOWS ANNUITY IN FORCE-2115

CAUSE: Self-explanatory

ACTION: Verify record status, if annuity in force, no further action required; otherwise, correct record status and corresponding data.

ALERT - PENALTY PERCENT AND RESIDENCY CODES CHANGED TO REFLECT NEW RPD AND RESIDENCY-2621

ALERT - PENALTY PERCENT CHANGED TO AGREE WITH RPD-2620

CAUSE: A G-810 activity other than a 17 changed the RPD on MIRTEL and is not in agreement with the catastrophic data code. The MIRTEL validation changed the catastrophic data to agree with the RPD and/or address.

ACTION: Verify rate. If rate and catastrophic data are correct, check for refund or arrearage. If information is incorrect, prepare a G-810 activity code 17 to correct MIRTEL and check for a refund or arrearage.]

ALERT - POSSIBLE DUAL DEDUCTIONS -MIRTEL NOT UPDATED-2811

CAUSE: Both SSA and RRB set up Medicare records and possibly began billing or deductions.

ACTION: Prepare a G-810 code 22 if RRB HI and/or SMI date should be changed. Refund any excess premiums paid through the Medicare Payment System (MPS).

ALERT - REPLY CONVEYING TERM - MIRTEL NOT UPDATED-2801

ALERT - REPLY CONVEYING SBI ENROLLMENT - MIRTEL NOT UPDATED-2802

ALERT - REPLY HAS YES OPTION - MIRTEL TERM - NOT UPDATED-2803

ALERT - REPLY SHOWS 2ND ENROLL - MIRTEL 1ST ENROLL - MIRTEL INFORMATION RETAINED-2804

ALERT - REPLY HAS CONFLICTING DATA - MIRTEL INFORMATION RETAINED-2805

ALERT - REPLY SHOWS 1ST ENROLL - MIRTEL 2ND ENROLL - MIRTEL NOT UPDATED-2806

ALERT - REPLY RECEIVED - MIRTEL SHOWS DUAL ANNUITANT - MIRTEL NOT UPDATED-2807

ALERT - REPLY RECEIVED ON INACTIVE CASE - REPLY NOT PROCESSED-2808

CAUSE: These are rescreening replies which indicate a conflict between SSA and RRB Medicare records.

ACTION: Determine which record is correct. If the RRB record is incorrect; drop and reestablish the record correctly. Check whether any refund is due.

ALERT - REP PAYEE CODE CHANGED TO AGREE WITH OTHER DATA-2103

CAUSE: NAME/ADDRESS indicates REP PAYEE involved, no code shown; system enters REP PAYEE CODE 2. NAME/ADDRESS does not indicate a REP PAYEE, a REP PAYEE CODE was shown; system deletes code.

ACTION: Determine correct name and address and if a REP PAYEE was named. Initiate corrective action, if necessary.

ALERT - RESCREENING REPLY CONVEYING EARLIER SED - MIRTEL NOT UPDATED-2809

CAUSE: SSA has an earlier SED than shown on MIRTEL.

ACTION: Determine correct SED.

ALERT - RESIDENCE CHANGED AND RATE ASSUMED VARIABLE - VERIFY-2642

CAUSE: A G-810 activity other than a 17 changed the RPD on MIRTEL. The SMI premium rate on the MIRTEL master is not in agreement with the catastrophic data code. The catastrophic data coding was updated by the validation process.

ACTION: Verify the SMI premium rate. If the catastrophic data code and effective date are correct, NAN. If incorrect, submit a G-810 activity code 17. Also check for arrearages or refund.]

ALERT - RESIDENCY CHANGED - NEW VARIABLE RATE DEVELOPED-2641

CAUSE: A new variable rate with a penalty percent was established from a different rate table based on a change of residency.

ACTION: Verify new rate. If it is correct, check for refund or arrearage. If it is incorrect, prepare a G-810 activity code 17 to correct MIRTEL and check for refund or arrearage.

ALERT - -RPD AND RESIDENCY CHANGED TO REFLECT NEW ADDRESS-2602

ALERT - RPD CHANGED FOR NEW RESIDENCY - NEW RATE LESS THAN VARIABLE - REVIEW-2603

ALERT - RPD CHANGED TO CONFORM TO MASTER CATASTROPHIC CODING-2604

ALERT - RPD CHANGED TO REFLECT NEW RESIDENCY AND PENALTY PERCENT-2601

ALERT - RPD NOT MATCHED TO TABLE - VARIABLE RATE ASSUMED VERIFY-2697

CAUSE: The MIRTEL validation changed the RPD to agree with the information in the MIRTEL record.

ACTION: Verify the RPD and other information. If MIRTEL is correct, check for refund or arrearage. If MIRTEL is incorrect, prepare a G-810 activity code 17 to correct MIRTEL and check for refund or arrearage.]

ALERT - RPD MATCHED TO NEW AND OLD RATE TABLES - VERIFY PENALTY PERCENT-2699

CAUSE: The RPD matched a rate on both the old and new rate tables so MIRTEL could not determine the penalty percent.

ACTION: Verify RPD and penalty percent, prepare G-810 activity code 17 to show correct penalty percent in the catastrophic data.

ALERT - SBI ACCRETION ON VARIABLE CASE - NO VARIABLE RATE-2630

CAUSE: Catastrophic data on the MIRTEL master indicates a variable SMI rate but there is no variable base rate on MIRTEL.

ACTION: Submit a G-810 activity code 17 with catastrophic data and show the variable base SMI premium amount in item 14.

ALERT - SBI DELETION - PREVIOUS VARIABLE RATE NOT AVAILABLE - OBTAIN-2238

CAUSE: Catastrophic data on the MIRTEL master indicates a variable SMI rate but mechanical action is unable to restore it because there is no variable base rate on MIRTEL.

ACTION: Submit a G-810 activity code 17 with catastrophic data and show the variable base SMI premium amount in item 14.]

ALERT - SBI PRIOR TO SMI TERM DATE - POSSIBLE REFUND OR ARREARAGE DUE-2222

CAUSE: This occurs when a SBI Accretion prior to the SMI termination date is processed.

ACTION: If premiums were paid after the SBI accretion date, refund the excess premiums through the Medicare Payment System (MPS). If premiums were not paid through the month prior to the accretion, correct the arrearage amount and take action to recover the corrected amount.

ALERT - SCREENING REPLY RECEIVED - MIRTEL NOT PENDING-1813

CAUSE: G-810 or G-811 code 32 was prepared to force Medicare record before SSA clearance received.

ACTION: Determine the most advantageous HED and SED and correct the MIRTEL record.

ALERT - SMI EFFECT DATE CHANGED TO LATER DATE-2223

CAUSE: This occurs whenever the SMI effective date is changed to a later date.

ACTION: Verify that the later SMI effective date is correct. If it is not, prepare Form G-810 activity 22 to change the date.

ALERT - SMI OPTION CHANGED FROM 1ST TO 2ND ENROLLMENT-2221

CAUSE: This occurs whenever the SMI option is changed directly from 1st enrollment to 2nd enrollment.

ACTION: Verify the correct option.

ALERT - SMI TERMINATED - ARREARAGE DUE-2220

CAUSE: This occurs when the paid through date is prior to the SMI termination date.

ACTION: Determine if premiums are due and take action to collect them.

ALERT - TERMINATED DIB-ENROLLED FOR AGE - PREVIOUS ENROLLMENT HAD ARREARAGE-2314

CAUSE: This occurs when a previously terminated disabled beneficiary is reenrolled for SMI based on attainment of age 65.

ACTION: Determine if premiums are due for the prior period and take action to collect them.

ALERT - UNABLE TO COMPUTE RATE - BASIC RATE IN MIRTEL-2210

CAUSE: G-811 processed to set up GEP enrollment and MIRTEL cannot compute the SMI premium rate.

ACTION: Prepare G-810 activity code 20 to correct SMI premium rate. Items 12, 13, and 14 must be completed.

ALERT - VARIABLE RATE EXCEEDS LIMIT FOR PENALTY PERCENT - CORRECT RATE OR CODE-2640

CAUSE: MIRTEL shows a variable rate, but the RPD with penalty percent shown is equal to or greater than the nonvariable rate with that penalty.

ACTION: Verify RPD and catastrophic data codes. Prepare a G-810 activity code 17 to correct MIRTEL and check for refund or arrearage.

ALERT - VARIABLE RATE INVOLVED - CURRENT HI - RPD USED-2212

CAUSE: MIRTEL is unable to determine the SMI premium rate due to catastrophic coding. Rate on master was used.

ACTION: Verify rate. If it is correct, NAN. If it is incorrect, prepare a G-810 activity code 17 to correct MIRTEL.

ALERT - VARIABLE RATE INVOLVED - PENALTY ADDED TO VARIABLE BASE RATE-2213

CAUSE: A variable rate was established. The amount of the existing penalty percent was added to the variable base rate.

ACTION: Verify the SMI rate. If it is correct, check for refund or arrearage. If it is correct, prepare a G-810 activity code 17 to correct MIRTEL and check for refund or arrearage.]

ALERT - -ZIP CODE INCORRECT OR OMITTED - WAS DEVELOPED FOR ZIP MASTER-2109**ALERT - ZIP CODE OMITTED - NOT FULLY DEVELOPED FROM ZIP MASTER-2210****ALERT - ZIP CODE OMITTED - DEVELOPED IN ISOLATED AREA ONLY-2112**

CAUSE: G-810 was prepared with name and address but ZIP code was omitted or incorrect.

ACTION: Enter correct ZIP code and resubmit G-810.

Exhibit 4 - Conversion Referrals**MESSAGE: AUX-(DIB) DUP CODE AND PSEUDO NUMBER INCONSISTENT.**

CAUSE: This message was produced in the AUX and DIB conversions when there was an entry in only one of the fields.

ACTION: If there is a pseudo number and it is correct, prepare Form G-811 activity code 17 to remove the earmark. If the pseudo number is correct or missing, prepare Form G-811 activity code 05 to drop the record, then Form G-810 activity code 13 to reestablish the correct record. Also prepare Form G-811 activity code 22 to correct the HIM.

MESSAGE: AUX DUPLICATE - THIS RECORD RETAINED.

CAUSE: This occurred when there were two records for the same beneficiary on the AUX file. If only one record contained a pseudo number that record was retained. In other cases, the record to be retained was selected at random.

ACTION: ESA has the referral of the record which was dropped. Compare the dropped record to the retained record either using the referral or an old WHIM, and determine the correct data. Prepare Form G-811 activity code 17 to remove the conversion referral earmark or Form G-810 activity code 17 to make any necessary changes.

MESSAGE: AUX INVALID PSEUDO NUMBER - MIRTEL CONTAINS SPACES

CAUSE: This occurred in the AUX conversion when the entry in the pseudo number field was not a valid pseudo.

ACTION: Determine whether or not there should be a pseudo number. If not, prepare Form G-811 activity code 17 to remove the earmark. If a pseudo number is required, prepare Form G-810 activity code 05 to drop the record. Then prepare Form G-810 activity code 13 to set up the record with the pseudo number. Form G-811 activity code 21 is also required to send a universal RIC to the HIM.

MESSAGE: AUX INVALID RECORD STATUS - MIRTEL CONTAINS 02.

CAUSE: This occurred when the data in the AUX fields, SMI option, record status and jurisdiction was inconsistent. For example, if the jurisdiction code was 3 or 4, the record status should not have been 1, 2 or 4.

NOTE: The conversion entered a record status 02 (no annuity application filed - jurisdiction pending.)

ACTION: Determine the correct MIRTEL record status. Prepare Form G-811 activity 17 to clear the conversion referral earmark. Then prepare either Form G-810 or Form G-811 activity code 32 to change the record status.

MESSAGE: AUX - UNABLE TO ISOLATE NAME.

CAUSE: This occurred in the AUX conversion because: (1) the group mark did not precede the first line of the address; (2) in representative payee case, if the work "for" did not appear at the beginning of a line; (3) there was only one name; or (4) there were non-alpha characters in the name.

ACTION: Prepare Form G-810 activity code 17 to correct the name and address.

MESSAGE: BEN SYM INCONSISTENT WITH PREF OR TYPE BEN.

CAUSE: This occurred when the symbol was inconsistent with either /or the prefix or type of beneficiary, i.e., the beneficiary symbol was blank and the prefix was other than A or H and/or the type of beneficiary was other than 01, 11 or 21.

ACTION: Determine the correct entries for these items. Prepare Form G-811 activity code 05 to drop the record. Prepare Form G-810 activity code 13 to reestablish the correct record. If symbol or type of beneficiary was incorrect also prepare Form G-811 activity 22 to send a universal RIC to SSA. If the prefix was incorrect Form G-811

activity code 35 is required to send a kill credit from the wrong prefix and number to the correct one.

MESSAGE: DIB TOO YOUNG TO QUALIFY FOR MEDICARE.

CAUSE: This occurred in a disability case if the HI effective date is prior to a disabled child's attainment of age 20.

ACTION: If the child is not age 20, prepare Form G-810 activity code 17 to correct the effective dates. If he is not yet age 20, prepare Form G-811 activity code 06 to drop the MIRTEL record and the HIM. Notify the child when he will become eligible.

MESSAGE: DIB DIS HI EFF DATE PRIOR TO JULY 1973.

CAUSE: This message was produced in the conversion of the DIB file.

ACTION: Prepare Form G-810 activity code 17 to remove the conversion referral earmark and correct either the HI effective date or the type of beneficiary to non-disabled.

MESSAGE: DIB DIS SMI EFF DATE PRIOR TO JULY 1973.

CAUSE & ACTION: Same as previous message.

MESSAGE: DIB DUPLICATE - THIS RECORD RETAINED.

CAUSE: This occurred when there were two records on the DIB file. If only one record contained a pseudo number, that record was retained. In other cases, the record to be retained was selected randomly.

ACTION: Same as AUX Duplicate.

MESSAGE: DIB MATCH DUP - THIS RECORD RETAINED.

CAUSE: This occurred when a DIB record matched a record created in the AUX conversion

ACTION: Same as AUX Duplicate

MESSAGE: EXCESS PREM ANN IN FORCE.

CAUSE: This occurred when the record status showed annuity in force (code 11 or 31) and there was an excess premium amount.

ACTION: Determine whether or not a refund is due. If a refund is due, issue the refund through the Medicare Payment System (MPS). Always prepare Form G-810 activity code 17 to remove the earmark and x out the excess premium amount.

MESSAGE: INVALID OR MISSING...

There is a series of messages involving invalid or missing data. The invalid data includes date of birth, SMI and HI effective dates, paid through date, etc.

CAUSE: These messages were produced after the final conversion if the field was blank, or a date was not valid.

ACTION: Prepare Form G-810 activity code 17 to remove the earmark and enter or correct the data.

MESSAGE: NO MATCH CHICO...

CAUSE: There are four messages to refer out cases in which the MIRTEL record indicated an annuity was in force or in suspense and no matching CHICO record was located. This could have occurred because the matching criteria differed or the MIRTEL record status was incorrect.

ACTION: If there is a CHICO record but the fields used for matching differ, correct the erroneous record. If CHICO is incorrect, either make the correction or refer the case to the appropriate module. Prepare Form G-811 activity code 17 to remove the earmark.

MESSAGE: NO MATCH MIRTEL . . .

CAUSE: One of five referral messages was produced when either an in force CHICO record with a SMI option of 2, 3, 4 or 8 or a suspended CHICO record did not match a MIRTEL record.

ACTION: The conversion program sets up a MIRTEL record based on the information in CHICO. Therefore, it is only necessary to verify that the record is correct. If it is, prepare Form G-811 activity code 17 to remove the earmark. If the record is incorrect, prepare Form G-810 activity code 17 to correct the record.

MESSAGE: OP DISC - CHICO INFORCE . . .

CAUSE: One of two option discrepancy messages was produced to indicate one record had a "yes" option and the other had a "no" type option.

NOTE: This message will not be produced in certain cases in which the discrepancy is temporarily acceptable, i.e., CHICO has a 4 option and MIRTEL has a 5 option.

ACTION: Determine the correct option. If the option on MIRTEL is correct, prepare Form G-811 activity code 17 to remove the earmark and correct CHICO either by an award action or Form G-607.

MESSAGE: POSSIBLE REFUND DUE - CHECK PAID THRU DATES.

CAUSE: This occurred when CHICO was in force with deductions and MIRTEL had a paid through date which was either current or in the future.

ACTION: Determine whether or not a refund is due. If so, refund the excess premiums through the Medicare Payment System (MPS). Prepare Form G-810 activity code 17 to remove the earmark and X out the paid through date.

MESSAGE: RPD DISCREPANCY.

CAUSE: This occurred when the recurring premium rate in MIRTEL and CHICO were not equal.

ACTION: Determine the correct premium rate. If CHICO is incorrect prepare an award to correct the rate. Also prepare Form G-811 activity code 17 to remove the earmark.

If MIRTEL is incorrect prepare Form G-810 activity code 17 to correct the rate.

MESSAGE: RR(SS) TERM FOR RSN NOT = DEATH CK QRRB STAT.

CAUSE: This occurred when a MIRTEL record matched a CHICO record (either an RR or SS benefit) which is terminated for other than death.

ACTION: Prepare Form G-810 activity code 17 to change the record status to 98, inactive - no longer QRRB. If jurisdiction transfers to SSA, prepare Form PR-80. If jurisdiction remains at RRB but on a different claim number, take action to cross-refer the numbers.

MESSAGE: SMI EFF DATE INCONSISTENT BETWEEN TWO FILES.

CAUSE: This occurred when MIRTEL and CHICO had the same SMI options but the effective dates were not equal.

ACTION: Determine the correct effective date. If CHICO is incorrect, prepare Form G-607 to correct the date. Also prepare Form G-811 activity code 17 to remove the earmark.

If MIRTEL is incorrect, prepare Form G-811 activity code 17 to correct the date.

Exhibit 5 - MIRTEL Folder Notice

ANNUITY IN FORCE W/DED - POSSIBLE REFUND DUE-3229

CAUSE: This occurs when a MIRTEL record with a paid through date which is current or in the future matches a CHICO record that is in force with premium deductions.

ACTION: Determine whether or not the paid through date is correct. If it is correct, refund the excess premiums through the Medicare Payment System (MPS).

CESSATION OF DIB - MIRTEL TERMINATED-3303

CAUSE: Result of G-811 activity code 51. If the termination date is prior to or in the same month as the processing month the referral will be printed when the activity is processed. If the termination date is in the future, the referral will be printed in the first processing run that corresponds to termination date.

ACTION: Referral will be sent to Claim Files to be associated with file.

IEP OPTION CHANGE - POSSIBLE REFUND DUE-3222

CAUSE: Result of a manual activity changing election from Part A & B to Part A only. MIRTEL record indicates that premiums have been paid starting with SMI effective date or after Part B termination date.

The paid through date and any excess will be printed below the message.

ACTION: Referral will be matched to activity and returned to examiner. (When you are changing from a Part A & B option to a Part A only, annotate activity that refund has been made or not applicable).

It will be the examiner's responsibility to determine correct action. If activity form indicates action taken previously stamp "FILE ONLY" and forward to Claim Files. Otherwise, request file and refund premiums.

LOSS OF QRRB - PREV ARREARAGE - CHECK ACCTS REC FOR AMT-3231

CAUSE: Beneficiary's entitlement is terminated and MIRTEL record indicates a previous arrearage.

ACTION: Check to determine the amount of the arrearage and whether premiums are due or have been collected.

MIRTEL DROPPED-3301

CAUSE: G-811 Activity Code 05 or 06 prepared.

ACTION: Referral will be associated with G-811 and returned to examiner only if requested. This will notify the examiner that his subsequent actions, if applicable, may now be submitted. If no further action is necessary, mark "FILE ONLY" and send to claim files.

PREMIUMS DUE FOR PERIOD PRIOR TO SBI-3221

CAUSE: An activity (MANUAL OR MECHANICAL) was processed indicating a buy-in accretion. However, the MIRTEL record indicates that premiums are still due for a period prior to the accretion date.

The paid through date and any excess will be printed below the message.

ACTION: If the referral from a G-810 or G-811, it will be matched with the form and returned to the examiner. (When you are processing SBI accretions and are aware of this situation, you should annotate the form that premiums are or are not due).

It will be the examiner's responsibility to determine correct action. If the activity form indicates premiums are to due, stamp "FILE ONLY" and send to Claim Files. Otherwise, request file and take necessary action to collect premium arrearage.

If the referral resulted from a mechanical activity, the file will be requested and returned to a GS-5 claims clerk in MPS.

PREMIUMS PAID AFTER SBI - POSSIBLE REFUND DUE-3220

CAUSE: An activity (MANUAL OR MECHANICAL) was processed indicating a buy-in accretion. However, the MIRTEL record indicates that premiums were paid after the accretion date. The paid through date and any excess premiums will be printed below the message.

ACTION: If the referral resulted from a G-810 or G-811, it will be matched with the form and returned to the examiner. (When you are processing SBI accretions and are aware of this situation, annotate the form that refund was made or isn't applicable). The examiner will determine the proper action. If refund is applicable, folder should be requested, otherwise stamp "FILE ONLY" and forward to claim files. If the referral resulted from a mechanical activity, the file will be requested and forwarded to a GS-5 claims clerk in MPS.

PREMIUMS PAID AFTER TERM DATE - POSSIBLE REFUND DUE-3223

CAUSE: Result of a manual activity changing election from Part A & B to Part A only. MIRTEL record indicates that premiums have been paid starting with SMI effective date or after Part B termination date.

The paid through date and any excess will be printed below the message.

ACTION: Referral will be matched to activity and returned to examiner. (When you are changing from a Part A & B option to a Part A only, annotate activity that refund has been made or not applicable).

It will be the examiner's responsibility to determine correct action. If activity form indicates action taken previously stamp "FILE ONLY" and forward to Claim Files. Otherwise, request file and refund premiums.

PREVIOUS ARREARAGE - CHECK ACCTS. REC. OR ARREARAGE AMT-3224

PREVIOUS ARREARAGE - AMOUNT UNKNOWN - CHECK ACCTS REC.

CAUSE: Record is being reactivated. Activity changing a first termination to a second enrollment or when a QRRB previously entitled to Medicare based on disability is attaining age 65.

The arrearage amount will be printed when available.

ACTION: Referral will be matched to activity and returned to examiner. (When you are processing second enrollment or an age attainment for a QRRB who was previously entitled based on disability, annotate the activity that premiums are due or have been collected).

It will be the examiner's responsibility to determine correct action. If activity form indicates previous action was taken, stamp "FILE ONLY" and return to Claim Files. Otherwise, request file and take necessary action to collect arrearage.

If the referral resulted from a mechanical activity, the file will be requested and given to a GS-5 claims clerk in MPS.

REVERSE TERMINATION - PREVIOUS ARREARAGE-3227

CAUSE: Activity processed reversing termination for nonpayment and past premiums still due. Applies to the current eligibility period.

ACTION: Referral will be sent to Claim Files. Past premiums will be collected when the next billing notice is released or when the annuity is adjusted.

RRB JURISDICTION - REPLY PROCESSED

CAUSE: An activity processed that cleared pending jurisdiction. The contents of the updated MIRTEL will be printed.

ACTION: Referral will be set to Claim Files if there is a paid through date on the referral. If no paid through date is shown, the referral is discarded.

SCREENING REPLY PENDING 30 DAYS - TRACER-3302

CAUSE: Screening reply pending 30 days from initial screening request date, MIRTEL generated another request.

ACTION: File is requested from Claim Files to determine why clearance has not been received.

SMI OPTION CHANGED - POSSIBLE REFUND DUE-3228

CAUSE: Result of a manual activity changing election from Part A & B to Part A only. MIRTEL record indicates that premiums have been paid starting with SMI effective date or after Part B termination date.

The paid through date and any excess will be printed below the message.

ACTION: Referral will be matched to activity and returned to examiner. (When you are changing from a Part A & B option to a Part A only, annotate activity that refund has been made or not applicable).

It will be the examiner's responsibility to determine correct action. If activity form indicates action taken previously stamp "FILE ONLY" and forward to Claim Files. Otherwise, request file and refund premiums.

Exhibit 6 - Monthly MAMMA Referrals

8001 - MECHANICALLY ADJUSTED - ARREARAGE DUE

CAUSE: This occurs when MAMMA is unable to determine the correct amount of the arrearage due. Deductions for the current month are started.

ACTION: Determine the correct amount of arrearage and take action to recover the arrearage.

8002 - COMPUTATION ERROR - CHECK SMIB EFFECTIVE DATE AND RPD

CAUSE: This occurs when there is discrepant information on the MIRTEL/MOLI record and MAMMA cannot create an award to start, stop, or change the premium deduction. No adjustment is made.

ACTION: Refer to P&S – PAS.

8003 - MECHANICALLY ADJUSTED - POSSIBLE REFUND DUE

CAUSE: This occurs when MAMMA is unable to determine the correct amount of the refund, mostly because of the State paying the premium and there is or was a variable rate involved. If the accretion and deletion dates on the MIRTEL/MOLI record are close together, an 8931 - SBI ACCRETION & RECENT DELETION - POSSIBLE ARREARAGE OR REFUND referral is also generated. Deductions are stopped.

ACTION: Determine the correct amount of refund due and take action to issue the refund check.

8004 - IMPOSSIBLE CONDITION - REFER TO ESA

CAUSE: This occurs when there is discrepant information on the MIRTEL/MOLI record and MAMMA cannot create an award to start, stop, or change the premium deduction. No adjustment is made.

ACTION: Refer to P&S – PAS.

MESSAGE: 8100 - SMI OPTION DISCREPANCY - ANNUITY WILL BE ADJUSTED NEXT MONTH

CAUSE: This occurs when the Part B option on MIRTEL/MOLI is not the same as the Part B option on CHICO/DATAQ. No adjustment is made.

ACTION: Refer to P&S – PAS.

8200 - CASE SELECTED FOR ADJUSTMENT – REJECTED

CAUSE: This occurs when there is discrepant information on the MIRTEL/MOLI record and MAMMA cannot create an award to start, stop, or change the premium deduction. No adjustment is made.

ACTION: Refer to P&S – PAS.

8300 - CRITICAL CONVERSION REFERRAL ON MIRTEL/MOLI

CAUSE: This occurred when the old Medicare system was converted to the new MIRTEL/MOLI system and there was something wrong with the Medicare record. This is obsolete.

ACTION: Refer to P&S – PAS.

8301 - UNABLE TO ADJUST MIRTEL/MOLI - REJECTED

CAUSE: This occurs when there is discrepant information on the MIRTEL/MOLI record. No adjustment is made.

ACTION: Refer to P&S – PAS.

MESSAGE: 8400 - MIRTEL/MOLI SHOWS SBI WITHOUT ACC DATE - UPWARD ADJ TO CHICO/DATAQ REQ

CAUSE: This occurs when the Part B option on MIRTEL/MOLI is 8, state buy-in with no accretion date, and CHICO/DATAQ has a Part B option 1 or 5. No adjustment is made.

ACTION: Determine the correct Part B option. If the Part B option is state buy-in, create a MEDCOR Activity 20L to enter the accretion on MIRTEL/MOLI. If the Part B option is not state buy-in, create a MEDCOR Activity 20L or 22L to correct the Part B option on MIRTEL/MOLI.

MESSAGE: 8500 - MIRTEL/MOLI HAS TERM OPT - UPWARD ADJ TO CHICO/DATAQ REQ - REFUND DUE

CAUSE: This occurs when the month of termination is prior to the processing month or there is no Part B termination date on MIRTEL/MOLI or MAMMA does not have enough

information to calculate the amount of the refund. Deductions are stopped, but a refund was not made.

ACTION: If the termination is correct, prepare a refund of any excess premiums. If necessary, create a MEDCOR Activity 22L to enter the Part B termination date on MIRTEL/MOLI or reverse the Part B termination if incorrect.

MESSAGE: 8600 - SMI OPTION DISCREPANCY - CHECK BOTH FILES

CAUSE: This occurs when the Part B option on MIRTEL/MOLI and CHICO/DATAQ are different and no adjustment can be made mechanically.

ACTION: Determine the correct enrollment data and correct either MIRTEL/MOLI or CHICO/DATAQ.

MESSAGE: 8700 - RPD DISCREPANCY - ANNUITY ADJUSTED

CAUSE: This occurs when the premium rates in MIRTEL/MOLI and CHICO/DATAQ are different. CHICO/DATAQ is mechanically adjusted to correct the rate to the one shown on MIRTEL/MOLI. This referral is no longer generated. However, there is data printed in the syslist.

ACTION: Determine the correct premium rate and if necessary, create a MEDCOR activity 17L to correct MIRTEL/MOLI. If necessary, prepare a refund or take action to collect the arrearage.

MESSAGE: 8800 - TERMINATION - CHECK JURISDICTION

CAUSE: This occurs when a MIRTEL/MOLI record with a record status other than 98 or 99 matches a CHICO/DATAQ record that was terminated for a reason other than death.

ACTION: Determine whether or not the beneficiary is still a QRRB. If no longer a QRRB, create a MEDCOR Activity 52S and take necessary action to transfer jurisdiction to SSA. If necessary, notify the beneficiary of the transfer. If the beneficiary remains a QRRB on the same number, create a MEDCOR Activity 05S to drop the MIRTEL/MOLI record and a day later, create a MEDCOR Activity 13L to reestablish the MIRTEL/MOLI record.

MESSAGE: 8900 - POSSIBLE REFUND DUE - CHECK PAID THRU DATE

CAUSE: This occurs when a MIRTEL/MOLI record with a paid through date which is current or in the future matches a CHICO/DATAQ record that is in force with premium deductions.

ACTION: Determine whether or not the paid through date is correct. If it is correct, prepare a refund for the excess premiums and create a MEDCOR Activity 20L to X-out the paid through date. If the paid through date is erroneous, create a MEDCOR Activity

20L to X-out the date. Enter all XXXs in the PAID THRU DATE field on the MEDCOR Activity 20L.

MESSAGE: 8901 - MIRTEL/MOLI PENDING – CHICO/DATAQ SUSPENDED WITH DED

CAUSE: This occurs when a paid through date should be applied to the MIRTEL/MOLI record because a CHICO/DATAQ record with Part B deductions was suspended.

ACTION: Determine why the record is still pending. Create a MEDCOR Activity 32L or 34L to clear the MIRTEL/MOLI record and update the paid through date.

MESSAGE: 8902 - MIRTEL/MOLI SHOWS LOSS OF QRRB STATUS – CHICO/DATAQ IN FORCE

CAUSE: This occurs when the record status on MIRTEL/MOLI is 98 and the CHICO/DATAQ record is in pay status (regardless of Part B option).

ACTION: Determine if the beneficiary is a QRRB or not. If the beneficiary is no longer a QRRB, send an e-mail to RBD or SBD to terminate the annuity. If the beneficiary is still a QRRB, drop the MIRTEL/MOLI record by creating a MEDCOR Activity 05S, then create a MEDCOR Activity 13L to reestablish the MIRTEL/MOLI record. If there is a surname change, once the MIRTEL/MOLI is reestablished, create a MEDCOR Activity 22L, adding the address and have a new Medicare card released.

MESSAGE: 8903 - MIRTEL/MOLI SHOWS CESSATION OF DIB – CHICO/DATAQ IN FORCE WITH DED

CAUSE: This occurs when the record status on MIRTEL/MOLI is 90 and the CHICO/DATAQ is in force with a Part B deduction.

ACTION: Determine the correct status of the beneficiary. If MIRTEL/MOLI is correct and the beneficiary is no longer disabled, send an e-mail to RBD or SBD to prepare an award to stop deductions. Make a refund of any excess premiums. If the beneficiary is still disabled, create a MEDCOR Activity 22L with XXXX in the PART A TERM DATE field and the PART B TERM DATE field to remove the termination dates.

MESSAGE: 8904 - MIRTEL/MOLI RSC SHOWS BENEFICIARY DECEASED – CHICO/DATAQ NOT TERMINATED

CAUSE: This occurs when the record status on MIRTEL/MOLI is 99 and the CHICO/DATAQ record is either in force or in suspense.

ACTION: Determine what generated the death notice to the MIRTEL/MOLI record and if that action was correct. If the beneficiary is deceased, send an e-mail to RBD or SBD and advise them that the annuitant is deceased. If the beneficiary is alive, create a MEDCOR Activity 22L with an active record status and XXXXs in the DATE OF DEATH field to remove the date of death.

8905 - RPD AND PAID THRU DISCREPANCIES - ANNUITY ADJUSTED

CAUSE: This occurs when there is a discrepancy between the Part B premium and the paid through date on MIRTEL/MOLI.

ACTION: Determine if the Part B premium and the paid through date is correct. If necessary, prepare a MEDCOR Activity 17L to correct the Part B premium. Also determine if the paid through date is correct and if a refund is due or an arrearage needs to be recovered.

MESSAGE: 8906 - NO MATCHING MIRTEL/MOLI – CHICO/DATAQ HAS SMI CODE

CAUSE: This occurs when a CHICO/DATAQ record, which is either in current pay status or in suspense, contains a Part B option code and there is no matching MIRTEL/MOLI record.

ACTION: If there is a MIRTEL/MOLI record for the claim number, check the matching criteria and correct either the MIRTEL/MOLI record or the CHICO/DATAQ record, if necessary. If there is no MIRTEL/MOLI record, determine whether or not the case was ever screened, and then create a MEDCOR Activity 12L to screen or Activity 13L to reestablish the MIRTEL/MOLI.

MESSAGE: 8907 - NO MATCHING CHICO/DATAQ - MIRTEL/MOLI SHOWS ANNUITY

CAUSE: This occurs when the record status on MIRTEL/MOLI is 11, 13, 21, 23, or 24; the screening reply date is more than three months in the past; and there is no CHICO record. This will also occur immediately if the record status on MIRTEL/MOLI is 31 and there is no matching CHICO/DATAQ record.

ACTION: If the problem is the matching, determine the correct data and take action to correct the appropriate file. If there is no CHICO/DATAQ record and it is evident the record status on MIRTEL/MOLI is erroneous, create a MEDCOR Activity 22L with the address screen to correct MIRTEL/MOLI; otherwise, refer the case to RBD or SBD to determine why the annuity was not paid. If the record status on MIRTEL/MOLI is 31 and there is no CHICO/DATAQ record, handle in accordance with RCM 3.5 Exhibit 1, Section C.

MESSAGE: 8908 - BEN SYM/TOB INCONSISTENT ON MIRTEL/MOLI AND CHICO/DATAQ FILES

CAUSE: This occurs when the MIRTEL/MOLI record partially matches a CHICO/DATAQ record, but the beneficiary symbol and type of beneficiary on the two files are not compatible. No adjustment is made.

ACTION: Determine which data is correct, and take action to correct the erroneous record.

MESSAGE: 8909 - INVALID OR MISSING PAID THRU DATE

CAUSE: The MIRTEL/MOLI system was unable to develop a valid paid through date.

ACTION: Prepare a MEDCOR Activity 20L to enter the correct paid through date.

MESSAGE: 8910 - ALERT - TERM OF DIB - ELIGIBLE FOR HI ADDITIONAL 7.5 YEARS

CAUSE: The disability annuity has been terminated for substantial gainful activity (SGA). The annuitant may be eligible for an additional 7.5 years of Medicare coverage.

ACTION: Notification only. No examiner action is necessary.

MESSAGE: 8911 - ALERT - ANNUITY ADJUSTED DURING MEDICARE EXTENSION PERIOD

CAUSE: The annuity has been adjusted (reinstated) after a disability annuity was terminated for substantial gainful activity (SGA) while Medicare coverage was extended for the 7.5 years.

ACTION: Notification only. No examiner action is necessary.

8920 - ANN NOT ADJ - MONTHLY RATE NOT MORE THAN A DOLLAR AFTER DED

CAUSE: This occurs when MAMMA does not start Part B premium deductions because the check rate will be less than a dollar after the Part B premium deduction amount.

ACTION: If necessary, create a MEDCOR Activity 20L or 22L to set up direct billing.

8921 - ANN NOT ADJ - VAR RATE CODE NOT N OR S AND NO CURR DEC ACT 17

CAUSE: This occurs when the MIRTEL/MOLI record was not updated with an Activity 17L in December to update the Part B premium rate.

ACTION: Create a MEDCOR Activity 17L to update the Part B premium rate on MIRTEL/MOLI.

8922 - RETROACTIVE IRMAA - EQUITABLE RELIEF APPLIES

CAUSE: This occurs when the past due IRMAA exceeds 5 times the current standard Part B premium plus the individual's IRMAA amount. Current Part B with IRMAA deductions is started.

ACTION: Take action to recover the IRMAA arrearage.

8923 - CURRENT PAYMENT INSUFFICIENT TO WITHHOLD IRMAA DUE FOR PREVIOUS MONTHS

CAUSE: This occurs when the monthly payment is insufficient to recover an IRMAA arrearage due. Current Part B with IRMAA deductions is started.

ACTION: Take action to recover the IRMAA arrearage.

8924 - STATE BUY-IN INITIATED - IRMAA APPLIES

CAUSE: This occurs when MAMMA adjusts a payment because of SBI and IRMAA is also involved.

ACTION: Refer to P&S – PAS.

8925 - STATE BUY-IN DELETED - IRMAA MAY APPLY

CAUSE: This occurs when MAMMA adjusts a payment to start Part B deductions because the State is no longer paying the premiums and IRMAA may be involved.

ACTION: Determine if there is an arrearage and if so, take action to collect the arrearage.

8926 - IRMAA HIST SEQ PROBLEM - POSSIBLE ARREARAGE OR REFUND - SPECIAL LETTER REQUIRED

CAUSE: This occurs when MAMMA cannot collect an arrearage or make a refund because the IRMAA data on MIRTEL/MOLI is questionable.

ACTION: Prepare a letter advising the individual of the award action and determine if there is an arrearage or refund. Then take the necessary action to either collect the arrearage or prepare a refund.

8927 - IRMAA/OTHER PART B CHANGES - POSSIBLE ARREARAGE OR REFUND

CAUSE: This occurs when MAMMA adjusts only the current month for Part B and IRMAA and is not able to determine if there is an arrearage or refund for the Part B premiums and/or IRMAA premium.

ACTION: Determine if there is an arrearage or refund for the Part B premium and/or the IRMAA premium. Then take action to either recover the arrearage or prepare a refund.

8928 - IRMAA INCREASE PREVENTS DEDUCTIONS - DIRECT BILL REQUIRED

CAUSE: This occurs when MAMMA cannot take the entire premium, Part B and IRMAA, and stops the Part B deduction. The individual should be billed for the Part B premium with IRMAA.

ACTION: Create a MEDCOR Activity 22L with name and address and paid through date to set up direct billing.

8929 - IRMAA ADJUSTMENT MADE - NO ARREARAGE OR REFUND - SPECIAL LETTER REQUIRED

CAUSE: This occurs when MAMMA creates an award to adjust the IRMAA premium and there is no arrearage or refund due but does not generate a letter.

ACTION: Prepare a letter advising the individual of the award action.

8930 - WITHDRAWAL WITH IRMAA - POSSIBLE REFUND

CAUSE: This occurs when MAMMA creates an award to stop Part B deductions with IRMAA but cannot determine the refund amount.

ACTION: Determine the refund amount and prepare a refund.

8931 - SBI ACCRETION & RECENT DELETION - POSSIBLE ARREARAGE OR REFUND

CAUSE: This occurs when MAMMA creates an award to either start or stop deductions because of SBI involvement but cannot determine if the previous arrearage was collected or if a previous refund was made. An 8003 – Mechanically Adjusted – Possible Refund referral may also be generated.

ACTION: Determine if there is an arrearage or refund due. Then take action to collect the arrearage or prepare a refund.

8932 - UNABLE TO ADJUST - SOC = 1 OR 5, NO RPD & NO VAR RTE CD

CAUSE: This occurs when MIRTEL/MOLI has a Part B option of 1 or 5 but there is no Part B premium or no variable rate code on the MIRTEL/MOLI record.

ACTION: Determine if the Part B option is correct. If it is correct, determine the correct Part B premium and create a MEDCOR Activity 17L to update MIRTEL/MOLI with the correct Part B premium and variable rate code. If the Part B option is incorrect, create a MEDCOR Activity 22L to update MIRTEL/MOLI.

8933 - PREMIUM FLOATED, RECOVER ARREARAGE

CAUSE: This occurs when MAMMA stops the Part B premium deduction on one benefit and starts the current Part B deduction with IRMAA on the other benefit. Both the RR and SS benefits are being paid by RRB.

ACTION: Determine if there is an arrearage due. If so, take action to collect the arrearage.

8934 - RETROACTIVE IRMAA - WILL BE PROCESSED IN JANUARY

CAUSE: This occurs when a MIRTEL/MOLI record was updated with retroactive IRMAA (for the current year) information after the November MAMMA Run. An adjustment is not made.

ACTION: Notification only. No examiner action is necessary.

8935 - PART B REDUCTION & STATE BUY-IN

CAUSE: This occurs when MAMMA creates an award for a MIRTEL/MOLI record that reflects a Part B reduction as well as State Buy-in coverage.

ACTION: Refer to P&S – PAS.

8936 - MCR & OTHER PART B CHANGE POSSIBLE ARREARAGE OR REFUND

CAUSE: This occurs when MAMMA adjusts only the current month for Part B with a Part B reduction and is not able to determine if there is an arrearage or refund for the Part B premiums and/or Part B reduction.

ACTION: Determine if there is an arrearage or refund for the Part B premium and/or the Part B reduction. Then take action to either recover the arrearage or prepare a refund.

8937 - RETROACTIVE MCR CHANGE - EQUITABLE RELIEF APPLIES

CAUSE: This occurs when the past due Part B reduction arrearage exceeds 5 times the current standard Part B premium. Deductions are started for the current month.

ACTION: Take action to recover the Part B reduction arrearage.

8938 - MCR CHANGE - CURRENT PAYMENT INSUFFICIENT TO WITHHOLD ARREARAGE

CAUSE: This occurs when the monthly payment is insufficient to recover a Part B reduction arrearage due.

ACTION: Take action to recover the Part B reduction arrearage.

8939 - MCR CHANGE IN PRIOR YEAR - POSSIBLE ARREARAGE OR REFUND

CAUSE: This occurs when MAMMA is unable to collect an arrearage or make a refund for a prior year Part B reduction.

ACTION: Determine if there is a Part B reduction arrearage or refund due. Then take action to recover the arrearage or prepare a refund.

8940 - MCR CHANGE & STATE BUY-IN DELETION - POSSIBLE ARREARAGE

CAUSE: This occurs when MAMMA adjusts a payment to start Part B deductions with a change in the Part B reduction amount and the State is no longer paying the premiums.

ACTION: Determine if there is an arrearage for Part B and/or Part B reduction and if so, take action to collect the arrearage.

8941 - MCR ADJUSTMENT MADE - NO ARREARAGE OR REFUND - SPECIAL LETTER REQUIRED

CAUSE: This occurs when MAMMA creates an award to adjust the Part B reduction amount and there is no arrearage or refund due but does not generate a letter.

ACTION: Prepare a letter advising the individual of the award action.

8942 - MCR CHANGE - PREVIOUS DIRECT BILL OR TRANSFER - POSSIBLE ARREARAGE OR REFUND

CAUSE: This occurs when MAMMA adjusts only the current month for Part B and Part B reduction and is not able to determine if there is an arrearage or refund for the Part B and/or Part B reduction premiums.

ACTION: Determine if there is an arrearage or refund for the Part B and/or Part B reduction premiums. Then take action to either recover the arrearage or prepare a refund.

8943 - MCR HISTORY INSUFFICIENT OR CORRUPTED - POSSIBLE ARREARAGE OR REFUND

CAUSE: This occurs when MAMMA cannot collect an arrearage or make a refund because the Part B reduction data on MIRTEL/MOLI is questionable. Current adjustment is made.

ACTION: Determine if there is an arrearage or refund for Part B reduction premiums. Then take the necessary action to either collect the arrearage or prepare a refund.

8944 - PT B REFUND WITHHELD FOR POSSIBLE ARREARAGE

CAUSE: This occurs when MAMMA creates an award for a Part B reduction change but does not issue a refund because there may be an arrearage due.

ACTION: Determine if there is an arrearage due and if so, take action to collect the arrearage. If no arrearage, prepare a refund.

8945 - MIRTEL/MOLI SHOWS NO IRMAA – CHICO/DATAQ SHOWS CURRENT IRMAA - ADJUSTMENT NOT MADE

CAUSE: This occurs when there is a Part B premium deduction with IRMAA being made on CHICO/DATAQ and the MIRTEL/MOLI record does not reflect the IRMAA amount.

ACTION: Refer to P&S – PAS.

8946 - MESSAGE: POSSIBLE C/D REFUND NO ANNUITY IN FORCE

CAUSE: This referral is produced when CMS sends the RRB a refund request on the Part C and D Request File, but CHICO is not in force.

ACTION: If the annuity is in suspense or terminated for a reason other than death, use the Medicare Payment System (MPS) to make a refund to the beneficiary. Use Fund Code CREF on MPS for Part C refunds and Fund Code DREF on MPS for Part D refunds.

ACTION: If the annuity is terminated due to death, follow the instructions below.

1. Find the adjustment month on the Part C and/or Part D Adjustment screen for the check dated a month after the referral date. Ex: If the referral date is 12-13-2011, find the adjustment month for the 01-12 check date.
2. If the adjustment month is after the date of death on the referral, no action needs to be taken other than deleting the referral if the deductions came from a RR benefit. These are situations where CMS owes the RRB a credit, however the credit has already been taken when the Master Records Assistant prepares the monthly Part C/D funds transfers to CMS. Move to step 3 if the deduction occurred from an SS benefit.
3. If the C and/or D amount was originally deducted from an SSA benefit, send an e-mail to Mike Kelly in P&S. P&S will add those amounts to the accrual side of the SSA Trust Fund Transfer Request memo for accounting purposes. If there is a 900 series voucher number in the VCH field on the ALL DEDUCTIONS screen, Part C HISTORY, or PART D HISTORY screen, then the deduction came from the SS benefit.
4. If the adjustment month is equal to or prior to the date of death on the referral, develop for eligible survivors. Use Fund Code CREF on MPS for Part C refunds and Fund Code DREF on MPS for Part D refunds.
5. It is possible that some adjustment months could be credits and others actual refunds for the same beneficiary. If that happens, ignore the credits if the deductions came from RR benefits and take action to develop for eligible survivors. Notify P&S – Mike Kelly if the credits were deducted from SS benefits.

NOTE: Refunds can be applied to other debts on PAR. In addition, if the refund is not payable to a third party or another bene in CPS, do not develop for other survivors at this time. Place a 6 month call up on the case. We are waiting to hear from CMS what the minimum amount is to develop for survivors.

8947 - INVALID VARIABLE RATE CODE OR IRMAA AMOUNT

CAUSE: This occurs when the MIRTEL/MOLI record has an incorrect variable rate code or an incorrect IRMAA amount. No adjustment was made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a 17L to correct the variable rate code. If there is IRMAA and/or Part B reduction involved, refer to P&S - PAS.

8948 - INVALID PREMIUM RATE, VARIABLE RATE CODE OR PENALTY AMOUNT

CAUSE: This occurs when a MIRTEL/MOLI record has a Part B option of 1 or 5 and a premium rate, but the variable rate code is D or Z and the penalty percent and IRMAA are both zero. No adjustment was made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a 17L to correct the premium rate, or the variable rate code or the penalty percentage. If there is IRMAA and/or Part B reduction involved, refer to P&S - PAS.

8949 - INVALID VARIABLE CODE OR BASE RATE-1

CAUSE: This occurs when MIRTEL/MOLI has a variable rate code of V, C, or D and there is no variable base rate. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a 17L to correct the variable rate code or the variable base premium rate. If there is IRMAA and/or Part B reduction involved, refer to P&S - PAS.

8950 - INVALID VARIABLE CODE OR BASE RATE-1

CAUSE: This occurs when the MIRTEL/MOLI record has a variable rate code of N, R, or Z and also has a variable base rate. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a 17L to correct the variable rate code or the variable base rate. If there is IRMAA and/or Part B reduction involved, refer to P&S - PAS.

8951 - INVALID VARIABLE CODE, PART B OPTION OR PREMIUM RATE-1

CAUSE: This occurs when a MIRTEL/MOLI record has a variable rate code of N, a Part B option of 8, and the premium rate is not equal to the basic premium rate. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a 17L to correct the Part B option, the variable rate code or the premium rate. If there is IRMAA and/or Part B reduction involved, refer to P&S - PAS.

8952 - INVALID VARIABLE CODE, PART B OPTION OR PREMIUM RATE-2

CAUSE: This occurs when a MIRTEL/MOLI record has a variable rate code of N, a Part B option of 8, and the premium rate is not equal to the basic premium rate. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a 17L to correct the Part B option, the variable rate code, or the premium rate. If there is IRMAA and/or Part B reduction involved, refer to P&S - PAS.

8953 - INVALID VARIABLE RATE CODE OR PREMIUM AMOUNT

CAUSE: This occurs when the MIRTEL/MOLI record has a variable rate code of V, C, D, R, or Z; no Part C or D or IRMAA is involved; the percent is equal to zero; and the premium is not less than the basic rate. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a 17L to correct the variable rate code or the percent or the Part B premium rate. If there is IRMAA and/or Part B reduction involved, refer to P&S - PAS.

8954 - INCONSISTENT -HIB-SMIB-DATA-1

CAUSE: This occurs when the MIRTEL/MOLI record has a Part B option, or a Part B effective date, or a penalty percent, or a premium effective date, or a premium effective accounting date that is not numeric. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the fields that are incorrect. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8955 - INCONSISTENT -HIB-SMIB-DATA-2

CAUSE: This occurs when the MIRTEL/MOLI record has an invalid premium effective accounting date. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the premium effective accounting date. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8956 - INCONSISTENT -HIB-SMIB-DATA-3

CAUSE: This occurs when the MIRTEL/MOLI record has an invalid premium effective accounting date. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the premium effective accounting date. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8957 - INCONSISTENT -HIB-SMIB-DATA-4

CAUSE: This occurs when the MIRTEL/MOLI record has an invalid premium effective accounting date. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the premium effective accounting date. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8958 - INCONSISTENT -HIB-SMIB-DATA-5

CAUSE: This occurs when the MIRTEL/MOLI record has an invalid premium effective accounting date. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the premium effective accounting date. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8959 - INCONSISTENT -HIB-SMIB-DATA-6

CAUSE: This occurs when the MIRTEL/MOLI record has a Part B option of 0, 2, 3, or 9 and there is no Part C or D premium and MIRTEL/MOLI has one of the following: a premium rate, a residency code, a variable rate code, a penalty percentage, or a premium effective accounting date. No adjustment is made

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the fields that are incorrect. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8960 - INCONSISTENT -HIB-SMIB-DATA-7

CAUSE: This occurs when the MIRTEL/MOLI record has a Part B option of 1 or 5 and the variable rate code is not N, V, R, Z, C, or D; or the residency code is not P, C, or S; or the penalty percentage is not zero. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the fields that are incorrect. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8961 - INCONSISTENT -HIB-SMIB-DATA-8

CAUSE: This occurs when the MIRTEL/MOLI record has a Part B option of 8 and the variable rate code is not N, R, or Z and the variable base rate is zero; or the residency code is not P, C, or S; or the premium is not zero and the C and D amounts are zero; or the penalty percentage is not zero. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the fields that are incorrect. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8962 - INCONSISTENT -HIB-SMIB-DATA-9

CAUSE: This occurs when the MIRTEL/MOLI record has a Part B option of 8 and the variable rate code is not V, C or D and the variable base rate is greater than zero; or the residency code is not P, C, or S; or the premium is not zero and the C and D amounts are zero; or the penalty percentage is not zero. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the fields that are incorrect. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8963 - INCONSISTENT -HIB-SMIB-DATA-10

CAUSE: This occurs when the MIRTEL/MOLI record has a Part B option of 4 or 6 and the Part C and Part D premiums are zero and the Part B premium is not zero; or the residency code is not spaces; or the variable rate code is not spaces; or the penalty percentage is not zero.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the fields that are incorrect. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8964 - INVALID PREMIUM

CAUSE: This occurs when the MIRTEL/MOLI record has a premium rate less than zero. No adjustment is made.

ACTION: Refer to P&S – PAS.

8965 - INVALID VARIABLE RATE CODE OR PENALTY AMOUNT

CAUSE: This occurs when the MIRTEL/MOLI record has a Part B option of 1 or 5; the Part B premium is zero; the variable rate code is D or Z; and the penalty percentage is greater than zero. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the Part B premium or the variable rate code or the penalty percentage. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8966 - INVALID PART A DATE

CAUSE: This occurs when the MIRTEL/MOLI record does not have a Part A effective date. No adjustment is made.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 22L to add the Part A effective date. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

8967 - POSSIBLE DUAL DEDUCTIONS-1

CAUSE: This occurs when the CHICO/DATAQ record has an SS benefit in current pay and the Part B option is 1, 5, or 8 and there is a Part B premium deduction; or the variable rate code is D or Z and MIRTEL/MOLI has a Part B premium rate or a variable rate code of D or Z.

ACTION: Determine if a refund is due. If so, prepare a manual refund.

8968 - POSSIBLE DUAL DEDUCTIONS-2

CAUSE: This occurs when the CHICO/DATAQ record has an SS benefit in current pay and the Part B option is 1, 5, or 8 and there is a Part B premium deduction; or the variable rate code is D or Z and MIRTEL/MOLI has a Part B premium rate or a variable rate code of D or Z.

ACTION: Determine if a refund is due. If so, prepare a manual refund.

8969 - MIRTEL/MOLI – CHICO/DATAQ RATES NOT EQUAL

CAUSE: This occurs when there is a problem with the monthly payment rate that MAMMA calculated for the award. No adjustment is made.

ACTION: Refer to P&S – PAS.

8970 - MULTIPLE PT-B REDUCTIONS, POSSIBLE ARREARAGE OR REFUND

CAUSE: This occurs when the MIRTEL/MOLI record has multiple Part B reduction activities and MAMMA is not able to determine the correct action to take.

ACTION: Refer to P&S – PAS.

8971 - INVALID SMIB RECURRING DATE

CAUSE: This occurs when MIRTEL/MOLI has an incorrect Part B premium rate.

ACTION: Refer to P&S – PAS.

8972 - PREMIUM VARIABLE RATE CODE OR PENALTY AMOUNT

CAUSE: This occurs when a MIRTEL/MOLI record has a Part B option of 1, 5, or 8 and the variable rate code is V, C, or D and there is a current IRMAA amount.

ACTION: If there is no IRMAA or Part B reduction involved, prepare a MEDCOR Activity 17L to correct the Part B option, or the variable rate code or IRMAA amount. If there is IRMAA or a Part B reduction involved, refer to P&S – PAS.

The following two referrals should be obsolete. If they are generated, please refer them to P&S – PAS for further investigation.

MESSAGE: RPD & PAID THRU DISCREPANCIES - CHECK BOTH FILES.

CAUSE: This occurs when the recurring premium rate is different in both files and the paid through date on MIRTEL/MOLI is the current month or later.

ACTION: Determine the proper premium rate and paid through date and take action to correct the MIRTEL/MOLI record if necessary.

MESSAGE: TOB CHANGED AGE 65 - RPD CHANGED TO BASIC - CHECK FOR POSSIBLE REFUND

CAUSE: This occurs when a disabled beneficiary with a penalty rate attains age 65. The MIRTEL/MOLI record is changed to show a type beneficiary "DIB, Now 65", and the Part B premium rate is changed to the basic rate. Action is also taken to automatically adjust the CHICO/DATAQ record.

ACTION: If Part B deductions are in force, verify that CHICO/DATAQ was adjusted timely and refund any excess premiums if necessary. If premiums were paid direct, determine if any premiums were paid at the penalty rate after the beneficiary attained age 65.

Exhibit 7 - Miscellaneous Referrals**MESSAGE: NOTIFY BA () STEEL COMPANY RAILROAD OF DISABILITY ANNUITANT MEDICARE ENTITLEMENT.**

CAUSE: Annuitant may be covered by group health insurance coverage that may be affected by his or her entitlement to Medicare before age 65 based on disability.

ACTION: Use RRAILS to prepare one copy of Form RL-10, "Notice to Employer of Medicare Coverage Before Age 65." Use MOLI to obtain the Medicare effective date to be entered on the Form RL-10. Use the RRAILS Contact Official lookup (see FOM-I-1596.25) to address Form RL-10 to the railroad's benefits manager or RRA Awards Contact Official. The railroad's BA number is shown on the MEDREF referral. Use RRAILS to send a copy of Form RL-10 to RRA Imaging.

MESSAGE: DAISY REFERRAL; WARNING-POSSIBLE DUPLICATE SMI RECOVERY

CAUSE: A DAISY referral is generated when an RBD/SBD examiner does not complete a MEDCOR 20 (or completes the MEDCOR 20 after cut-off) to advance the paid through date on MOLI after reinstating an annuity where premiums were withheld.

Example 1 - The PREH 3277 screen for recurring payments indicates premium deductions through May 2009. The 3277 screen indicates the June check was in suspense, code 65, because direct deposit was deleted. The July check is in suspense, code 88, because multiple months of Part B will be withheld. Recurring payments started again in August and the premium was withheld. –PREH's 3275 screen for non-

recurring payments indicates the June check was reinstated on voucher 183 and the premium for June was withheld. (SMI-ACCRU-OP-AMT field on page 3 of the reinstatement voucher shows \$96.40 withheld.) 3275 also has a 004 voucher dated 7-1-09. Page 3 of the voucher indicates \$192.80 for June and July was withheld. June was withheld from the 183 reinstatement voucher and the 004 voucher. A refund for June is due.

Example 2 – The PREH 3277 screen indicates premiums were deducted from the May 2009 payment for a disabled employee. The June payment was in suspense, code 06. The suspension occurred because the May 2009 payment was returned. The July check was in suspense, code 88. Recurring payments started again in August and the premium was withheld. The PREH 3275 screen indicates the May check was reissued on voucher 697 and the May premium was withheld again. The June payment was reinstated on voucher 0001 and no premiums were taken. The 499 voucher on July 1, 2009 took premiums for June and July. Since the May premium was twice sent to the Part B trust fund, a G-240 is needed to transfer \$96.40 from the Part B disability fund to the SSEB equivalent fund.

ACTION: Follow the steps below to process a DAISY referral.

1. Determine the period that is in question by the Accounting date on the referral. This is found under the "INFORMATION FROM DAISY" section on the referral.
2. Use PREH 3277 screen to determine which months were deducted prior to the suspension of the monthly benefit. Enter the information under "PREVIOUS VOUCHER WITH INITIAL PREMIUM DEDUTION" on the referral.
3. Verify which months of premiums were recovered from the voucher by using PREH 3275 and checking the award form on imaging. Enter the amount of the premiums recovered and the period under "INFORMATION FROM AWARD FORM".
4. Fill in the blanks under the "DETERMINATION WHETHER TO REFUND" section on the referral.
5. If there is a period of duplicate premium deductions, a refund is due. Check the appropriate box under "BASED ON THE INFORMATION FROM THE AWARD FORM". Enter the period of the refund that is due on the referral. Process the refund that is due to the beneficiary. Complete a G-240 if needed to transfer funds that may have been sent to the Part B trust fund.
6. If there are no duplicate premium deductions, no refund is due. Check the appropriate box under "BASED ON THE INFORMATION FROM THE AWARD FORM" on the referral.

7. Examiner should sign and enter the date form was processed on the referral.

The completed DAISY referral form should be imaged after all actions have been completed.

NO REFERRAL GENERATED – INITIATED THROUGH EMAIL OR PHONE CONTACT: PART B CLAIM REJECTS

CAUSE: The Common Working File (CWF) is queried for entitlement data when a claim is presented for payment. The CWF and the Health Insurance Master (HIM) records should have the same entitlement data. If the entitlement data on CWF does not match the information on the claim, a reject will occur. Data must initially match on the last name, first initial, month and year of the DOB, and address before the provider information is verified. Other possible reasons why claims reject include:

- Erroneous DOD
- Erroneous Entitlement Date(s)
- Incorrect Name
- Incorrect Sex Code
- Incorrect Cross Reference (Showing incorrect SSA or RRB entitlement)
- Erroneous Cross Reference (shows SSA entitlement under a number which does not belong to the beneficiary)

ACTION:

First determine if MOLI, BERT or CWF has any erroneous information listed or the records do not have all of the same identifying information. If the MOLI, BERT and CWF records do not agree, make the necessary corrections so that all records are in agreement. If the records agree, access Palmetto's claim system to determine the reject code.

Correct erroneous information on MOLI by performing a Medcor 22 Long activity. This action will also update BERT, specifically the DOB and address.

Correct erroneous information on BERT by performing the appropriate corrective action using ERNIE (Press PF 9 from Beneficiary Identification Screen). From this point, an examiner will be able to correct the following items: Beneficiary's name, Sex code, Date of Death, Medicare entitlement dates and Cross references.

To correct erroneous information on the CWF, perform an overlay from BERT once the record is corrected. An overlay is performed from BERT using ERNIE (Press PF 9 from Beneficiary Identification Screen and then OC).

3.7.1 Scope of Chapter

This chapter covers the basic rules and procedures involved in the collection of SMI premiums, whether by annuity deduction, direct remittance or State buy-in. Various special situations are also covered, including delayed premium collection, recovery of unpaid premiums, refunds of excess premiums, and premium collection after termination.

3.7.2 Effective Date of SMI Premium Increase

Prior to 1983, the Secretary of Health and Human Services (HHS) was required by law to determine and publish in December of each year the monthly SMI premium applicable for the 12 month period beginning with the following July.

Due to the enactment of SS Act Amendments of 1983 (P.L. 98-21), the SMI premium is determined and published in September of each year to be effective for the following January. The regularly scheduled rate increase effective July 1, 1983 was delayed until after January 1, 1984 to conform with the new law.

3.7.3 Computation Of SMI Premium

- A. Standard or Basic Premiums - The supplementary medical insurance program is voluntary. Enrollees pay a monthly premium. This premium does not cover the entire cost of the program. The remaining cost is subsidized by the Federal government from general revenue funds. Over the years, as program costs increase, the portion paid by the enrollee is reevaluated.
 1. Premiums Prior to January 1989 - The law from 1966 through June 1973 had, basically, provided for the premiums to be set at one-half of program costs per aged beneficiary. Because of concern with the increasing financial burden which the premium could present with the program costs rising each year, Congress provided that, effective in July 1973, the SMI premium would be the lower of one-half of program costs for the aged, or the current premium increased by the same percentage by which social security benefits had been last increased. However, the increase in program costs did not level off. They continued to run so far ahead of benefit increases that there was never any year during which the program costs were the lower figure. Thus, program costs increased and the enrollee paid a decreasing share of them. In 1983, less than 25 percent of costs were met through the beneficiaries' premium contributions.

To improve the financial soundness of the medical insurance program, various laws were enacted that had the effect of limiting the SMI premium to 25 percent of the program costs per aged enrollee, with no consideration to be given to the cost of living rate increase in Social

Security benefits. The first month this premium limit went into effect was January 1984.

The basic premium rate applies to individuals:

- who are subject to automatic enrollment (see RCM 3.4.50); or
 - who enroll in their IEP or "deemed IEP" (see RCM 3.2.48) and who have continuous coverage; or
 - who enroll no more than 11 non-enrollment months after the last months of the IEP; or
 - whose premiums are paid under a State buy-in agreement;
 - who have terminated and reenrolled within 12 months after the last month of State buy-in coverage; or
 - who were enrolled based on disability with a penalty rate upon attainment of age 65; or
 - who enroll when coverage under a group health plan (GHP) ends.
2. Premiums Beginning January 1989 - The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) established expanded Medicare benefits, commonly referred to as catastrophic coverage. To help finance the expanded coverage, the law provided for a Part B catastrophic monthly premium. Effective January 1989, this catastrophic premium was added to the basic premium. The catastrophic premium rate varied according to place of residence, with residents of Puerto Rico paying one rate; residents of Guam, American Samoa, U.S. Virgin Islands and Northern Mariana Island paying another rate; and residents of all other locations paying a third rate. (See RCM 3.1 Exhibits 2.1, 2.2 and 2.3 for specific rates.)

The law also provided for escalating prescription drug coverage beginning January 1990. A prescription drug premium was established to finance this coverage. In 1990, this prescription drug premium was to be implemented for residents of Puerto Rico and other U.S. Commonwealth/Territories. It was to be added for everyone else in 1991. The prescription drug premium varied according to place of residence.

In cases of change-of-residence, the new premium rate was to be effective with the first full month of residence.

The 1988 Act set the catastrophic premium and drug premium rates for the years 1989 through 1993. After 1993, the rate was to be indexed

according to data on (a) program costs and premium revenues in the second and third preceding years (with an adjustment for recent trends in the consumer price index; and (b) actual shortfalls in reserves.

Note: The Medicare Catastrophic Coverage Repeal Act of 1989 retracted the major provisions of the 1988 Medicare Catastrophic Coverage Act, including both the outpatient drug benefit and the out-of-pocket limit. QMB benefits were retained.

- B. Variable Premium - Effective January 1989, an individualized SMI premium can be computed for railroad retirement recipients if the annuity is paid under the railroad formula, and certain conditions as explained in B.1 below are met. The individually computed amount is called the variable SMI rate. The variable rate is computed using the base SMI premium before penalty surcharge. The variable SMI provision has applied to pure SS cases since 1986.

At the time a COL increase is applied to an annuity, it is also determined if the variable SMI rate will apply. See Appendix D for a detailed description of the conditions which will cause a variable rate to apply.

If a variable rate is established, it remains in effect until the next COL increase, unless there is an error in the determination or calculation process, or a State assumes premium liability. If it is initially determined that a variable rate does not apply, that decision will not be reversed, unless the annuitant questions his or her SMI rate, and a review indicates an error or processing delay.

1. Determining If The Variable SMI Rate Applies - The variable SMI rate should be computed when these three conditions are met:
 - The increase amount of the net "base SMI premium rate" is greater than the December net Tier 1 plus SS benefit minus the November net Tier 1 plus SS benefit. For pure SS cases, compare the December SS benefit to the November SS benefit. (The amount to compare in a pure SS case is the benefit amount before work deductions, overpayment reductions, attorney fee deductions, garnishment withholding, installment payments, and alien taxation.); and

NOTE: The reference to "base SMI premium increase" means the difference between the annuitant's December SMI premium amount before penalty surcharge (variable or table rate) and the January table rate is computed, the penalty surcharge amount at the table rate is added back in to get the total SMI premium deduction.

 - A Tier 1 or SS LAF E benefit payment for November must be received (or held because of code 98 status) in the December calendar month. A SMI premium must be deducted from this payment. If the annuitant was in direct bill status because his railroad annuity was too small to deduct SMI and we

were not able to deduct SMI from the SS LAF E benefit this condition is also met; and

- A Tier 1 or SS LAF E benefit payment for December must be received (or held because of code 98 status) in the January calendar month. A SMI premium must be deducted from this payment. If the annuitant was in direct bill status because his or her railroad annuity was too small to deduct SMI and we were not able to deduct SMI from the SS LAF E benefit, this condition is also met.

The variable SMI premium is computed on Form G-700 "Variable SMI Computation Worksheet" when the above conditions are met. Form G-700 instructions, along with a detailed description of the situations which make the variable SMI rate applicable, are in Appendix D. The variable premium amount can never be less than the "old December base premium" amount. Beginning with the December 1988 COL, the "old December base premium" is \$24.80. The only exception would be few SS pure cases where the variable rate applied in 1987. In such cases, the "old December base premium" could be \$17.90 or the variable premium established in the 1987 COL.

2. Retroactively Changing The SMI Rate (Variable Or Not Variable) Once Established - Retroactive changes in an annuitant's Tier 1 or SS (LAF E or C) benefit will not cause a recomputation of the variable SMI rate. In other words, retroactive adjustments such as an AERO recomp, family change, changes to the SS offset amount, etc., have no effect on the SMI premium once established.

If there is a break in SMI entitlement or benefit entitlement after the variable rate determination has been made, the annuitant keeps the SMI premium as established if the SMI entitlement or benefit entitlement resumes before the next COL increase.

C. Basic Rate - The basic premium rate applies to individuals:

- who are subject to automatic enrollment (see 3.4.50; or
- who enroll in their IEP or "deemed IEP" (see 3.2.48, and who have continuous coverage; or
- who enroll no more than 11 non-enrollment months after the last month of the IEP; or
- whose premiums are paid under a State buy-in agreement; or
- who have terminated and reenrolled within 12 months after the last month of State buy-in coverage.

- D. **Penalty Rate** - Under the law, SMI premiums must be increased by 10 percent over the basic rate for each 12 months an individual could have been, but was not enrolled in SMI.

Prior to April 1, 1981, an individual was limited to two lifetime enrollments in SMI, and after the expiration of his or her IEP, an individual could only enroll during a GEP (January – March of each year). P.L. 96-499 amended the law effective April 1981 by eliminating the two enrollment limitation and by allowing open enrollment in any month with coverage beginning the first day of the third month after the month of enrollment.

P.L. 97-35 amended the law further by eliminating the open enrollment provision. Effective October 1, 1981, SMI enrollment after the close of an individual's IEP can only be processed during a GEP, i.e., January 1 through March 31 each year. Elimination of the two enrollment limitation was not affected by P.L. 97-35 and individuals may still enroll any number of times after terminations.

These amendments altered substantially the calculation of the months to be used in determining premium increases for late and delayed enrollments. Consult the following chart in determining the number of months to be counted to compute the correct premium increase (for enrollments effective October 1, 1981 and later):

Months To Be Counted	
Initial Enrollment	Second or Later Enrollment
Add All Months in the Following Periods	
All months of non-enrollment after the last month of the IEP up to and including:	The months which elapsed after the last month of a previous period of coverage up to and including:
March of the GEP year in which the individual enrolls.	The last month of the GEP in which the individual enrolls a second or later time.

EXAMPLE: Anna Smith attained age 65 and was otherwise eligible for SMI in August 1975. She first enrolled for SMI during the 1976 GEP and her coverage began in 7-76. No premium increase applied since there were only 4 months after the end of the IEP (12-75 thru 3-76) in which she could have been enrolled but was not. SMI was terminated in 12-77. She reenrolled in SMI in the 1979 GEP with coverage beginning 7-79. She was assessed a 10 percent premium increase since there were 19 months (12-75 thru 3-76 and 1-78 thru 3-79)

counted against her. SMI was terminated effective 6-30-81, and she reenrolled for the third time in the 1982 GEP with coverage beginning 7-82. A 20 percent premium increase is assessed because there are 28 months (12-75 thru 3-76, 1-78 thru 3-79, and 7-81 thru 3-82) in which she could have been enrolled in SMI but was not.

It would not be reasonable to increase a person's premium for failing to enroll during a period when the law prevented him or her from doing so. Accordingly, no person will be subject to a premium increase for any period during which he or she was barred by the two-enrollment limitation from reenrolling. In computing the premium increase for a person who was barred under prior law from reenrolling after his or her second termination from SMI, do not count any months elapsing after the last month of the second period of SMI coverage and before April 1, 1981, the first month he or she could reenroll without regard to the two enrollment limitation.

EXAMPLE: Ken Palmer, a retired employee, attained age 65 in 9-75. He enrolled in SMI during his IEP but voluntarily withdrew effective 6-76. He again enrolled in SMI during the 1977 GEP with coverage beginning 7-77. Termination of this second period of coverage occurred effective 3-31-78. Mr. Palmer enrolled for a third time in 6-81. Counted against him in computing the applicable premium rate effective 9-1-81 are 9 months from 7-76 thru 3-77 and 3 months from 4-81 (the first month he could reenroll without regard to the two enrollment limitation) thru 6-81 (the end of the month in which he enrolled). Months from 4-78 thru 3-81 are not counted because he was barred from reenrolling in SMI by the two-enrollment limitation. Since there are a total of 12 months in which he could have been but was not enrolled in SMI, a 10 percent premium increase is applicable.

EXCEPTION: 3-Year Exclusion Rule - Prior to the 1972 amendments, an individual could not enroll for the first time unless he or she did so in a GEP beginning no later than 3 years after the end of his or her IEP. An individual could not reenroll unless he or she did so in a GEP beginning no later than 3 years after the last day of previous SMI coverage.

Effective January 1, 1973, this restriction was eliminated. No person is subject to a penalty increase for any month in which he or she was barred from enrolling due to the 3-year limit on enrollment and reenrollment. Therefore, for persons

1. who are enrolling for the first time after 1972 whose IEP ended in or before 1969, or
2. who are reenrolling after 1972 whose previous period of coverage ended in or before 1969,

do not count any months elapsing after the last GEP available to him or her under the law in effect prior to the 1972 amendments and January 1,

1973 (which is the first month he or she could reenroll without regard to the prior limitations).

See RCM 3.1, Exhibits 3, 4 and 5 for a complete list of basic and penalty premium amounts since July 1, 1966.

3.7.4 Months For Which Premiums Are Due

A premium is due for each month of SMI coverage, beginning with the first month and continuing for all months of coverage, including each month in the grace period. A premium is due for the month of death (if SMI coverage was not previously ended) even if the enrollee dies on the first day of the month.

3.7.5 Methods Of SMI Premium Collection

SMI premiums are collected by one of the following methods:

- Deduction from annuity
- Direct remittance - either by enrollee or by a third party
- State buy-in.

3.7.15 Deduction From Annuity

The purpose of deducting premiums from the annuity is to help keep collection costs at a minimum. For this reason, the annuitant does not have an option to pay his or her premiums by direct remittance when annuity payments are in force. Collection must be made from the annuity unless the annuitant is covered under a State buy-in agreement.

3.7.16 Priority Of Deductions

The deduction for payment of SMI premiums has priority over any other claim against the annuity. The amount of any premium currently payable or overdue must be deducted before recovery of any overpayment of annuity, RUIA benefits or SS benefits.

3.7.17 Premium Deductions

A. Establishing the HI Record

The HI record must be established, and clearance received, before SMI premium deductions can be started. Check the file for an HI clearance referral, the MIRF (MIRTEL file), or MOLI for a cleared status. See RCM 3.4 for more information on the establishment of the HI record.

B. Mechanical Initiation of Premium Deductions

1. Attainment Cases - Premium deductions are started mechanically through the SMI Recert program. If the case is in PREH in time for the monthly search for attainment cases (see RCM 3.4.2) or if the record is screened and clearance received, deductions will be started in the month of attainment or shortly afterwards.
 2. GEP Enrollments – Forms G-44 are mechanically prepared for release in January of each year to all QRRBs who are eligible for enrollment in the GEP. Processing of the returned Forms G-44 by MS will effect automatic deduction of premiums beginning with the July 1 check. See RCM 3.4.50 for more information on the processing of GEP cases.
 3. Initial Awards - Neither RASI nor SURCAL will deduct SMI premiums from an initial award. RASI does send a screening request as part of its initial processing of a case in which the applicant is age 64 and 6 months or older. In initial SURCAL cases and cases dumped from RASI before a screening request is released, it is necessary to prepare a MEDCOR activity release a G-810 to screen the record if the applicant is age 64 and 6 months or older. Premium deductions will be started mechanically in these cases, after clearance is received and after the initial or partial accrual check has been released. Deductions will be started effective with the later of:
 - the SMI effective date, or
 - the month after the last month for which premiums were paid by direct remittance.
 4. SMI Recertification Program - Each month, the MIRTEL record is matched against the Checkwriting Integrated Computer Operations (CHICO) record to make any required adjustments in the annuity rate. These adjustments are made as a result of the attainment processing, GEP enrollments, annuity reinstatements, current termination actions, MEDCOR activity processing, and State buy-in accretions and deletions. SMI premiums will be deducted from RR annuities whenever possible. However, if SMI deductions were initiated in pure SS case, the deductions remain on the SS benefit even when the RR annuity becomes payable; if an RR annuity is less the premium amount, the SMI premiums are deducted from the SS benefit; or if the RR annuity is suspended, the deductions are "floated" to the SS benefit.
- NOTE: SMI premium deductions remain where they are initiated unless that benefit is suspended, terminated or reduced to the level where deductions can no longer be made.
- a. One-Month Adjustment - These include all current types of activity (i.e., when the activity is effective in the month of processing.)

Retroactive State buy-in accretions are also one month recert actions with a refund made on a separate check.

- b. Multiple Adjustments - Multiple adjustments are made when the activity processed is retroactive. The program determines the amount of premiums to be deducted and adjusts the payment accordingly. The maximum which can be deducted for non-State buy-in adjustments is five months of retroactive premiums plus the current month and the maximum for State buy-in deletion adjustment is three months of retroactive premiums plus the current month or 50% of the payment accrual. The payment accrual is either the RR or the SS payment amount where deductions are initiated, not the combined RR and SS payment amount. If the premiums due exceed these guidelines, the system will make a one month adjustment and produce an arrearage referral for manual handling. See RCM 3.2.98 – RCM 3.2.105 for further information.

3.7.18 Preparation Of Awards - General Guidelines

Whenever certifying a manual award (either initial, reinstatement, recertification, or reinstate - recert), always check the SMI enrollment status (folder record, MOL, or MIRF) to determine whether or not an HI record has been established.

- A. No HI Record Established - Complete a MEDCOR activity to screen and set up the HI record as discussed in RCM 3.4. Pay the award, premium deductions will be mechanically started after clearance is received.
- B. HI Record Has Been Established - Check the SMI paid through date to determine if accrued premiums are due. If:
 - 1. the paid through date is the current month or a future month, pay the award. Premium deductions will be mechanically started; or
 - 2. the paid through date is past, deduct all unpaid accrued premiums including the month after the accrual month and prepare a MEDCOR activity to correct the SMI premium paid through date in MIRTEL.

3.7.19 Delayed Premium Collection

Refer to RCM 3.2.105.

3.7.20 Annuity In Suspense At Time Of Enrollment

When the RR annuity is in suspense at the time of enrollment and there is no SS benefit payable, the enrollee is billed direct.

3.7.21 Suspension After Premium Deduction In Force

When an RR annuity or SS benefit that had SMI deductions is suspended, the MIRTEL system will check to determine if there is another payment still in pay status at an amount that is large enough to deduct the SMI premium. If so, MIRTEL will cause an adjustment to CHICO to begin deductions from the annuity or benefit that is still in pay status. When the suspended payment is reinstated, the SMI deduction will not "float" back. It will continue to be made from "the other" payment until a suspension, termination or reduction in the payment amount makes it necessary to "float" the deduction.

EXAMPLE: An annuitant is receiving both a RR annuity and a SS benefit. The SMI deduction is being made from the RR annuity. The RR annuity is suspended. Later in the month, in the SMI Recert run, the MIRTEL system will (1) recognize the RR suspension, (2) test to see that there is an SS benefit in force, (3) test to verify that the SS benefit is larger than the SMI amount and (4) begin the SMI deduction from the SS benefit.

- A. To Recover An Overpayment - When an annuity is suspended to recover an overpayment and there is no "other benefit" payable from which the premium can be deducted, the SMI premium is considered paid by deduction from the annuity. Apply only the balance of the annuity against the overpayment. Complete a MEDCOR activity to prevent year-end billing if the annuity is not to be reinstated by the end of the current calendar year or if it will be reinstated with an accrual ending after the December cut-off. (Refer to RCM 3.3.)

EXCEPTION: MS may start quarterly billing in an overpayment case if the recovery period will last a long time. Before reinstatement, examiners should check MOLI to determine the paid-thru date.

- B. Other Suspension - If the annuity is suspended for a reason other than to recover an overpayment and no other benefit is payable, collect premiums according to one of the following methods:
1. Reinstatement Expected In Current Year - If it is apparent that payment can be reinstated within the current calendar year, collect the overdue premiums at the time of reinstatement. If the annuity will be reinstated with an accrual extended after the December cut off, prepare and release a MEDCOR activity code "61" at the time of suspension to prevent year end billing.
 2. Annuity Payments May Not Resume Within Calendar Year - If it appears that annuity payments cannot be reinstated before the end of the calendar year, enclose Code Paragraph 977 with the suspension letter. This paragraph tells the beneficiary that he or she may pay premiums on a quarterly basis and that if he or she does not submit regular payments

during the year, we will bill immediately after the end of the year for all premiums due for the past year.

When completing this paragraph, show the months for which premiums should be paid to place the beneficiary on a regular quarterly billing cycle (not necessarily a calendar quarter cycle). Ordinarily, this will be the next three succeeding months after the last month for which a payment was released.

EXAMPLE: The last payment released was dated October 1 and covered benefits due for September. The premium deduction was for October. Code paragraph 977 would show "November through January."

Request any overdue premiums. If the individual makes a direct remittance as a result of this letter, regular quarterly billing will begin. Delinquency notices will not be released to such persons during the calendar year.

3.7.22 Constructive Awards

Prepare a MEDCOR activity to initiate clearance in constructive award cases. Use code "03" (Annuity in Suspense) for the Record Status. Add Code Paragraph 977 to the award letter, as described in RCM 3.7.21.

3.7.23 Year End Billing

Enrollees Included In Year-End Billing - If a suspended annuity is not reinstated by the December cut-off, the enrollee will be billed early in January unless action is taken to prevent the billing.

Year-end bills should not be released if:

- The annuity is being withheld to recover an overpayment. (The monthly SMI premium is considered to have been paid by deduction from the annuity. Therefore, only the balance of the amount of the annuity, after the premium deduction, can be considered in the offset of any overpayment of annuity, RUIA or SSA benefit); or
- The annuity was suspended for a reason other than to recover an overpayment, and it will be reinstated with an accrual ending later than November 30.

3.7.25 General

SMI enrollees not entitled to monthly benefits, or entitled to monthly benefits but the rate is zero or less than one month's premium, and not covered by a State buy-in agreement, pay their premiums by direct remittance. The premiums need not be paid by the enrollee himself. Many individuals are covered under a group payment arrangement until they become annuitants. In other situations, a relative, friend, or

fraternal organization may pay the premiums. Annuitants who are not currently in pay status due to a suspending event, and who will not be reinstated in the current taxable year, are included in the year-end billing. This procedure is described in RCM 3.7.23.

New enrollees who may pay their own premiums are generally billed quarterly (not necessarily a calendar quarter). About the first day each month, computer-generated premium notices (Forms G-800) are prepared and forwarded to the Medicare Section for processing. Initial bills cover the current quarter plus any unpaid months in the current coverage period. Enrollees may make their remittance by check or money order. Tracer bills are released if payment is late. If payment is not received by the last day of the grace period, a termination notice is released and coverage is terminated. For a detailed description of the direct payment operation, see RCM 3.10, processing Direct Premium Payments.

Enrollees on direct bill may want their Medicare jurisdiction transferred to SSA since they may be receiving monthly payments from SSA from which premiums could be deducted. However, once we have established jurisdiction over Medicare deductions, we do not transfer jurisdiction to SSA as long as the enrollee remains a QRRB. In addition, Medicare jurisdiction that is already established at SSA should be transferred here if the person is entitled to a benefit from the Railroad Retirement Board, with one exception. If a person is entitled to non-disability monthly railroad retirement payments and is also entitled to a DIB, CDB or DWB and early Medicare coverage at SSA, SSA will maintain jurisdiction over Medicare until the person attains age 65.

3.7.26 Processing Miscellaneous Premium Amounts

Although the direct payment system is based on a quarterly basis, miscellaneous amounts are processed to accommodate enrollees.

- A. Monthly Payments - At or after the time of enrollment, the enrollee may ask to pay monthly basis despite the extra expense and inconvenience of such frequent payments. In such a case, advise the enrollee that though he will be billed initially on a quarterly basis and must pay the full amount in each quarter, he may pay the quarterly premium in one, two, or three installments. When the enrollee pays only part of the amount due, a premium notice (G-801) is released for balance due. The original grace period still applies and the balance due must be paid by the end of the grace period.

An enrollee who demonstrates the need for making monthly payments will be allowed to pay on a monthly basis with a 90-day grace period for each month's premium.

- B. Payment in Large Installments - Payment for any number of quarters will be allowed and properly credited to the enrollee's account.

3.7.30 State Buy-In

The SBI Program was enacted in the Social Security Amendments of 1965 and was effective concurrently with Medicare on July 1, 1966.

Under the SBI Program, States may enroll certain groups of needy people under the Supplementary Medical Insurance Program (also referred to as SMI or Medicare Part B) and pay their premiums. (In some situations, the State may also enroll an individual for Medicare Part A.) The purpose of SBI is to permit the State, as part of its total assistance plan, to provide Medicare protection to certain groups of needy individuals. It also has the effect of transferring some medical costs for this population from the Title XIX Medicaid program, which is partially State financed, to the Title XVIII Medicare program, which is funded by the Federal Government and individual premiums.

Generally, a SBI group could include certain individuals who are entitled to cash assistance or "deemed" cash assistance for Medicaid eligibility purposes, and who also meet the eligibility requirements for Medicare coverage.

NOTE: "Deemed" cash recipients are those individuals who lose their eligibility for cash assistance because of an increase in their Social Security benefits, VA benefits or earnings. Congress determined that in certain cases, medical assistance should be provided for these individuals as if they were entitled to cash assistance. Therefore, the State pays the Medicare Part B premiums for these individuals.

Each State has its own annual income and resource level for determining whether an individual is eligible for Medicaid cash assistance or "deemed" cash assistance under the State Welfare program. Generally, a person who meets the State eligibility requirement for Medicaid also meets the requirement for the Medicare SBI Program.

Effective January 1, 1989, the Medicare Catastrophic Coverage Act of 1988 (MCCA) mandated that the State Medicaid programs cover a new category of individuals known as Qualified Medicare Beneficiaries (QMBs) for payment of monthly Part B premiums. These individuals exceed the State's annual income or resource level for cash payments or "deemed" cash payments. The legislation requires, in part, that the States pay the monthly Medicare Part A and Part B premiums for the QMBs. The States determine QMB eligibility. The States pay the Medicare Part B premium for the QMBs through the Section 1843 SBI Enrollment Program. Section 1843 of the Social Security Act is limited to Part B enrollment and the payment of monthly Part B premiums. It does not apply to premium Part A. The States pay Part A premiums, instead, through the group payer arrangement.

A State is not required to modify its SBI Agreement solely to incorporate QMBs as a coverage group. QMBs are deemed to be included in all existing SBI Agreements in the 50 States and the District of Columbia because of the MCAA.

The monthly Part B premium paid by the States on behalf of QMBs qualifies for the Federal Medical Assistance Percentage (FMAP). In order for an individual to be eligible as a QMB, he must be entitled to Medicare Part A.

An individual's enrollment under a SBI Agreement is involuntary. The State may enroll the individual even though he/she does not wish to enroll, or has enrolled individually. An individual cannot voluntarily terminate SBI coverage.

When an application for Medicare is taken, the individual should be advised about QMB eligibility requirements. The annual income or resource level for QMB eligibility is subject to change each year. The income level for the specific year is found in the Medicare & You handbook.

3.7.31 Eligibility and Entitlement Requirement

SBI coverage groups include all individuals eligible for SMI enrollment who are receiving or are eligible for a category of assistance under Medicaid as specified in the SBI Agreement, or are reported by the State to be a member of its coverage group. The State pays, on behalf of each individual who is enrolled, the premium charge to which one enrolled in the initial enrollment period would be subject. In order to be eligible for SBI, an individual must first be eligible to enroll in SMI.

3.7.32 The Buy-In Agreement

Any State which desires to participate in the buy-in program has to have signed a Buy-In Agreement with the Secretary of Health and Human Services specifying the categories of Medicaid recipients for whom it wishes to buy-in.

- A. Buy-In Agreement Prior to January 1, 1974 - The States made all Medicaid eligibility determinations and thus were responsible for all accretions and deletions in the buy-in program.
- B. Buy-In Agreement After December 1973 - When the Supplemental Security Income (SSI) program was implemented in January 1974, the States were given the option of entering into a "1634 Agreement" with SSA. The 1634 Agreement, which derives its name from the section of the Social Security Act, authorizes the Secretary of Health and Human Services to determine Medicaid eligibility for the aged, blind, or disabled based upon the individual's entitlement to SSI benefits or federally administered State supplemental payments.
- C. SSI Automatic Accrete (Auto-Accrete) States - A number of States entered into 1634 Agreements and as a consequence became auto-accrete States for purposes of SBI. Each month, SSA transmits data exchange records for SSI recipients to CMS's buy-in system. Based upon information contained in the data exchange records, CMS accretes or deletes individuals to the SBI Master File, commonly referred to as the Third Party File.

- D. SSI Alert States (209.b States) - States that did not enter into 1634 Agreements are referred to as "Alert States" or "209.b" States for purposes of SBI and they continue to make their own accretion and deletion eligibility determinations. These States can use the SSI standards under Title XVI or a more restrictive eligibility standard. The "Alert States" or "209.b States" which use the SSI eligibility standards for Medicaid determinations generally require only a signed State Medicaid application after the individual has filed for SSI. Those States which opted to use a more restrictive standard for Medicaid eligibility require a complete State application regardless of SSI status. When the data exchange records for SSI recipients residing in "Alert States" are transmitted from SSA to CMS, CMS prepares accretion or deletion alert records. The accretion and deletion alert records are transmitted to the States for appropriate action.
- E. A State must notify the Social Security Regional Office in writing if it wants to enter into a 1634 Agreement or terminate an existing agreement. The Social Security Regional Office will contact the CMS regional office so that a realistic time frame can be established for the change. Modifications are required in the Third Party System whenever a State enters into or terminates a 1634 Agreement.

NOTE: Refer to the Appendices section for the SBI Coverage Chart which shows a list of States with "1634 Agreements" and whether the State is an "accrete" or "alert" state. Those using SSI standards but making their own SBI determinations are shown as alert*. The chart reflects changes since December 31, 1973, including agreements entered into, or expansion of coverage made as permitted by statute, based on a request made during 1981.

3.7.33 Effect of the SSI Program on Coverage Groups

The SSI program which became effective January 1, 1974, replaced the State administered Titles I, X, XIV, and XVI (each Title provides aid for the blind and/or disabled) which formed the basis for SBI coverage groups between July 1, 1966 and December 31, 1973. The federally administered Title XVI (SSI) is effective in the District of Columbia, the Northern Mariana Islands and the 50 States. The State administered Titles I, X and XIV remain in effect in Puerto Rico, Guam and the Virgin Islands. With the implementation of the SSI program, the description of the coverage groups were changed as follows:

- A. Coverage Groups Prior to January 1, 1974
1. Individuals receiving money payments under a plan of the State approved under Title I or Title XVI.
 2. Individuals receiving money payments under a plan of the State approved under Titles I, X, XIV, XVI or Part A of Title IV.

3. Individuals eligible for medical assistance under a plan of the State approved under Title XIX.

B. Coverage Groups after December 31, 1974

1. Individuals receiving SSI under Title XVI or a State supplement (whether or not federally administered) who are categorically needy under the plan of the State approved under Title XIX (Medicaid).
2. Individuals receiving SSI under Title XVI, a State supplement (whether or not federally administered) or money payments under a plan of the State approved under Part A of Title IV (Aid to Families with Dependent Children) who are categorically needy under the plan of the State approved under Title XIX (Medicaid).
3. Individuals eligible for medical assistance under a plan of the State approved under Title XIX (Medicaid).
4. Enrollment of QMBs in State Buy-In.

3.7.34 When A SBI Period Begins

- A. If CMS makes an accretion based on data contained in the SSI master record, the SBI period begins with the first month for which CMS determines the individual meets the eligibility requirements for inclusion in the coverage group. This would be the first month the person is eligible for both Medicare and SSI or a federally administered State supplement and is a resident of the State. For recipients of cash assistance - either SSI, a State supplement, or a Part A of Title IV - reported to CMS by the State, the SBI period begins with the month reported by the State as the date the individual became a member of the coverage group; i.e, the first month the person is eligible for both Medicare and cash assistance and is a resident of the State.
- B. Medical Assistance Only (MAO) recipients are the non-cash category of Medicaid eligibles. States which have included MAO in their SBI agreement have accretion and deletion responsibility for individuals who are entitled under this program. SBI coverage for these eligible individuals begins the first day of the second month in which the State makes the determination that the individual is eligible for MAO. However, SBI coverage is continuous for an individual who loses eligibility for cash assistance but whose Medicaid eligibility continues without interruption.
- C. If an individual begins to receive cash for a month earlier than the month coverage as a MAO eligible would begin, the beginning date of SBI coverage is the first month for which a cash payment was received.

- D. State submitted accretions are adjusted to a later date by CMS if one of the following conditions exists:
1. CMS's records shows that the individual does not meet all the requirements for Part B coverage (e.g., is not yet 65) on the requested accretion date.
 2. The accretion date submitted falls in the middle of a period of SBI coverage for another State on CMS's records (i.e., it is later than the accretion date and earlier than the deletion date.)
 3. The accretion date submitted is earlier than the effective date of the submitting SBI Agreement.

3.7.35 When A SBI Coverage Period Ends

SBI coverage ends with the earliest of the following events:

- A. Death - SBI coverage ends on the last day of the month in which the individual dies.
- B. Loss of entitlement to Part A Coverage - If an individual is under age 65 and loses entitlement to Part A, SBI coverage ends on the last day of the last month for which he/she is entitled to Part A.
- C. Loss of eligibility in a State's coverage group - If an individual loses eligibility for inclusion in a State's coverage group, SBI coverage ends as follows:
 1. On the last day of the last month for which he/she is eligible for inclusion in the coverage group, if the State notifies CMS within a reasonable time.
 2. On the last day of the second month before the month in which CMS receives a deletion notice which the State did not submit within a reasonable time. A deletion notice received by CMS after the 25th day of the month will be considered to have been received in the following month.

3.7.36 Termination of SBI Agreement

If the SBI agreement is terminated, SBI coverage ends on the last day of the last month for which the agreement is in effect.

3.7.37 Termination and Withdrawal of SMI After SBI Coverage Ends

When an individual's SMI coverage under a SBI Agreement ends he/she is deemed to have enrolled for SMI in his/her Initial Enrollment Period with continuing coverage and premium liability from the month after the month in which the buy-in coverage

terminates. However, SMI coverage can be terminated after SBI Agreement ends if the beneficiary files a written request for termination.

- A. Effective April 1, 1981, any individual whose SBI coverage has been terminated and who files a notice requesting termination of his/her individual SMI during the last month of buy-in coverage or during the six succeeding months will have his/her individual SMI terminated at the end of the month in which his/her notice was filed.
- B. Effective July 1, 1987, in cases where the insured individual waits more than six months after SBI coverage ends to request withdrawal for SMI, Part B coverage ends at the end of the month after the month in which he/she notifies SSA, RRB or CMS that he/she wishes to withdraw.
- C. Prior to July 1, 1987, if the individual waited more than six months after SBI coverage ended to withdraw, Part B coverage ended at the close of the calendar quarter following the calendar quarter in which he submitted his/her withdrawal request. If he/she is not receiving social security or railroad retirement benefits and he/she does not pay the Part B Premium, Part B coverage ends at the end of the month after the month in which the premium bill is sent.

3.7.38 Equitable Relief After Termination of SBI Coverage

The law was not intended to penalize individuals who had no opportunity to request termination during the last month they were covered by the State.

An individual's SMI coverage under SBI can be terminated retroactively for as many as two months before the State's notice to CMS that the individual is no longer eligible. After CMS receives notice from the State it notifies RRB of the deletion. When notification is received from CMS, RRB takes action to adjust the beneficiary's monthly payments to start premium deductions. Form RL-119d is mechanically released to the beneficiary advising him/her that the State has stopped paying SMI premiums and that premiums must now be deducted from RR or SS monthly payments.

In some cases, there may be administrative delays, causing a beneficiary to be in the third month after SBI coverage termination and owe three months SMI premiums before he/she is notified that his/her SBI coverage has been terminated. Such individuals are not required to pay more than three months of premium liability.

- A. AUTOMATIC EQUITABLE RELIEF - Whenever there is more than a three month arrearage to be collected, the program automatically applies equitable relief. In some instances, the monthly benefit is not large enough to sustain a multiple month adjustment. The system will only make a one month adjustment. The record will then be identified by the monthly system and a referral captioned "MECHANICALLY ADJUSTED-ARREARAGE DUE" will be printed. SEE RCM 3.2.95.

- B. MANUAL CHANGE OF TERMINATION DATE - If an individual was not advised by the State of the SBI deletion in or before the month of the deletion, equitable relief can be granted to allow SMI coverage to end effective with the termination of the SBI coverage (thus allowing the individual to avoid entirely any premium liability) if all of the following conditions are met:

1. The individual submits a written request to have his/her individual SMI coverage end effective with the end of SMI coverage.
2. Such request is filed within 30 days of the date of the notice informing the beneficiary of his SBI coverage termination.

EXAMPLE: SBI coverage terminated on May 31, 1992. Request for SMI termination was made on June 2, 1992. Based on date of request, the termination date of SMI coverage would be June 30, 1992.

3. The individual certifies that he/she has incurred no medical services covered under SMI during the months after SBI coverage termination. The examiner should check the appropriate common working file if and when regular Part B or out-patient Part B services were done. If the individual did receive medical services covered under SMI after the end of the buy-in coverage, SMI entitlement must continue until the end of the month in which the termination request was made (if the request is filed within 6 months of buy-in termination). No intermediate date may be selected for the termination date.

ACTION: Prepare MEDCOR Activity code 23 to process the termination. Use event code "4" followed by the date of termination. (Remember do not use the date of the request.)

- C. WAIVER - If the individual spontaneously complains that he or she cannot afford to pay one, two or three months retroactive premiums, it is possible to grant relief from even the 3 months' arrearage. MS will request the field office (F/O) to furnish Form DR-423 to the beneficiary. "Hardship" cannot be assumed without this development because the individual's loss of State buy-in presupposes an improvement in the beneficiary's financial status. MS will determine if the arrearage situation meets the criteria for waiver and will so notify the enrollee. If the waiver request must be denied, MS will advise that installment payment and partial withholding are still permissible. See RCM 3.2.95 and 3.2.96 for more information on delayed deletion from SBI rolls.

3.7.39 SBI Process

After a State determines that an individual is either eligible for the State to pay their premiums (SBI accretion), or that the State should no longer pay their premiums (SBI deletion), the State transmits the information to CMS. The State transmits this

information to CMS prior to the 25th of each month. Any other record changes are also included with the monthly transmissions of the accretions and deletions.

At the beginning of the next month, CMS processes the information received from the States. Information about accretions, deletions and other record changes are maintained on CMS's Third Party Master File (TPM), also known as the SBI file.

The TPM is CMS's master file which contains a history of all transactions transmitted by the States. After the TPM is updated, CMS transmits a file to RRB of all the transactions received for QRRB's. The file contains the accretions, deletions and other record changes for QRRB's. This file is received by RRB in the same month that CMS updated the TPM.

Generally, MIRTEL master records are updated around the 12th of each month with the file received from CMS to reflect the accretions, deletions and other record changes. If inconsistent or impossible information is received or more than one transaction is received from CMS which does not match the information on our MIRTEL master record, MIRTEL is not updated. A manual input activity referral is generated for manual handling.

The matching criteria for SBI records are as follows:

- The initial match to MIRTEL is based on claim number (and prefix for six digits or less numbers), and beneficiary symbol. Tolerances are allowed for MA, WA, CA and WCA symbols.
- If the activity matches a cross reference record, it will be coded with the RRB claim number and input into the next MIRTEL RUN. When it is processed in the following run, the activity must match on sex code. This match will be ignored if either the activity or MIRTEL contains an unknown sex code.
- If the activity matches a MIRTEL master, it is further matched and must agree on either year of birth or first five characters of given name. If this agrees, a final match is made on sex codes. The transaction will reject if either the activity or MIRTEL contains an unknown sex code.

In the same month, during the monthly processing in the MIRTEL system, an award is created for the MIRTEL master records that were updated from the file received from CMS to either stop deductions and make a refund or initiate deductions. This adjustment will take place on the individual's payment dated the following month. The SBI vouchers are:

003 - Retroactive SBI accretion (including premium refund - RR annuity

007 - Retroactive SBI deletion (including multiple premium deduction from RR annuity)

991 - Retroactive SBI accretion (including premium refund) - SS benefit

994 - Retroactive SBI deletion (including multiple premium deduction from SS benefit)

995 - Current SBI deletion (SS benefit)

3.7.40 F/O Handling of SBI Inquires Received

To secure information when contacted about a SBI accretion or deletion, the F/O will take the following actions:

- A. The F/O will check the MOLI 'SB' screen to see what SBI information is currently shown. They will also check the MOLI 'GD' screen to be sure that the sex code and other identifying information is correct.
- B. The F/O will secure all the social security and Medicaid claim numbers on which the individual may be entitled.
- C. If the SBI allegation does not agree with MOLI, the F/O can check the SBI information available on BERT on both the RRB and SSA claim numbers. If BERT confirms the SBI allegation, the field office will request MS to update the MIRTEL master.

NOTE: MS will update the MIRTEL master if BERT has the correct information. If the SBI information was found to be under an incorrect number, MS will prepare Form RL-379 to advise CMS to correct their records.

- D. If BERT does not have a record of the SBI for the enrollee, the F/O will release Form RL-380-F to the appropriate State Medicaid agency.
- E. If an inquiry is received regarding QMB entitlement, the F/O will refer the individual to the appropriate State Medicaid agency. This is necessary because a specific application is required. RRB does not make any determinations regarding the QMB entitlement.

3.7.41 State Medicaid Agency Handling of Form RL-380-F Inquiries Received

The purpose of the Form RL-380-F is to give the State Medicaid agencies the correct identifying information so the correct SBI accretion/deletion information can be quickly obtained. Correct identifying information to be used on the Form RL-380-F should be picked up from MOLI. When the State welfare agency receives the Form RL-380-F, it will:

- A. Use the identifying information on the Form RL-380-F to verify the correct SBI status.

- B. Ask the appropriate local Medicaid agency to investigate the SBI allegation if no record is found for the beneficiary.
- C. Check the inputs and reprocess with the correct data if an action was made to do an accretion or deletion.
- D. Advise RRB of status of SBI actions.

3.7.42 F/O and MS Processing of State Medicaid Agency Replies Received

When replies are received from a State Medicaid agency the F/O will take the following actions to process the replies received.

- A. If an enrollee is not eligible for SBI, the F/O will advise the inquirer accordingly.
- B. If a Medicaid application must be filed, the F/O should direct the inquirer to the appropriate State Medicaid agency to file an application.

NOTE: It might take up to 90 days for processing if an application is filed.

- C. If the State took an action under an incorrect claim number, the F/O will check BERT under the incorrect claim number. If SBI information is found under the incorrect claim number, the field office should request MS to correct MIRTEL. MS will notify CMS by releasing Form RL-379 if the BERT record needs to be corrected. If the State Medicaid agency has not indicated whether or not they are transmitting the correct number and/or correct SBI effective date, the F/O will advise them to do so.
- D. If the State's processing action will not update the TPM and BERT until a later date, the F/O will pend their files for a call-up on the 20th day of the month that the State's processing action should take effect. The F/O will check the MOLI 'SB' screen to see if the SBI information was processed. If correct information is not shown on the MOLI screen, F/O should check to see if BERT has been updated with the correct SBI information. If BERT has been updated, the field office should request MS to correct the MIRTEL master record.
- E. The F/O will send a tracer (Form RL-380F) to the State Medicaid agency if there is no reply to the initial inquiry after 60 days. The top right hand corner of the tracer should be marked "Second Request". A copy of the tracer should be sent to MS. No further action will be taken by the F/O.

When the tracer is received in MS, BERT should be checked for a State buy-in record. Since more than 60 days has passed since the initial request was released to the State Medicaid Agency, MS should immediately contact the Office of Public Engagement, Division of Ombudsman Exceptions at StateBuy-In@cms.hhs.gov. The state name should also be included in the subject line of

the email along with the inquiry status (First Inquiry, Second Inquiry ...). After 60 days or in critical cases, the DOE Director should be contacted.

- F. If the reply received from the State Medicaid agency advises that the action to accrete, correct or delete a record should have already processed, the F/O will re-check the MOLI `SB' screen to verify the information. If the record is not found or updated as advised, MS should be contacted for a re-check of BERT, and to either correct the MIRTEL master or to follow-up with the appropriate CMS regional office. No further action will be taken by the F/O.

If MS is unable to locate a State buy-in record for the beneficiary or the current record has not been updated as advised, the examiner should send an encrypted email to CMS at StateBuy-in@cms.hhs.gov, the listing of general CMS regional office contacts maintained in the Medicare Section. This listing is no longer maintained in RCM Appendix J, because the contact information changes too frequently.

NOTE: If MS is unable to resolve the case after following above procedure, or if a Congressional inquiry is involved, the examiner should e-mail a State buy-in analyst at a regional CMS office under the Office of Public Engagement, Division of Ombudsman Exceptions (DOE), explaining the issue and possible solutions. E-mail communications is the preferred method. The e-mail should be encrypted per current agency practice and sent to the following address:

StateBuy-in@cms.hhs.gov

The email should include the State name in the subject line of the email.

See RCM Appendix J for instructions.

- G. If the State's reply indicates the inquiry was referred to a local welfare office, the F/O will pend their file for an additional 60 days.

3.7.43 MS Handling of SBI Inquiries Received

If a SBI inquiry is received by MS, examiners will take the following action:

- A. Examiners will check the MOLI screen. If a SBI record is not found on the MOLI screen, examiners should check BERT under the RRB and any SSA claim numbers available.
- B. If BERT indicates there is an accretion date under another claim number and the MOLI screen does not have this information, examiners should prepare MEDCOR Activity Code 20 to update the MIRTEL master with the accretion date. If the accretion date is listed under a non-RRB claim number, the Medicare examiner will check SSA's records to verify that jurisdiction of the beneficiary's

Medicare is shown under RRB. The examiner will take appropriate screening actions if applicable.

NOTE: If the SBI information is found under an SS claim number, Medicare examiners should prepare and release Form RL-379 to CMS for them to fix the record to show RRB jurisdiction. Examiners should attach the RL-379 to an encrypted e-mail per current agency practice, and release the e-mail to the following address: StateBuy-in@cms.hhs.gov.

- C. If no SBI entitlement is found, MS examiners will refer the SBI inquiry to the F/O for their handling. Form RL-85 should be released to the inquirer by field office personnel.
- D. For Congressional inquiries, CMS' Office of Public Engagement, Division of Ombudsman Exceptions (DOE) should be contacted by e-mail at StateBuy-in@cms.hhs.gov as discussed in RCM 3.7.42 Section F above. For State buy-in communications with CMS' Office of Financial Management (OFM), Division of Premium Billing & Collections (DPBC), an electronic mailbox is available at DPBCStateBuy-in@cms.hhs.gov for the following inquiries:
 - issues relating to State buy-in program rules and regulation;
 - Part A and/or Part B premium billing and collections activity;
 - daily and/or monthly TPS State Agency Input Excel data spreadsheets;
 - and reconsideration requests for the premium liability amount shown on a Part A and/or Part B monthly bill. A CMS DPBC State Buy-in Specialist listing by region is included in RCM 3.7 Appendix J.

3.7.44 Mechanical Processing

The monthly State buy-in accretion/deletion actions are used to update MIRTEL record and are processed as Activity Code 20 "MECHANICAL". This activity is processed the same way as manual processing except that it can change SMI effective dates. A mechanical activity must pass the same matching and editing as any other type of activity. If possible, the MIRTEL record is updated with the SBI information. If not, reject referrals are produced showing "ACTIVITY 20 MECHAN". In some situations, the MIRTEL system generates an adjustment, but also produces alerts and folder notices requiring some manual handling due to questionable information in the record.

- A. DAILY REFERRALS - These referrals are produced when a SBI action is unable to process.
 - 1. No record on MIRTEL

2. Identifying data inconsistent
 3. SBI information on MIRTEL inconsistent (e.g., SBI accretion on a case with SBI)
- B. FOLDER NOTICES - These notices are generated if SBI information being transmitted shows an earlier Part B effective date than the date shown on MIRTEL.
- C. PRE-EDIT MIRTEL REJECTS - These rejects are produced for closed period adjustments and other corrections.
- D. ACCOUNTS RECEIVABLE REFERRALS - These referrals are produced if accretions are matched against an open accounts receivable item (type "30" or "35"). MS will request the folders involved and take the necessary action to recover any unpaid premiums and to set up SMI under State buy-in. (MEDCOR activity code 20.
- NOTE; If the SBI refund is used to offset an arrearage, refer to section RCM 3.7.45.A.2
- E. MECHANICAL SBI ADJUSTMENTS - These adjustments are made based on the contents of the updated MIRTEL record and are processed in the same computer run as other mechanical SMI adjustments to the check writing master record. The mechanical adjustments start or stop premium deductions, refunds premiums, if required, and releases letter RL-119d to the beneficiary.
- F. MECHANICAL EQUITABLE RELIEF - Whenever there is more than a three month arrearage to be collected, the computer automatically applies equitable relief. In some instances, the monthly benefit is not large enough to sustain a multiple month adjustment. The system will only make a one month adjustment. The record will then be identified by the monthly system and a referral captioned "MECHANICALLY ADJUSTED-ARREARAGE DUE" will be printed. SEE RCM 3.2.95.

3.7.45 Manual Handling Of Computer Reject Referrals

Upon receipt of SBI referrals MS examiners tries to handle referrals without the folder.

- A. ANNUITY IN FORCE WITH PREMIUM DEUCTIONS - SBI Accretions
1. If premiums were collected from the SBI accretion effective date, prepare MEDCOR activity code 20 or 22 and enter the SBI accretion effective date to update MIRTEL.

NOTE: The system will mechanically refund all premiums from the accretion effective date through the current processing month.

2. If premiums were not collected from the SBI accretion effective date, prepare MEDCOR activity code 20 or 22. Enter the current processing month to update MIRTEL. Premiums will be refunded from the current processing month only.

NOTE: After SBI information is shown on MIRTEL, update MIRTEL again to enter the correct SBI accretion effective date.

3. If the SBI accretion was not handled mechanically, suspend the annuity on FAST - suspension/termination on DATAQ by pressing PF7 key and completing the necessary items. Then reinstate the annuity and explain the reason for the adjustment on the ALTA award letter. If necessary, refund any excess SMI premiums. See RCM 3.7.72 and 3.7.73.

B. ANNUITY IN FORCE WITHOUT PREMIUM DEUCTIONS - SBI DELETIONS

1. If SBI deletion was not handled mechanically, prepare Form G-607 type 8 with "OSMIB" or "OSMIS" completing the necessary items. (Make sure that the zeros are slashed)
2. If the premiums are not deducted the following month, refer the case to your supervisor.
4. Determine if an arrearage exists. Remember an arrearage can only be collected for three months prior to the deletion effective date.

C. ANNUITY IN FORCE WITHOUT PREMIUM DEUCTIONS - SBI ACCRETION

1. Prepare MEDCOR activity code 20 or 22. Include the accretion effective date. Determine if any excess premiums have been paid and refund premiums is necessary. See RCM 3.7.72 and 3.7.73.
2. Prepare Form G-607 to update the benefit payment file with SMI option code 8. (See G-607 instructions RCM 9.4.)

D. ANNUITY IN FORCE WITH PREMIUM DEDUCTIONS - SBI DELETION (CLOSED - PERIOD)

1. If premiums were collected during the closed period, make a refund of premiums collected during this period. See RCM 3.7.72 and 3.7.73.
2. If MOLI shows the correct information for the latest SBI period, no other manual action is necessary. Otherwise correct the last period with a MEDCOR activity code 20 or 22.

E. ANNUITY IN SUSPENSE AND BENEFICIARY CURRENTLY IN BILL-DIRECT OR IPI STATUS - SBI ACCRETION

1. SMI Previously Elected – Complete MEDCOR activity code 20 or 22. Enter the accretion effective date. Determine if any excess premiums have been paid and refund premiums is necessary. See RCM 3.7.72 and 3.7.73.
2. SMI Not Previously Elected - Prepare MEDCOR activity code 22. Enter the accretion effective date. Determine if any excess premiums have been paid and refund premiums if necessary. See RCM 3.7.72 and 3.7.73.

3.7.50 When Premiums Are Considered Paid

In general, premiums will be considered paid if deducted from a benefit even if it is determined later that the benefit was paid in error. Premiums will be considered unpaid and due if it is later determined that the monthly benefit was not paid to the beneficiary regardless of the circumstance.

- A. Annuity Later Found To Be Not Due - If the premium was deducted from an annuity payment, the premium is considered paid even though the annuity payment for that month was erroneous. If a check was not cashed, but was returned for cancellation, see RCM 3.7.45 for instructions.

EXAMPLE: Mrs. Brown was receiving a divorced widow's annuity when she married in March 1982. The RRB was not informed of her marriage until June 1982. The last check released to Mrs. Brown was dated July 1, 1982. Her SMI premiums are considered to be paid through July 1982, even though she was not due an annuity after February 1982. When preparing a Form RR-80 to transfer SMI jurisdiction to SSA, enter July 1982 as the paid through date.

This provides the most continuous coverage to the beneficiary while the administrative transfer of Medicare jurisdiction is taking place. It also alleviates the need for a large initial premium deduction when deductions are resumed at SSA.

- B. Withheld Annuity Later Found To Be Due - If a withheld annuity is later determined to be due, consider the premium to be paid at the time the annuity was first withheld only when:

- evidence showing the annuity was due is submitted before the end of the direct billing grace period, and
- all overdue premiums for the past calendar year can be deducted from the accrual.

EXAMPLE: An annuitant reported expected excess earnings which resulted in her annuity payments being withheld for the entire year of 1976. Her premiums could not be deducted from her monthly annuity and she failed to make cash premium payments, although billed regularly for such payments. She was notified in January 1977 of her premium obligation and subsequently notified that the SMI

coverage would terminate on April 30, 1977 unless premiums were paid by that time. She failed to make any cash premium payments and her SMI coverage terminated on April 30, 1977. In 1978, she submitted an annuity report for 1976 showing she had no earnings from October 1, 1976 through December 31, 1976 and was subsequently paid her annuity for those months. Since the annual report was not submitted before the end of the grace period, April 30, 1977, and the annuitant did not make timely cash payments, her SMI coverage was correctly terminated.

3.7.51 Recovery Of Unpaid Premiums

If there are any premiums due but unpaid, including premiums for months in the grace period or the premium for the month of death, enter the unpaid premium amount on the Program Accounts Receivable system (PAR) according to RCM 3.12. Recover any unpaid premiums by whichever of the following methods is the most readily available:

- A. Adjustment of Monthly Benefits - Unpaid premiums can be recovered by withholding from any monthly benefits due to the enrollee. This includes any annuity due but unpaid at the time of the enrollee's death.
- B. Arrearage Recovery through Direct Collection Efforts – If premiums are unpaid, the Medicare Section may request payment directly from the enrollee or the enrollee's estate. PAR is used to generate request for unpaid premiums.
- C. Beneficiary Dies Before Full Recovery Is Made - When the enrollee dies and there are still premiums to be collected for some months of coverage, enter the arrearage amount on PAR and take the following actions to recover the unpaid premiums:
 1. Survivor benefits currently payable - A SMI arrearage can be recovered from an accrued annuity, lump sum death payment, residual lump sum, or monthly survivor benefits. Include paragraph 979 in the award letter.
 2. No survivor benefits currently payable - In a case where the debtor is deceased and no other individual is entitled to benefits on the same earnings record, recovery may be attempted from the estate of the deceased. See RCM 3.7.52 for instructions on estate development.
- D. Recovery From Part B by The Part B Carrier - Unpaid premiums may also be recovered from any unassigned SMI benefits due to the enrollee or the enrollee's estate. When SMI coverage is terminated for non-payment of premiums, MS will release Form RL-461, Request for Offset of Unassigned Claims to the Part B Carrier, to request recovery of unpaid premiums from any unassigned SMI benefits payable. Upon recovery, the Part B carrier will send a check payable to the RRB. This check is to be deposited in the SMI trust fund; the recovered amount should be posted to the open receivable record on PAR.

- E. Waiver - Recovery of unpaid premiums from a beneficiary or from any survivor eligible for benefits on the employee's earnings record may be waived if certain conditions are met.
- F. Uncollectible Determination - If unpaid premiums cannot be collected by any of the methods described in A through E, MS will consider declaring the unpaid amount to be uncollectible. See RCM 3.7.52 for guidelines in making uncollectible determinations in Medicare debts.

3.7.52 Action To Collect Unpaid Premiums

- A. General Rules - SMI premium arrearages not refunded directly can be recovered from RR or SS payments due the enrollee or the estate of a deceased enrollee under the Railroad Retirement Act or Social Security Act. Recovery attempts should always be made to recover a SMI premium arrearage regardless of the amount.

A record should be established on PAR for all arrearages. A Form G-363 and prints of PAR input screens should be completed as a file record of the arrearage.

Advance notice must be given before recovery actions are taken. The Medicare Section will release a PAR notice explaining the arrearage to the beneficiary. The beneficiary is requested to make payment arrangements within 30 days from the date on the notice.

- B. Actions Following Release of Request for Payment - Take the following recovery actions when an arrearage exists:
 - 1. Enter the arrearage onto PAR and based on information supplied by the referral or other file information, prepare the appropriate PAR letter to notify the enrollee of the reason for the arrearage and to request payment of the overdue premiums.
 - 2. Generally, beneficiaries are given 30 days from the date of the notice to make payment arrangement. See Section C for actions to take when the 30 days expires or a response is received.
- C. Actions at Expiration on Due Date or Enrollee Response - Take the following actions when the enrollee responds to our request for payment or when the 30 days expires and no payment arrangements have been made.
 - 1. Beneficiary Claims and Good Cause
 - a. General - When SMI coverage terminates because the individual failed to pay premiums within 90 days of the premium due date, the coverage may be reinstated if the enrollee demonstrates good

cause for his or her failure to pay in that period. The 1972 amendments to the SS Act provided a 90-day extension of the original 90-day period during which an enrollee may retain entitlement to SMI coverage by paying all past-due premiums in any case where "good cause" is a factor.

- b. Due Date For Premium Payments - The due date for premiums is ordinarily the 5th day of the quarter for which the premium is payable in the case of "direct bill" enrollees. For beneficiaries in suspense status during a year, the due date for any premiums owed for months in that year is normally February 5 of the following year.
- c. Definition of Good Cause - "Good cause" will be found where the enrollee establishes by a credible statement, not contradicted by any evidence available in file, that his or her failure to make timely premium payments resulted from conditions over which he or she had no control, such as:
 - He or she was mentally or physically unable to make a timely payment and no one was acting on his or her behalf; or
 - He or she had reasonable basis to believe payments were made because he or she had made arrangements for the payment of bills while absent from home; or
 - He or she failed to receive billing notices because they were misaddressed or were lost in the mails; or
 - Because of senility a second party took care of his or her regular bills but overlooked the SMI premiums.
- d. Good Cause Determination - An enrollee must be advised of his or her rights to have SMI coverage reinstated if he or she pays the overdue premiums in the 90-day period immediately following the SMI termination date. Since good cause determinations are quite expensive in relation to the small amount of premiums involved, the following instructions are designed to keep them at a minimum while still apprising the enrollee of his or her rights.
- Enrollee Requests Relief - If the original request for relief does not cover the facts, secure a signed statement explaining why the premiums were not paid timely. Determine whether the statement meets the good cause criteria defined in the preceding section.
- Reinstatement of Coverage - If reinstatement of coverage is in order, advise the enrollee that SMI coverage may be reinstated if premiums due up to the

end of the extended grace period are paid promptly. If payment for this period has already been made, tell the enrollee that the coverage has been reinstated and that premiums should be paid promptly in the future.

The "bill direct" cases will be reinstated under protective code "002" procedure explained in RCM 3.10. All other cases will be referred to the supervisor of the group handling adjustments to the HI records.

- Denial of Extension of Grace Period - A determination that the enrollee has not shown good cause is subject to regular appeals procedures. Any premiums paid for months after the month of termination will be refunded if the termination is upheld.
- 2. Payment Received - If payment is received, the Medicare Section will process the payment in accordance with RCM 3.10 and credit the payment to PARS record according to RCM 3.12.
- 3. Full Withholding Selected (or Applied by MS) - Take the following actions when the enrollee request full withholding. Except in option cases, if no payment or other response is received after 30 days, MS will apply full withholding to recover the amount from any benefits payable on the account.

If RR benefits are currently payable and the arrearage can be recovered from one month's benefits, MS will suspend and recover the arrearage from current payments due and enter the amount recovered on PAR.

If recovery of the arrearage will take more than 1 month or if arrearage will be recovered from an SS benefit, MS will suspend and forward to the appropriate adjudicative section for reinstatement. Be sure to set an MS call-up for 2 months after the month of expected recovery.

In 'no current pay' cases, if the beneficiary or payor does not respond to the initial notice within 30 days and no other beneficiary is in pay status on the record, current collection efforts should be terminated. Refer to RCM 3.7.52.

- 4. Installment Arrangement Selected - If the payor/beneficiary request to make monthly installment payments is approved, take the following actions:
 - a. Post the remittance to the open receivable by creating a cash document.
- When appropriate, forward correspondence for examiner handling.
 - Establish a record for the open receivable on the Installment Billing Table (INBT) for the agreed installment amount.

- b. The MS examiner or specialist will make any appropriate changes to the Medicare record.

5. Partial Withholding Selected

The MS specialist will take the following action when the Payor/Beneficiary request to have his or her annuity adjusted for more than 1 month to recover the receivable is approved.

- a. Modify the Billing Document as described in RCM 3.12.12 to change the Payor name and address to reflect the appropriate OP adjudicative section handling the adjustment as shown in the example below.
- b. If this record represents an option case, the cause code should also be changed from C01 to cause code C07.
- c. Set a MS call-up to review the case 2 months after the expected date of recovery.
- d. Forward claim to appropriate OP Section for handling.

6. Full Cash Remittance Received - If a case remittance is received for the full amount of the receivable, create case documents on PARS for the amount of the remittance according to RCM 3.12.17 or RCM 3.12.20.

7. Over-Remittance Received - If more than the amount owed is received, create a cash document as described in RCM 3.12.17 or RCM 3.12.20. Refund the excess amount in accordance with established procedures.

8. Waiver Requested - If the beneficiary request that the receivable be waived, take the following actions.

- a. Change the Waiver Request Flag to "Y" on the WAIV Table. Instructions for completing the WAIV table are located in RCM 3.12.25.
- b. Develop for waiver in accordance with RCM 3.9.25.
- c. If waiver is granted, create a cash document using the write-off Table (WROT). Instructions for this table are located in RCM 3.12.19. If waiver request is denied; release a notice to advise the beneficiary and enter date of waiver denial notice on WAIV Table.

9. Request for Additional Information - If the beneficiary requests additional information about the receivable, provide the requested information. Complete appropriate entries on the WAIV TABLE to indicate that a

review is in process. Instructions for completion of the WAIV TABLE are located in RCM 3.12.25.

10. Undeliverable Notice - Address Change Request - If a notice is returned as undeliverable, change the PAR record to show that the information is in development as described in RCM 3.12.5 and 3.12.12, and release Form G-831 to the appropriate field office to develop for a correct address.

When a corrected or changed address is received, change the PAR records to reflect correct information.

- D. Recovery of Unpaid Premiums From the Estate - If no current entitlement exists and no other method of recovery is available, MS will pursue recovery from the estate.

Note: Effective August 2008, action to recover unpaid premiums from a deceased beneficiary's estate is handled by the Medicare Section with the assistance of the Debt Recovery Division in the Bureau of Fiscal Operations. If information is developed that there is an open estate from which unpaid premiums may be collected, refer complete information related to the arrearage and the open estate to BFO-DRD.

BFO-DRD will take some or all the actions otherwise taken by the Medicare Section as described in item 2 below, and advise the Medicare Section of the results of their actions.

1. Initiating Estate Development - Take the following actions to develop estate.
 - a. Release an e-mail to the servicing field office to request estate development. The e-mail should include all identifying information, including the date of death, amount of unpaid premiums and any other information which might assist the field in their development.
 - b. Pend the case for 60 days after the request for estate development is released to the field office. Because of the limited amount of time required to file a proof of claim with the court in open estate situations, it is important that the request be traced promptly if no response is received within 60 days.
2. Handling Responses to Estate Development - When the response is received, take appropriate action as described below:
 - a. Estate is Open

If information is received that the estate is open for probate, take the following action:

1. Prepare a Form DR-0302, Statement and Proof of Claim and a Statement of Indebtedness.

Use Form DR-0302 to recover a debt when the estate of the deceased debtor is still open and there are sufficient assets to satisfy a significant portion of the debt and the administrator or executor of the estate has not made any repayment or contacted the RRB within 60 days of the notice of debt.

The Statement of Indebtedness is a detailed summary of the background of the debt and should provide the reason, period and supportive facts regarding the debt. It should be attached to all copies of the Proof of Claim. 1. Prepare the Original Form DR-0302 and Statement of Indebtedness for the clerk of the court in which the estate is to be probated.

2. Prepare a duplicate original copy of Form DR-0302 and Statement of Indebtedness for the legal representative. Label this copy "Duplicate Original" in the upper right corner.
3. Refer both copies to the Attorney adviser for Notary Public.
4. Send both notarized copies under Form G-305, Cover Memorandum for Estate Development, to the field office having jurisdiction for the location of the court for filing with the court.
5. Prepare 2 photocopies of the entire development package, one for the field office and one for the file.

- b. Estate has been Closed - If information is received that the estate has been closed, the debt should be declared uncollectible if;

1. The amount of the debt is \$1,500.00 or less,

-AND-

the amount distributed from the estate is not adequate to liquidate a substantial amount of the debt

-OR-

distribution was made more than 1 year prior to our request.

2. The amount of the debt exceeds \$1,500.00,

-AND-

the amount distributed from the estates is not adequate to liquidate a substantial amount of the debt

-OR-

distribution was made more than 3 years prior to our request.

- c. Estate was not Submitted for Probate - If no estate will be submitted for probate, the debt should be declared uncollectible.

3.7.60 When Collection Attempts May Be Terminated

If recovery of a debt cannot be made by the means listed in RCM 3.7.51 and RCM 3.7.52, MS is authorized to make a determination that an overpayment is uncollectible. Once a debt has been determined to be uncollectible, collection efforts should be terminated. Collection efforts may only be renewed in accordance with RCM 3.7.61.

- A. Definition of Uncollectible Medicare Debts - A Medicare debt will be considered to be uncollectible whenever evidence indicates no source of recovery currently exists because:
1. The individual is not currently entitled to SS or RR benefits and is not currently enrolled in SMI, or
 2. Recovery of the debt cannot be accomplished by:
 - Further active collection efforts; at least 2 tracers have been released at 30 day intervals, or
 - Full or partial withholding of a currently payable railroad annuity or supplemental annuity of the debtor or other family group member living with the debtor currently or at the time the debt was incurred, or
 - Waiver of recovery.
 3. The individual has been deceased for more than 27 months (the maximum amount of time allowed for claiming SMI) and the individual or legal representative of the estate demonstrates that the estates present and prospective inability to pay the debt.
 4. No estate can be located. The survivors, if any, should not be contacted about accepting responsibility for the deceased individual's debts unless they are in pay status.

5. The estate has been closed and the amount of the debt is \$1,500.00 or less, and the distributed is not adequate to liquidate a substantial amount of the debt or distribution was made more than 1 year prior to our request.
6. The amount of the debt exceeds \$1,500.00, and the amount distributed is not adequate to liquidate a substantial amount of the debt or distribution was made more than 3 years prior to our request.
7. The Medicare debt is the result of an incorrect Part B premium refund issued to the debtor, **and** tolerance applies to the debt. See section C. below for information on applying tolerance.

B. Terminating Collection Efforts - If an unpaid premium amount has been determined to be uncollectible, process the uncollectible determination as follows:

1. Complete a Medicare Uncollectible Determination worksheet, Form G-270.
2. Close out the debt on Program Accounts Receivable (PAR) system using the Write-Off table (WROT) as described in RCM 3.12.19. A copy of the WROT screen should be placed in the file along with the completed Form G-270.
3. If it can be determined that future entitlement might occur, use PAR write-off code (X51).

Example 1: A Medicare only beneficiary was enrolled for Part B and incurred a premium arrearage of \$115.40. The beneficiary did not respond to the initial PAR notice and did not respond to the tracer collection notices. The beneficiary's debt is reflected on the PAR "120 Day No Activity Report". Since, the beneficiary may file for an annuity at a later date, the Medicare examiner will write off the debt using X51. See RCM 3.7.61 for renewing collection efforts.

Example 2: A Medicare beneficiary was enrolled in Part B and incurred a Part B premium arrearage of \$192.80. The beneficiary is no longer in pay status, because he/she returned to work and cancelled his/her annuity application. After all appropriate collection attempts have been made, write off the debt using code X51. The beneficiary in this example may stop working and become re-entitled to an annuity at a later date. See RCM 3.7.61 for renewing collection efforts.

C. Tolerance – An incorrect or erroneous Medicare premium refund is not considered a benefit overpayment or a premium arrearage, and tolerance rules apply to recovery of the incorrect refund, In the interest of efficient administration, the Centers for Medicare & Medicaid Services (CMS) has

established a tolerance amount below which the RRB will not attempt to collect an incorrect Medicare refund. If the incorrect Medicare refund does not exceed 3 months Part B premiums at the beneficiary's rate, no recovery action will be taken by RRB.

- If a case involves multiple erroneous refunds of 3 months or less at the beneficiary's rate, the tolerance applies to the sum of the erroneous refunds. In other words, collection efforts must be initiated if the sum of all the outstanding erroneous refunds exceeds 3 months of SMI premiums at the beneficiary's rate.
- In a case involving one or more erroneous refunds and a premium refund that is due the enrollee, the erroneous refund(s) are to be offset by the premium refund due the enrollee. If the amount of the debt after offsetting the amount of the refund is equal to or less than 3 months of SMI premiums, then tolerance can be applied.
- In a case involving current action on both an erroneous refund and an arrearage, the erroneous refund is to be collected along with the arrearage.

Example: Enrollee pays \$106.00 for SMI (including a 10 percent penalty). She received an incorrect refund of \$212.00. The tolerance in this case is \$318.00 (3 times her SMI premium). Because the amount of the refund is less than the tolerance amount, we will not attempt to recover the erroneous refund from the enrollee.

Document all determinations in which tolerance is applied by completing a Form G-363M showing the calculation of the incorrect premium refund, and enter a notation similar to "No action taken to recover erroneous refund; amount does not exceed CMS tolerance amount." In addition, establish the debts on the PAR system. See RCM 3.12.17 and 3.12.20 for instructions on closing out a debt on PAR when tolerance is being applied. Use Action Out code X50 (tolerance) to close out the debt.

3.7.61 Renewal of Collection Efforts on Uncollectible Debts

The Medicare Section (MS) is authorized to renew collection efforts on uncollectible Medicare debts.

- A. When to Renew Collection Efforts - In general, MS may renew collection efforts whenever a source of recovery becomes available. If a source of recovery becomes available, forward the case to the MS for a determination. If entitlement to RR or SS benefits occurs alert the MS to consider renewal of collection efforts. The MS will renew collection efforts if any of the following occurs:
- The individual enrolls for SMI or

- The individual or a family member becomes entitled to a RR or SS benefit and is put in current pay status. Policy & Systems will run a computer program on a semi-annual basis that will match written-off Medicare PAR debts against the Checkwriting Master to look for new RR or SS entitlement. If the individual or a family member is found to be in current pay status, a USTAR referral MED-OWO will be generated for the MS to handle recovery of the uncollectible debt.
- There is an accrual payable to the individual.
- Any other source of recovery is discovered.

B. Action to Renew Collection Efforts - Take the following action to renew collection efforts on a previous uncollectible debt for any of the reasons indicated above.

1. Complete Form G-271, Medicare Uncollectible Reactivation Worksheet, for all cases. After completing step 2, place Form G-271 in the Medicare Section Authorization tray.
2. Establish a reactivated accounts receivable record on PARS as described beginning in RCM 3.12.8. The amount established must be identical to the amount on the Uncollectible file. Remember that the Payor number and the debt amount are both used to match with the uncollectible file.
 - a. REACTIVATE THE ENTIRE AMOUNT THAT IS REFLECTED ON THE UNCOLLECTIBLE FILE as described beginning in RCM 3.12.8. Be sure to use the SU, reactivated Medicare Uncollectible, transaction code or the record will not be deleted from the Uncollectible file. Also the original billing document Id number should be entered in the comments section of the reactivated billing document.
 - b. Create a new uncollectible record for the portion of the debt for which collection efforts are not being renewed as described in RCM 3.12.19.

C. Renewing Collection Efforts in Current Entitlement Cases - If you are renewing collection efforts for an uncollectible debt for which the source of recovery is current entitlement to RR or SS benefits, follow the steps below in addition to those in B above.

1. If the benefit is not in pay status, prepare a Form G-812 to request the appropriate adjudication section to withhold the debt from the accrual due. Forward the G-812 to the Retirement Benefits Division (RBD) or the Survivor Benefits Division (SBD).

Forward the Form G-271, Medicare Uncollectible Reactivation Worksheet, to authorization via the imaging system.

The adjudicative unit will prepare the award forms to recover the debt from the accrual through the current month, and return the G-812 to MS indicating the action taken.

The MS will post the recovery to PAR.

If recovery is to be made from future accruals, the adjudication section will notify the annuitant that the debt is being recovered, giving the rates due and the month payments will begin on AB-25 back letterhead.

2. If the annuity is already in pay status, the MS will notify the annuitant of the intent to recover. Give appropriate options for repayment methods.

3.7.62 Adjusting SMI and RR, SSEB, Or SS Accounts

- A. Checks Issued After the Effective Date of Suspension - When payments are suspended because of work deductions, a return to railroad employer or last person service, a payment may be returned for cancellation after the effective date of the suspension. For example, the employee returned to railroad service in February 1986 and returned his March 1, 1986 check. Because the March 1 check was not due and payable, the appropriate account must be reimbursed from the SMI Account. If the payments will not be reinstated with a large enough accrual to recover the full amount of the SMI premiums due, take the following action:
 - Request a transfer of the SMI premiums from the SMI Account to the RR, SSEB, or SS Account by preparing Form G-240. (See RCM 11 for Form G-240 instructions.)
 - Request the Medicare Section (MS) to correct the premium "paid-through" date on the MIRTEL. It should show premiums paid through the effective date of the suspension.
- B. Checks Issued After Effective Date of Termination - Determine the correct action to take in adjusting the SMI and RR, SSEB, or SS Accounts according to the following:
 - Check Terminated by Death of Enrollee (Claim in Pay Status) - The program that processes terminations also produces two death listings of cases in which SMI premiums were deducted from checks issued after the date of death. One listing reflects the cases where the SMI table rate was deducted. The other listing reflects the cases where the SMI variable rate was deducted from SS benefits. The listings are sent to MS to take the appropriate action to transfer the funds, in accordance with RCM 3.10.

- Check Terminated by Death (Claim in Suspense) - If payments were in suspense when the first notice of death is received and payments were issued after the month of death, take manual action to adjust the RR, SSEB, or SS and SMI Accounts.
- Complete Form G-240 to request a transfer of funds from the SMI Account to the RR, SSEB, or SS Account. See RCM 11 for instructions on the completion of Form G-240. Forward the G-240 to the Unemployment & Programs Support Division (UPSD.)
- Check Terminated for Reason Other Than Death - When payments are terminated for a reason other than death of the enrollee, action must be taken to assure continued collection of premiums, either at RRB or SSA. See RCM 3.5 Exhibit 1 for procedures on handling these cases.

NOTE: If RRB maintains Medicare jurisdiction for a divorced and/or remarried beneficiary, it may be necessary to delete an existing terminated CHICO record before taking action to drop and reestablish the MIRTEL record.

- C. Erroneous Report of Death - After reinstating the payments, forward a completed Form G-217 to MS with a note about the erroneous report of death.

PSD will take action to reinstate the HI records and to void the entry on monthly transfer listing of death cases. See RCM 6.4.46 for complete information.

3.7.63 Termination Of Coverage - Annuitant Under Age 65

If SMI deductions based on an erroneous date of birth are in effect, and a FAST S/T is being entered to delete premium deductions, or for any other reason, enter the correct date of birth. Unless the correct date of birth is entered, the system will automatically re-institute premium collection based on the erroneous date of birth.

3.7.70 Priority Of Payment

If an enrollee dies or voluntarily terminates his or her entitlement so that coverage ends before the last month for which he or she has paid premiums, the excess premiums may be refunded only in the following order of priority:

- Premiums Paid by a Third Party - Excess premiums paid by a third party will be refunded to the third party. The refund will be made whenever it is apparent that excess premiums have been collected.
- Living Enrollee (Voluntary Termination) - Except as provided in (A) above, refund any excess premiums to the enrollee. Make the refund whenever it is apparent that excess premiums were collected. No request for refund will be necessary because the request for termination is considered an application for any excess premiums.

C. Deceased Enrollee - Make the refund to the legal representative of the deceased enrollee's estate. In the absence of a legal representative, make the refund to the enrollee's survivors in the following order of priority:

- the surviving spouse who was either living in the same household with the enrollee at the time of his or her death or was entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of death;
- the child or children of the enrollee who were entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of the enrollee's death;

NOTE: A stepchild or stepchildren of the deceased enrollee qualify in the same class as do natural or adopted children. Remember, if the enrollee is the widow, the employee's stepchild is the natural child of the enrollee.

- the parent or parents of the enrollee who were entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of the enrollee's death;
- the surviving spouse of the deceased who was not living in the same household with him or her at the time of death, and was not entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of death;
- the child or children of the deceased who were not entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of death.
- the parent or parents of the deceased who were not entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of death.

3.7.71 When Premium Refunds Can Be Made

Refund excess SMI premiums according to the following rules:

When a Formal Claim for Refund is Not Required - A formal claim for refund is not required when:

1. Someone other than the beneficiary paid the enrollee's premiums is identified as such from our records. Where our records do not indicate that a second party paid the premiums, presume that the enrollee paid them. Assume that the person or the organization who received the premium billing notice paid the premiums. Proof of payment is not required unless a question is raised regarding whose funds were used to pay the premiums. If the amount of the payment in question is less than \$25.00, a signed statement will be sufficient.
2. The refund can be added to a survivor's benefits payable.

3. The file establishes that there is a legal representative of the enrollee's estate, and contains sufficient identifying information to make payment to the representative. If the file does not establish that there is a legal representative, assume that there is no legal representative.
4. If a refund cannot be made under any of the first three conditions, a formal claim for the refund will be developed only if the amount of the refund due is equal to 3 or more months of premiums at the beneficiary's premium rate. If the amount is less than 3 months of premiums at the beneficiary's rate, make no refund until a survivor annuity becomes payable or a claim is received. However, if a request for refund is received, ask the field to secure a Form AA-21 and required proofs regardless of the amount. Documentation related to the refund should be imaged and detailed remarks entered on USTAR.

3.7.72 How a Refund is Made

The Medicare Unit(MU) issues Medicare premium refunds through the Medicare Payment System (MPS). See RCM 3.13.89 for instructions on completing a Medicare premium refund through MPS.

3.7.73 Premium Refund Proofs for Imaging

In order for the Medicare Unit (MU) to determine if a premium refund should be made, various external and internal agency informational sources must be reviewed. In premium refund cases where the information used to adjudicate the refund is not maintained and cannot be retrieved or recreated from the original source, the MU examiner or authorizer will assemble the supporting documentation as paper documents for scanning into the imaging system after the premium refund is processed and, if necessary, authorized. If the documents prove or support why a premium refund should **not** be made, the documentation should still be prepared for imaging.

A. The MU examiner or authorizer will package the following items for imaging as a single document with multiple pages in the order shown below :

- MEDREF or DAISY referral(s)
- MOLI DB screen(s)
- Form(s) G-363M, Payment Summary

Include Form G-363M only if the adjudication action results in a refund. If no refund is to be paid, image Form G-363M as a separate document.

- Correspondence

Correspondence includes but is not limited to: letters from beneficiaries, e-mails, memorandum, file notes, copies of checks, information from other

RRB organizations (Policy & Systems, Program Evaluation Section) or from other agencies, such as the Centers for Medicare & Medicaid Services.

B. If authorization is not required, the MU examiner will take the following actions to assemble the document. If authorization is required, the authorizer will assemble the documents:

- If a piece of correspondence is smaller than 8 ½" x 11", tape it to a blank piece of 8 ½ "x 11" paper. Apply tape on the left and right sides only.
- If a piece of correspondence has information on both sides, xerox one side and include it in the package in the order it should be in.
- Staple the package with one single staple in the upper left corner. Remove all other staples.
- Write the form type, i.e. "PREMIUM PYMT PROOFS," in the upper right corner of the first page of the stapled document. This is not to be confused with the form type "PREMIUM PAYMENT," which is the name for packages submitted to Imaging that document premium payments posted.
- Place the stapled documents in the outgoing tray for the clerical staff to complete the routing of these documents.

C. MU clerical staff will take the following actions with the documents for imaging:

- Prepare a blue Form G-156 as the transmittal document for each group of PREMIUM PYMT PROOFS packages placed in the outgoing tray. Enter "Medicare File Only" as the scanning application on the Form G-156.
- Forward these packages to PSD-IDS by placing them in the tray for Medicare scanning applications. The tray is in PSD-IDS.

Appendices

Appendix B - SMI Premium Collection

Instructions for Completion of MEDCOR Activity to Enter Protective Code (Floating SMIB)

If Activity Code corresponds to:	Record Status Code
20 or 22	22

22	If the record status code would be 23, use <u>24</u> .
22	24

Refer to RCM 3.3 Appendix A for full completion instructions.

Entering a protective code prevents direct bill from being released.

Appendix C - Voucher Numbers for Mechanical SMI Premium Adjustments

SMI Premium Collection

RR Voucher Number	SS Voucher Number	Type Of Mechanical Activity	Comments
002	990	Recert	Aged: (Part B adjustment only) Benefits reduced by a single month deduction.
003	991	Recert	State Buy-In: (Any adjustment) Benefits increased (deductions stopped) as a result of a retroactive State buy-in accretion. Refund made.
004	992	Reinstatement/ Recert	Aged: (Part B adjustment only) Benefits reduced by a multiple month deduction, current month and up to 5 retroactive months.
006	993	Recert	Aged/Disabled: (Any adjustment) Benefits increased (deductions stopped) as a result of a refusal or voluntary withdrawal from SMIB coverage. Refund made in some cases.
007	994	Reinstatement/ Recert	State Buy-In: (Any adjustment) Benefits reduced by a multiple month premium deduction as a result of a retroactive State buy-in deletion; current month and up to 3 retroactive months.
225	961	Recert	Aged: (IRMAA adjustment only) Benefits reduced by single month deduction. Adjustment because of an initial IRMAA or increase in IRMAA. This is used for current

			month only, and for multiple months if equitable relief applies or payment amount not large enough to take all that is due and the arrearage would be handled manually.
227	962	Reinstatement/ Recert	Aged: (IRMAA adjustment only) Benefits reduced by a multiple month deduction, current month and up to 5 retroactive months. Adjustment because of an initial IRMAA or increase in IRMAA, arrearage recovered from adjustment.
228	966	Recert	Aged: (IRMAA adjustment only) Benefits increased retroactively. IRMAA decrease processed.
229	963	Recert	Disabled: (IRMAA adjustment only) Benefits reduced by single month deduction. Adjustment because of an initial IRMAA or increase in IRMAA. This is used for current month only, and multiple months if equitable relief applies or payment amount not large enough to take all that is due and the arrearage would be handled manually.
231	964	Reinstatement/ Recert	Disabled: (IRMAA adjustment only) Benefits reduced by a multiple month deduction, current month and up to 5 retroactive months. Adjustment because of an initial IRMAA or increase in IRMAA; arrearage recovered from adjustment.
232	968	Recert	Disabled: (IRMAA adjustment only) Benefits increased retroactively for disabled beneficiaries. IRMAA decrease processed.
233	969	Recert	Aged: (Part B and IRMAA adjustment) Benefits either reduced or increased by single month deduction. Special letter required.
234	970	Recert	Disabled: (Part B and IRMAA adjustment) Benefits either reduced or increased by single month deduction. Special letter required.
475	995	Recert	State Buy-In: (Any adjustment) Benefits

			reduced by a single month deduction as a result of a State buy-in deletion from current month. No arrearage due.
476	996	Recert	State Buy-In: (Any adjustment) Benefits increased (deductions stopped) as a result of a State buy-in accretion from current month. No refund due or refund is greater than 18 months.
498	997	Recert	Disabled: (Part B adjustment only) Benefits reduced by a single month deduction for disabled beneficiaries.
499	989	Reinstatement/ Recert	Disabled: (Part B adjustment only) Benefits reduced by a multiple month deduction for disabled beneficiaries, current month and up to 5 retroactive months.

Appendix D - G-700, Variable SMIB Computation Worksheet

SMI Premium Collection

Use

Use a Form G-700 worksheet to compute the variable SMIB premium deduction amount when it has been determined that the variable SMIB rate could apply. Form G-700 is available on RRAILS. The determination should be made on December vouchers, certain reinstatement vouchers in January, and on COL reject vouchers throughout the year. If any of the situations listed below exist, the variable computation could apply, so the computation should be made.

Examiners may refer cases to the Operations and Claims Analyst for computation of the variable SMIB rate. The Operations and Claims Analyst will complete Form G-700 and return the case to the examiner.

Form G-700 is available on RRAILS. Many of the items on the form will pre-fill based on other entries that are made.

A. December Manual Award Actions

1. Recertification of an RR Annuity or Pure SS Benefit

- Recertification includes partial to final, and spouse to widow conversion award actions.

- Annuitant received a November Tier 1 or pure SS benefit in December (or payment was withheld because of code 98 status) and will receive a December Tier 1 or pure SS benefit in January, and
 - SMIB premiums are deducted from both the December and January payments, (or the annuitant was in direct bill status because the railroad annuity was too small to deduct SMIB, and we were not able to deduct SMIB from the SS LAF E benefit), and
 - The increase amount of the new base SMIB premium rate is greater than the net Tier 1 plus SS benefit portion of the December benefit minus the November net Tier 1 plus SS benefit portion. (For pure SS cases, compare the December SS benefit to the November SS benefit.)
2. Reinstate and Reinstatement/Recertification of an RR Annuity or Pure SS Benefit
- Annuitant is due a December Tier 1 or pure SS benefit in January, and will also be paid an accrual for a November Tier 1 or pure SS benefit in December, and
 - The SMIB premium is paid thru December (or January) because the annuitant has been on direct bill, or SMIB deductions will be started up mechanically and premiums due will be retroactively collected.
 - The increase amount of the new base SMIB premium rate is greater than the net Tier 1 plus SS benefit portion of the December benefit minus the November net Tier 1 plus SS benefit portion. (For pure SS cases, compare December SS benefit to the November SS benefit.)
3. Initial Award Actions - For an initial RR or pure SS award where the beginning date is November or earlier, and SMIB is effective November or earlier, the variable SMIB rate will apply if:
- Annuitant will be paid a December Tier 1 or pure SS benefit in January, and will receive an accrual payment for a November Tier 1 or pure SS benefit in December, and,
 - The SMIB effective date is December or earlier, and,
 - The increase amount of the new base SMIB premium rate is greater than the net Tier 1 plus SS benefit portion of the December benefit minus the November net Tier 1 plus SS benefit portion. (For pure SS cases, compare the December SS benefit to the November SS benefit.)

B. January Manual Award Actions

There is only one situation where the variable rate determination should be made. If you are handling a RR or pure SS benefit reinstatement or reinstate/recertification on a January voucher, and the following conditions are present, the variable SMIB rate will apply if:

- Annuitant was in current pay status (including code 98 status) for the December 1 payment, and SMIB was deducted from the December 1 payment (or the annuitant was in direct bill status because the railroad annuity was too small to deduct SMIB, and we were not able to deduct SMIB from the SS LAF E benefit), and
- Annuitant was suspended (for any reason) in December, but is being reinstated (reinst/recert) with accrual for December and SMIB deduction for January will be developed by MIRTEL, and
- The increase amount of the new base SMIB premium rate is greater than the net Tier 1 plus SS benefit portion of the December benefit minus the November net Tier 1 plus SS benefit portion. (For pure SS cases, compare the December SS benefit to the November SS benefit.)

Since this can get confusing when both an RR benefit and LAF E SS benefit are payable and only one or the other gets suspended in December (and reinstated in January), the following chart should help you to determine the proper action to take:

Benefit	Status Dec 1	Status Dec	Status Jan	Variable Computation
RR LAF E	CPS CPS	SUSP SUSP	Reinst Reinst	Yes - if conditions above apply
RR LAF E	CPS CPS	CPS SUSP	CPS Reinst	COL operation determines
RR LAF E	CPS CPS	SUSP CPS	Reinst CPS	Yes - if conditions above apply

C. COL Reject Award Actions

Except for cases that reject in the RR or SS COL operations because the RR annuity or pure SS benefit was in suspense, compute the variable SMIB rate if the 3 specific conditions for a December recert action apply. (See A.1. Recertification of an RR Annuity or Pure SS Benefit in this appendix.)

For cases where the annuitant is entitled to an RR annuity only, and the annuity was in suspense at the time of the COL operation, a variable rate should not be

considered, unless the situation described in B. January Manual Award Actions exists.

For pure SS cases where the benefit is in suspense at the time of the COL operation, a variable rate should not be considered, unless the situation described in B. January Manual Award Actions exists.

For cases where the annuitant is entitled to both an RR annuity and LAF E SS benefit, and either the RR benefit or SS benefit was in suspense at the time of the COL, use the chart below to determine if the annuitant is eligible for the variable computation. If yes, compute the variable if the annuitant has been in direct bill status, or SMIB will be deducted from the accrual, and the increase amount of the new base SMIB premium rate is greater than the net Tier 1 plus SS benefit portion of the December benefit minus the November net Tier 1 plus SS benefit portion.

<u>Benefit Type</u>	<u>Status Dec 1</u>	<u>Status Dec</u>	<u>Variable Computation</u>
RR LAF E SS Benefit	SUSP SUSP	SUSP SUSP	No
RR LAF E SS Benefit	SUSP CPS	SUSP CPS	Yes
RR LAF E SS Benefit	CPS SUSP	CPS SUSP	COL operation determined
RR LAF E SS Benefit	CPS CPS	SUSP SUSP	no - unless reinstating on a January voucher
RR LAF E SS Benefit	CPS CPS	SUSP CPS	yes
RR LAF E SS Benefit	CPS CPS	CPS SUSP	COL operation determined

D. Redetermination of a Non-Variable SMIB Rate

A Form G-700 should be completed if an annuitant requests a review of his or her non-variable SMIB rate, and the case review indicates that:

- there was a computational error on the original Form G-700, or,

- if processing of a SMIB enrollment, benefit adjustment, or reinstatement would have been handled timely, the conditions in A. December Manual Award Actions or B. January Manual Award Actions would have applied.

Completion

Item Entry

1 Claim Number

Enter the claim number.

2 COL Year

Enter the year of the COL/SMIB premium increase.

3 Amount of SMIB Penalty

Enter the dollar amount of the SMIB penalty surcharge, if applicable. In order to determine the SMIB penalty amount for the COL year, use the appropriate Table in RCM 3.1, Exhibit 5. Find the applicable penalty percentage and the total premium effective with the COL year. Deduct the base premium rate from the total premium. The result is the penalty surcharge amount.

EXAMPLE: For the 2005 COL year, the base premium rate is \$78.20. A penalty percentage of 80% would yield a penalty amount of \$62.60 (i.e., \$140.80 - \$78.20).

4 Tier 1 Downward Adjustment

Indicate whether a downward adjustment to the net Tier 1 plus SS benefit is effective with December. If yes, compute a fictional November net Tier 1 plus SS benefit amount based on the December criteria.

EXAMPLE: A survivor family group changes in December, where inclusion of an additional member decreases the December Tier 1 of existing members. Compute a fictional November amount based on the inclusion of the additional member in November (using November family maximum).

NOTE: For a pure SS case, a downward adjustment effective December would necessitate a fictional November computation of the pure SS benefit. (Divide the SS benefit effective in December by the COL percentage to get the fictional November SS benefit.)

5 Total December Benefit

In the first column, enter the annuitant's net Tier 1 and SS benefit (LAF E or C) effective in December. This is the amount after COL and any other applicable

adjustment. The total of these two amounts is the total December benefit to be used in determining the increase amount from the November to December benefit, unless the annuitant is a dual annuitant. In such cases, in addition to the first column entry, enter the net Tier 1 plus SS benefit of the other railroad annuity in the second column. Add the sum of all benefits payable to determine the total December benefit.

If only an RR benefit is payable (no LAF E or LAF C), enter the net Tier 1 only. If only a pure SS benefit is being paid, enter the Monthly Benefit Credited (MBC). The MBC is found on the MOR in the "New History Data" section, or on the COLA G-805 referral.

6. Total December Benefit

In the first column, enter the annuitant's net Tier 1 and SS benefit (LAF E or C) effective in November. This is the amount that was actually paid to the annuitant on his or her December payment, (or held due to code 98 status), unless the following conditions occur:

1. The annuitant's railroad annuity was in suspense in November, and he or she did not get a December 1 railroad annuity payment. The annuity is being reinstated and railroad accrual for November will be paid as part of the reinstatement.

Use the November net Tier 1 that is represented in the accrual.

2. There is a Tier 1 downward adjustment effective with December benefit.

Compute a fictional November net Tier 1 or pure SS benefit based on the December criteria.

3. There is a Tier 1 downward adjustment effective November or earlier.

Use the downwardly adjusted November net Tier 1 or pure SS benefit.

The total of these two amounts is the total November benefit to be used in determining the increase amount from the November to December benefit, unless the annuitant is a dual annuitant. In such case, in addition to the first column entry, enter the net Tier 1 plus SS benefit of the other railroad annuity in the second column. Use the sum of all benefits payable to determine the total November benefit.

If only an RR annuity is payable, enter the net Tier 1 only. If only a pure SS benefit is being paid, enter the MBC.

7. Total Benefit Increase

Subtract the total November benefit from the total December benefit. **Enter the rounded Benefit Increase.** If the result ends in 5 cents to 9 cents, round up to the nearest dime. If the result ends in 1 cents to 4 cents, round down to the nearest dime. The result is the net benefit increase to be compared with the SMIB premium increase.

8. SMIB Premium Increase

In order to determine the SMIB premium increase, deduct the annuitant's current SMIB premium (i.e., variable or table rate), before penalty surcharge from the January base SMIB premium before penalty surcharge. The result is the annuitant's SMIB premium increase before penalty surcharge.

In order to determine the December SMIB premium before penalty surcharge, use the appropriate table in RCM 5.1, Exhibit 5. Find the applicable penalty percentage and the total premium effective with the current year. Deduct the base premium rate from the total premium. The result is the penalty surcharge amount. This amount should be deducted from the annuitant's December premium (variable or table rate) to get the premium before surcharge.

9. Compare Increases

In item 9A, enter the benefit increase from item 7. In item 9B, enter the SMIB premium increase from item 8. Check either 9A or 9B, whichever is lower. If 9B is lower, the variable rate does not apply.

10. If item 9A is lower, the variable SMIB premium will apply. Enter the annuitant's current SMIB premium (i.e., variable or table rate), before penalty surcharge. Add to it the benefit increase amount from item 9A, and any penalty surcharge amount from item 3. The result is the annuitant's variable SMIB premium.

Disposition:

- The Operations and Claims Analyst will forward the completed Form G-700 to the examiner who referred the case for computation. After taking appropriate action, the examiner should forward the completed Form G-700 for imaging.
- If the computation results in a variable SMIB rate, complete a MEDCOR Activity 22L, with the Address Screen (PF16) and Variable Part B Screen (PF14), to update MIRTEL. The Address Screen is required in order to generate notice to CMS of the new SMIB rate.

Appendix E – Addresses of State Buy-In Agencies

STATE BUY-IN AGENCIES

The listing of all State Buy-In Agencies is now located in RRAILS. Once you access RRAILS, click on the “New Case” button, then click on the “Add Contact” button. This

will bring up the Lookup Information menu. Click on the State Buy-In button. This will bring up the State Buy-In Contact Listing. This list is maintained by the Policy & Systems Medicare Unit. Requests for corrections and/or updates should be sent to the P&S Inquiry Group mailbox.

Appendix F - States With Buy-In Agreement After December 1973

SSI STATUS

AGENCY CODE	STATE	ACCRETE OR ALERT	STATE SUPP ADM. MAN ^{/25}	TITLE XIX OPT.	MA ONLY
010	Alabama	Accrete	State	State	1/1/70
020	Alaska ^{/1}	Alert*	State	State	10/1/82
030	Arizona	Accrete ^{/2}			
040	Arkansas	Accrete	Federal		1/1/70
050	California	Accrete	Federal	Federal	1/1/70
060	Colorado	Accrete ^{/3}	State	State	3/1/69
070	Connecticut	Alert	State	State	
080	Delaware	Accrete	Federal	Fed. ^{/4}	
090	D. C.	Accrete	Federal	Federal	8/1/69
100	Florida	Accrete	Federal	State	2/1/69
110	Georgia	Accrete	Federal		4/1/86
650	Guam			I,IV,X,XIV ^{/26}	7/1/68 /24
120	Hawaii	Alert	Federal	Federal	
130	Idaho	Alert*	State	State	4/1/68
140	Illinois	Alert	State ^{/5}	State	
150	Indiana	Alert	Federal		1/1/70

160	Iowa	Accrete	Federal	Federal	1/1/70
170	Kansas	Alert*	Federal		4/1/68
180	Kentucky	Accrete	State	State	
190	Louisiana	Accrete / ²²	Federal	State	
200	Maine	Accrete	Federal	Federal	4/1/68 / ⁶
210	Maryland	Alert* / ⁷	Federal	State	1/1/72
220	Mass.-DPW / ⁸	Accrete	Federal	Federal	
22A	Mass.-Blind / ⁹	Accrete	Federal	Federal	
230	Michigan	Accrete / ¹⁰	Federal	Federal	8/1/81
240	Minnesota	Alert	State / ¹¹	State	
250	Mississippi	Accrete / ¹²	Federal		1/1/70 / ²⁶⁰
270	Montana	Accrete	Federal	Federal	3/1/70
280	Nebraska	Alert	State	State	4/1/68 / ¹³
290	Nevada	Alert*	Federal	Federal	5/1/69
300	New Hampshire	Alert	State	State	
310	New Jersey	Accrete	Federal	Federal	1/1/70
320	New Mexico	Accrete	State		1/1/70
330	New York	Accrete / ⁴	Federal	Federal	
340	North Carolina	Alert	State	State	1/1/70
350	North Dakota	Alert	State	State	
360	Ohio	Alert	Federal		4/1/68
370	Oklahoma	Alert	State	State	

380	Oregon	Alert	State	State	1/1/84 / ²⁰
390	Pennsylvania	Accrete	Federal	Federal	
400	Puerto Rico				
410	Rhode Island	Accrete	Federal	Federal	
420	South Carolina	Accrete	State / ¹⁵	State	7/1/68
430	South Dakota	Accrete	Federal	State	
440	Tennessee	Accrete	Federal		12/1/69 / ¹⁶
450	Texas	Accrete			4/1/68
460	Utah	Alert	State	State	10/1/71
470	Vermont	Accrete / ¹⁷	Federal	Federal	
480	Virgin Island			I,IV,X,XIV / ²⁶	9/1/68
490	Virginia	Alert	State	State	9/1/69
500	Washington	Accrete / ¹⁸	Federal	Federal	5/1/68
510	West Virginia	Accrete	State		
520	Wisconsin	Accrete	Federal	Federal	4/1/82 / ¹⁹
530	Wyoming	/ ²³	Federal		

Footnotes:

- 1 Alaska buy-in agreement (incl. Part A of Title IV) effective 10/1/82
- 2 Arizona Title XIX plan approved 1/1/82
- 3 Colorado was Alert 1/74-11/81

- 4 Delaware Federal Adm. Opt. Supp. effective 7/74
- 5 Illinois - State Adm. of Man. Supp. effective 10/74
- 6 Maine buy-in for Title XIX MA Only terminated 8/31/74
- 7 Maryland was accrete from 1/75-4/79; alert 1/74-12/74
- 8 Massachusetts DPW included RSDI (SSA Ins.) and RRB beneficiaries receiving SSI or a State supplement under buy-in coverage effective 11/1/75. (RSDI or RRB beneficiaries receiving cash assistance under Part A of Title IV are not covered under buy-in in Massachusetts.)
- 9 Massachusetts BL - see Massachusetts DPW
- 10 Michigan was Alert from 7/75-8/76; Accrete 1/74-6/75
- 11 Minnesota State Adm. of Man. Supp. effective
- 12 Mississippi was alert from 1/74-6/81
- 13 Nebraska buy-in for Title XIX MA Only terminated effective 3/31/69
- 14 New York was alert from 9/80-7/82
- 15 South Carolina State Adm. of Man. Supp. effective 7/75
- 16 Tennessee buy-in for Title XIX MA Only Terminated effective 3/31/76
- 17 Vermont was alert from 1/74-6/74
- 18 Washington was alert from 1/74-6/77
- 19 Wisconsin included RSDI (SSA Ins.) and RRB beneficiaries receiving SSI or a State supplement under buy-in coverage effective 11/1/75, beneficiaries receiving cash assistance under Part A of Title IV are covered under buy-in effective 4/1/82, Wisconsin buy-in for Title XIX MA Only terminated effective 7/31/83
- 20 Oregon buy-in agreement (incl. Part A of Title IV) effective 1/1/84
- 21 In using the information in this column, not that a number of States which have bought in for all their medical assistance recipients under Title XIX do not provide Title XIX approved medical assistance to the medically needy. In those States, the only non-cash recipients who are eligible for buy-in (the MAO group) are non-cash recipients who are categorically needy, e.g., certain institutionalized individuals.
- 22 Louisiana buy-in agreement (inc. Part A of Title IV effective 7/1/85

- 23 Wyoming does not have a buy-in agreement
- 24 Guam buy-in for Title XIX MA Only terminated 12/84
- 25 State Supplemental administration of mandatory or optional payments to SSI recipients
- 26 Title I - Grants to States for old-age assistance and Medical assistance for the aged
 - Title IV - Part A - Aid to families with dependent children
 - Title X - Grants to States for aid to the blind
 - Title XIV - Grants to States for aid to the permanently and totally disabled

Appendix G - Summary of SBI Mechanical Processing Activity on MIRTEL

SMI PREMIUM COLLECTION

THE FOLLOWING SUMMARIZES THE MECHANICAL PROCESSING OF STATE BUY-IN ACTIVITY ON MIRTEL

SOC SHOWN ON MIRTEL	SOC SHOWN ON MOMS	MECHANICAL ACTION TAKEN ON MIRTEL
1 or 5	8	One month downward adjustment if no deletion date is shown on MIRTEL and a monthly referral is printed. "MECHANICALLY ADJUSTED ARREARAGE DUE". Otherwise, will be based on deletion date.
2, 3, 4, 6, 9	8	Monthly referral "SMI option code discrepancy".
8	2, 3, 4, 6, or 7	MOMS option will be changed.
8	9	Monthly referral "SMI" option code discrepancy.
8	1 or 5	MOMS will be adjusted if an accretion date is shown; otherwise, a monthly referral "Upward Adjustment Required" will be produced.

Appendix H - Summary SBI Accretions and Deletion Adjustments

THE FOLLOWING SUMMARIZES SBI ACCRETIONS AND DELETION ADJUSTMENTS

MECHANICAL ACCRETIONS	MECHANICAL DELETIONS
<u>MIRTEL</u> - SBI - Code 8 established	<u>MIRTEL</u> - First enrollment established
<u>MOMS</u> - Code 8 SMIB option established	<u>MOMS</u> - Code 1 SMIB option established
<u>BENE</u> - RL-119d	<u>BENE</u> - RL-119d
<u>FOLDER</u> - G-96d	<u>FOLDER</u> - G-96d
<u>PREMS.</u> - Refund if necessary from accretion date.	<u>PREMS.</u> - Deduct beginning with month after date of deletion - or 3 months arrearage whichever is less.

MANUAL ACCRETIONS	MANUAL DELETIONS
Prepare MEDCOR Activity Code 20 or 22 to update MIRTEL	Prepare MEDCOR Activity 20 or 22 to update MIRTEL
<u>MOMS</u> - Code 8 SMIB option established	<u>MOMS</u> - Code 1 SMIB option established
<u>BEME</u> - RL-119d	<u>BEME</u> - RL-119d
<u>FOLDER</u> - G-96d	<u>FOLDER</u> - G-96
<u>PREMS</u> - Will be refunded from accretion	<u>PREMS.</u> - Deduct beginning with month after date of deletion - or 3 months arrearage whichever is less.

Appendix I - Voucher Control Listings

Voucher Control Listings - Mechanical adjustments of RR and SS monthly payment are shown on the following voucher listing which are maintained in MS.

RR Annuity Payments	SS Benefit Payments
<u>003</u> Retroactive SBI Accretion including accrual premium refund.	<u>991</u> Retroactive SBI Accretion including accrual premium refund
<u>007</u> Retroactive SBI deletion including multiple deductions.	<u>994</u> Retroactive SBI deletion including multiple deductions.

475SBI deletion from month with single month deduction.	995SBI deletion from current month with single premium deduction.
476SBI accretion from current month with single month premium refund.	996SBI accretion from current month with single month premium refund.

Appendix J – CMS Contacts for State Buy-in

State Buy-in problem resolution requests that cannot be corrected through regular channels, should be sent to CMS' Office of Public Engagement, Division of Ombudsman Exceptions (DOE) at StateBuy-in@cms.hhs.gov. Below is a State Buy-in contact listing for this office. The CMS State Buy-in analyst for each region is also available by telephone for Congressional level and urgent State Buy-in issues.

Only one Health Insurance Claim Number (HICN) per request is accepted. Allow 30 business days for the resolution of a State Buy-in problem request, prior to submitting a subsequent follow-up request.

CMS' DOE accepts State Buy-in problem resolution requests in three ways:

E-mail to:

CMS State Buy-in mailbox at StateBuy-in@cms.hhs.gov.

E-mail communications is the preferred method. In order to protect sensitive Personally Identifiable Information (PII), e-mail correspondences containing PII must be encrypted per current agency practice.

Fax to: 410-786-0319

U.S. Mail to:

Centers for Medicare & Medicaid Services, Office of Public Engagement, Division of Ombudsman Exceptions, State Buy-in Workload, P.O. Box 11977, Baltimore, MD 21207

To help route the request for problem resolution, indicate 'State Buy-in' and the 'Name of the State' in the subject line of each request.

CMS' Office of Public Engagement, Division of Ombudsman Exceptions (DOE)
State Buy-in Contacts by Regions

Shirley Ross 410-786-4629

NEW YORK
New Jersey

New York
Puerto Rico (no third party agreement)
Virgin Islands

SEATTLE

Alaska
Idaho
Oregon
Washington

DENVER

Colorado
Montana
North Dakota
South Dakota
Utah
Wyoming

Val Jackson 410-786-0158

BOSTON

Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

DALLAS

Arkansas
Louisiana
New Mexico
Oklahoma
Texas

Gwen Colvin 410-786-5606

CHICAGO

Illinois
Indiana
Michigan
Minnesota
Ohio
Wisconsin

ATLANTA

Alabama
 North Carolina
 South Carolina
 Florida
 Georgia
 Kentucky
 Mississippi
 Tennessee

KANSAS CITY

Iowa
 Kansas
 Missouri
 Nebraska

Sharmaine Anderson 410-786-6871

PHILADELPHIA

Delaware
 District of Columbia
 Maryland
 Pennsylvania
 Virginia

SAN FRANCISCO

American Samoa
 Arizona
 California
 Guam
 Hawaii
 Nevada
 Northern Mariana Islands

Communications with CMS' Office of Financial Management (OFM), Division of Premium Billing & Collections (DPBC) should be sent by e-mail to DPBCStateBuy-in@cms.hhs.gov. The State name should be included in the Subject line of the e-mail which is to be encrypted according to current agency practice. The contacts for exchanging correspondence with CMS' Office of Financial Management (OFM), Division of Premium Billing & Collections (DPBC) regarding the State Buy-in program are as follows:

CMS OFM/DPBC State Buy-in Specialists by Region

Lucia Diaz-Robinson 410-786-0598

NEW YORK

New Jersey
New York
Puerto Rico
Virgin Islands

PHILADELPHIA

Delaware
District of Columbia
Maryland
Pennsylvania
Virginia
West Virginia

SAN FRANCISCO

American Samoa
Arizona
California
Guam
Hawaii
Nevada
Northern Mariana Islands

DENVER

Colorado
Montana
North Dakota
South Dakota
Utah
Wyoming

SEATTLE

Alaska
Idaho
Oregon
Washington

Alicia Ryce 410-786-1075

BOSTON

Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

CHICAGO

Illinois
Indiana
Michigan
Minnesota
Ohio
Wisconsin

DALLAS

Arkansas
Louisiana
New Mexico
Oklahoma
Texas

KANSAS CITY

Iowa
Kansas
Missouri
Nebraska

ATLANTA

Alabama
North Carolina
South Carolina
Florida
Georgia
Kentucky
Mississippi
Tennessee

3.8.1 Scope Of Chapter

Medicare cannot generally pay for hospital or medical services furnished outside the United States except for certain care in qualified Canadian or Mexican hospitals. All medical claims for services received in foreign countries other than Canada and Mexico must be denied. This chapter describes the health insurance services furnished outside the U.S. that are reimbursable under the Medicare program. In addition, this chapter discusses claims processing for both hospital and medical insurance claims.

Section 7(d) (4) of the Railroad Retirement Act provides for the payment by the RRB of covered hospital services furnished in Canadian hospitals. The full text of section 7(d) (4) is as follows:

4) The rights of individuals described in subdivision (2) of this subsection to have payment made on their behalf for the services referred to in subdivision (1) but provided in Canada shall be the same as those of individuals to whom section [226](#) [42 U.S.C. [426](#)] and part A of title XVIII [42 U.S.C. [1395c](#) et seq.] of the Social Security Act apply, and this subdivision shall be administered by the Board as if the provisions of section [226](#) and part A of title XVIII of the Social Security Act were applicable, as if references to the Secretary of Health and Human Services were to the Board, as if references to the Federal Hospital Insurance Trust Fund were to the Railroad Retirement Account, as if references to the United States or a State included Canada or a subdivision thereof, and as if the provisions of sections 1862 (a)(4), 1863, 1864, 1868, 1869, 1874 (b), and 1875 [42 U.S.C. [1395y \(a\)\(4\)](#), [1395z](#), [1395aa](#), [1395ee](#), [1395ff](#), [1395kk \(b\)](#), [1395ll](#)] were not included in such title. The payments for services herein provided for in Canada shall be made from the Railroad Retirement Account (in accordance with, and subject to, the conditions applicable under subsection (b) of this section, in making payment of other benefits) to the hospital, extended care facility, or home health agency providing such services in Canada to individuals to whom subdivision (2) of this subsection applies, but only to the extent that the amount of payments for services otherwise hereunder provided for an individual exceeds the amount payable for like services provided pursuant to the law in effect in the place in Canada where such services are furnished. For the purposes of section [231i](#) of this title, any overpayment under this subdivision shall be treated as if it were an overpayment of an annuity.

Section 7(d)(4) of the Railroad Retirement Act (45 U.S.C. § 231f (d)(4)) provides that qualified railroad retirement beneficiaries who could be entitled to hospital insurance benefits if those services were provided in the United States have the same entitlement even though such services were provided in Canada. Section 7(d)(1) of the Railroad Retirement Act (45 U.S.C. § 231f (d)(1)) provides the Board with the same authority to determine the rights of qualified railroad retirement beneficiaries with regard to their entitlement to hospital insurance benefits as the Secretary of Health and Human Services has with respect to individuals entitled to hospital insurance benefits under section 226 of the Social Security Act. Section 7(d) (4) also provides that “The

payment for services herein provided for in Canada shall be made from the Railroad Retirement Account....”

3.8.2 Background

QRRBs are entitled to Medicare benefits under both the Railroad Retirement Act (RRA) and the Social Security Act. Since the inception of the Medicare program, the RRA has guaranteed that QRRBs receive **hospital** insurance benefits for covered services furnished in Canada, as well as in the United States. Before 1973, Social Security beneficiaries who were U.S. residents were limited to certain emergency inpatient care furnished in a more accessible Canadian or Mexican hospital. In 1973, the SS Act was expanded to include:

1. inpatient hospital care furnished in Canada or Mexico received by U.S. border residents regardless of whether an emergency exists, and
2. emergency inpatient hospital care required by a beneficiary traveling between Alaska and another State.

In addition, the SS Act covers physician and ambulance services furnished in connection with a covered foreign hospitalization. Payment may not be made for any other Part B medical and other health services, including outpatient services, furnished outside the United States.

The term “United States” means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. It also includes the territorial waters adjoining these entities. This means the 3-mile limit off the shores of most of the United States constitutes American territory. In the case of Texas and Florida, the limit extends into the Gulf of Mexico within 9 miles (three leagues) off the shores of these states. If a ship or aircraft, even of American registry, is not within or above the land area or territorial waters of the United States, it is not considered to be within an American territory.

Because physician and ambulance services furnished in connection with a covered foreign hospitalization are covered under the SS Act and not the RRA, it is more advantageous for QRRBs to have their claims considered under the SS Act if Part B benefits are involved. SSA has delegated to the RRB the authority to make entitlement determinations under the SS Act for QRRBs claiming Part B benefits for services furnished in Canada.

The RRB forwards claims for inpatient connected services received in Mexico to the CMS Regional office. Since other services in Mexico are not covered, those claims are sent to the Palmetto GBA Dallas office for denial.

3.8.3 Summary Of Hospital Insurance (Part A) Benefits Outside The U.S

Under the Railroad Retirement Act, payment can be made to any railroad retirement beneficiary for covered **hospital** insurance services furnished by a qualified Canadian hospital. Payment may be made for all covered hospital insurance services received anywhere in Canada regardless of where the beneficiary lives.

In Mexico, inpatient **hospital** services are covered under the following situations:

1. an emergency occurs in the U.S. and the Mexican hospital is closer than the nearest U.S. hospital equipped to deal with the injury or illness.
2. A U.S. resident receives services in a Mexican hospital which is closer to or substantially more accessible to his or her residence than the nearest hospital within the U.S., regardless of whether or not an emergency exists.

A hospital that is not physically situated in one of the United States' jurisdictions is considered to be outside the United States, even if it is owned or operated by the United States.

3.8.4 Summary Of Medical Insurance (Part B) Benefits Outside The U.S

Medical insurance benefits are limited to necessary physician and ambulance services furnished in connection with three specific situations.

Those situations are:

1. an emergency occurs in the U.S. and a Canadian or Mexican hospital is closer than the nearest U.S. hospital equipped to deal with the injury or illness.
2. a U.S. resident receives services in a Canadian or Mexican hospital which is closer to or substantially more accessible to his or her residence than the nearest hospital within the U.S., regardless of whether or not an emergency exists, or
3. a medical emergency occurs within Canada which requires admittance to a Canadian hospital while the beneficiary is traveling without unreasonable delay and by the most direct route between Alaska and another State. This provision does not apply when a beneficiary is vacationing in Canada.

Please note that medical insurance benefits are limited to physician and ambulance services furnished in connection with a covered foreign hospitalization. This means these services are covered both during the time period immediately before the beneficiary is actually admitted to the foreign hospital and during the covered foreign hospitalization itself. Payment may not be made for any other Part B medical services, including outpatient services, furnished outside the United States.

Payment may not be made for any item provided or delivered to the beneficiary outside the United States, even though the beneficiary may have contracted to purchase the item while they were within the United States or purchased the item from an American firm.

3.8.4.1 Medicare Services Received Aboard a Ship

Services rendered on board a ship in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished in United States territorial waters. Services not furnished in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished outside United States territorial waters, even if the ship is of United States registry.

The following services furnished aboard a ship are covered:

- Emergency and nonemergency services furnished by a physician or supplier aboard a vessel are covered when the ship is within the territorial waters of the United States.
- Emergency services furnished by a physician or supplier aboard a vessel are covered when the services are rendered while the ship is within the territorial waters of Canada (while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another State) and the emergency services are furnished in connection with a covered foreign hospitalization in Canada, including the day the patient is admitted to the Canadian hospital.

3.8.5 Chronic Care Services In Canada

Hospital insurance claims from beneficiaries living in Canada sometimes include claims for "chronic care" services. The term "chronic care" refers to a level of care lower than acute inpatient hospital care and significantly higher than custodial care. For purposes of claims processing, always consider a claim for chronic care services to be the same as a claim for skilled nursing services.

Chronic care services may be provided in one of two locales:

1. Chronic Care Wing of a Public General Hospital.

Some public general hospitals in Canada set up chronic care wings to make better use of available hospital space, especially in less populous areas. Though the full range of acute treatment services is available (surgery, x-ray, etc.), chronic care patients have less need for them. Chronic care patients receive regular skilled nursing care daily and medical care when needed. The Canadian provincial plans pay most of the cost of chronic care, leaving the patient responsible for a smaller co-payment. (The co-payment in 2007 was

approximately \$51.00 a day.) The patients' proportionate share of the cost generally increases the longer he or she stays in the chronic care wing. Patients usually leave the chronic care wing when space can be found for them in skilled nursing facilities.

2. Public Chronic Hospitals.

Patients are admitted to public chronic hospitals when no chronic wing is attached to the public general hospital. The level of care provided in the public chronic hospital is the same as that provided in a chronic wing of a public general hospital.

Chronic care facilities in Canada developed in response to a shortage of skilled nursing facilities. Today a large portion of the patients in skilled nursing facilities are transferred there from chronic care facilities. Likewise, a large portion of the patients in chronic care facilities are awaiting transfer to a skilled nursing facility. In most cases, skilled nursing facilities are smaller, less institutional, and have more comfortable accommodations than chronic care facilities. The actual care provided to patients in chronic care facilities versus patients in skilled nursing facilities is identical.

3.8.5.1 Alternative Level Of Care Services In Canada

On July 1, 2009 all acute and post-acute hospitals in Ontario began using a standardized Provincial Alternate Level of Care (ALC) Definition to designate patients as ALC. The definition applies to all patient populations waiting in all patient care beds in an acute or post-acute care hospital in Ontario.

Definition:

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this type of care setting, the patient must be designated Alternate Level of Care (ALC) at that time by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

This does not apply to patients who are:

- waiting at home.
- waiting in an acute care bed/service for another acute care bed/service (e.g. surgical bed to a medical bed).
- waiting in a tertiary acute care hospital bed for transfer to a non tertiary acute care hospital bed (e.g. repatriation to community hospital).

MS Examiner Actions:

Medicare generally covers 3 days to find a bed after discharge as administrative days. RRB will pay up to 3 days after the beneficiary's discharge to a continuing care facility. Only the co-payment portion of the charge, after the deductible, has been met will be reimbursed by the RRB.

3.8.6 Role Of Medicare Section (MS)

Under the RRA, the RRB administers the hospital insurance part of the Medicare program for QRRBs who receive services in Canada. Operations' Medicare Section (MS) acts as a fiscal intermediary to process claims for payment. Its functions include: coverage determinations, applying the deductible and coinsurance amounts, and determining whether all conditions of payment are met. The MS supervisor and designated claims specialist are authorized to certify payment or denial of Canadian hospital insurance claims.

3.8.7 Definition Of Terms Used In Claims Process

Below is a list of terms and their definition commonly used in the claims process.

- Application - Every beneficiary living in Canada who is enrolled for hospital insurance coverage (HI) is provided with a Form RB-104 describing HI benefits. An application, Form AA-104, must be filed for reimbursement of HI services furnished in Canada. To claim payment, the beneficiary returns a completed Form AA-104 with paid bills attached, and in some cases, a doctor's statement indicating that the services were medically necessary.
- Assignment - A beneficiary may, if he or she wishes, assign the payment due to the provider. An assignment must be a written request signed by or on behalf of the beneficiary requesting that payment on his or her behalf be made to the provider.
- Benefit Days for Reimbursement and Utilization Purposes - The number of days of care charged to a beneficiary for inpatient hospital services will always be in units of full days. In counting inpatient days for reimbursement purposes and determining the total number of days utilized by the beneficiary, either the day of admittance or the day of discharge is counted. In the Province of Ontario, the day of admission is not counted but the day of discharge is counted. Some provinces may be operating under a Canadian government ruling of January 1, 1968, which required hospitals to "charge for date of admission but not for date of discharge." The MS will certify payment for either the day of admission or for day of discharge. If admission and discharge occur on the same day, the examiner will count one inpatient day for reimbursement purposes.
- Benefit Period - A benefit period is a period of time measuring a beneficiary's use of hospital insurance benefits. It begins on the first day a bed patient receives services

in a hospital. It ends after a person has been out of the hospital or skilled nursing facility for at least 60 consecutive days.

- Canadian Provincial Plan - Canada's national health insurance program, which is also often referred to as "Medicare", is designed to ensure that all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis. Instead of having a single national plan, Canada has a national program that is composed of 13 interlocking provincial and territorial health insurance plans (i.e. Canadian Provincial Plans), all of which share certain common features and basic standards of coverage. Medicare payments made by the RRB are reduced by the amount of payment made for the same services by the Canadian Provincial Plan.
- Chronic Care - Chronic care is a term used in Canada to describe an intermediate level of care similar to skilled nursing services in the United States.
- Doctor's Certificate - A doctor's certificate is a statement confirming that the services furnished were medically necessary. It is required as follows:
 1. If no part of the charges for the services were payable under a provincial hospital plan.
 2. If accommodations more expensive than a semiprivate room are furnished, e.g., private room or intensive care facilities, reimbursement of the difference between the customary charges for the accommodations furnished and the customary charges for semiprivate accommodations may be made only if they are considered medically necessary. The more expensive accommodations will ordinarily be considered medically necessary only when the patient's condition required it for his or her own health or for that of others.
- Exchange Rate - The price or sum per unit at which the currency of one country is exchanged for currency of another country. The MS uses the exchange rate to convert the reimbursable amount from Canadian dollars into U.S. dollars.
- Excluded Services - These are services excluded from coverage under the Medicare program. These exclusions apply to domestic and foreign care. They include private nursing care, personal comfort items and custodial care.
- Inpatient Hospital Coinsurance - The beneficiary is responsible for a daily coinsurance amount of one-fourth of the inpatient hospital deductible for the 61st through the 90th days of inpatient hospital services used during each benefit period. Also, the beneficiary is responsible for a daily coinsurance amount of one-half of the inpatient hospital deductible for each of the lifetime reserve days used in a benefit period.

- Inpatient Hospital Deductible - The amount a beneficiary is responsible for paying before the Medicare program starts paying for inpatient hospital service in each benefit period.
- Inpatient Hospital Services - When a beneficiary has been admitted to a hospital for treatment of an illness or injury, hospital insurance can pay for most of the items and services that are furnished. Inpatient hospital services include: room and board, regular nursing care, drugs, laboratory tests and use of hospital facilities. For more information on services covered under hospital insurance, see RCM Chapter 3.1.
- Lifetime Reserve Days - A beneficiary can use an additional 60 inpatient hospital days after 90 days have been used in a benefit period.
- Post Hospital Home Health Services - When an individual needs skilled health services on a part-time basis after treatment in a hospital or skilled nursing facility, hospital insurance can pay for home health care provided at home. Medicare can pay for: part-time skilled nursing care, physical therapy, speech therapy and occupational therapy. If home health services are covered under Medicare, a supplemental questionnaire may be needed to determine what type of services were received.
- Proof of Services Received - General - The claimant must submit documentary proof that he or she received covered services for which reimbursement is being claimed. As proof, the beneficiary may submit a bill. The bill must show payment has been made for such services or it must be accompanied by an assignment indicating that the beneficiary wishes payments due for covered services paid directly to the provider furnishing such services. Where a receipted bill carries a notation that payment was by promissory note, such a receipt is acceptable as proof of payment.
- Promissory Note - A promissory note is a written promise to pay at a fixed or determinable future time a sum of money to a specific individual or to bearer.

If a receipted bill carries a notation that payment was by promissory note (or the beneficiary indicates that a promissory note was given as payment) assume an unconditional giving and acceptance of the note as payment in the absence of evidence to the contrary.

The fact that the beneficiary paid his or her hospital bill by a promissory note is immaterial. It is also immaterial that the hospital endorsed or cosigned the promissory note.

- Qualification Requirements for Providers of Service - Where the requirements for provincial approval of hospitals or nursing facilities are substantially the same as the requirements for participation in the HI program, the certified Canadian providers are deemed to be eligible for participation in the Medicare program. We do not require a certification to that effect from the provincial agency nor do we determine that the providers of services do, in fact, meet all of the requirements for participation.

Similarly, if a hospital is accredited by the Canadian Council for Accreditation of Hospitals, we deem the hospital to meet all of the requirements for participation except the requirement of utilization review.

Where Western Benefits Administration of Ontario, Canada certifies that the provider of services for which reimbursement is claimed, is a hospital, skilled nursing facility, or home health agency, as those items are defined in Section 1861 of the SS Act, assume that the requirements for participation have been met.

- **Receipted Bill** - A receipted bill is a written acknowledgement by the person or organization furnishing the covered services that all or part of the bill has been paid. The receipted bill must show the beneficiary's name and the amount paid. Acceptable proof that the bill was paid is the original receipted bill or a certified copy of such bill. It should show "Received Payment," "Paid in Full," "Paid" or a phrase with the same meaning with the initials or signature of the person receiving the payment.
- **Skilled Nursing Coinsurance** - The beneficiary is responsible for a daily coinsurance amount of one-eighth of the inpatient hospital deductible for the 21st through the 100th day of skilled nursing services used during each benefit period.
- **Skilled Nursing Services** - When a beneficiary no longer needs all the services that only a hospital can provide, but still requires skilled nursing or rehabilitation services, hospital insurance can pay for skilled nursing services provided in a qualified skilled nursing facility. In Canada, such services may also be provided in a public chronic hospital or in the chronic care wing of a public general hospital. These services include room and board, regular nursing services, rehabilitation services, drugs and medical supplies. See RCM 3.1 for a discussion of the conditions that must be met before skilled nursing services are covered under the hospital insurance program.

3.8.8 Amount Of Benefits

Hospital benefits for services provided in Canada are reduced by the greater of the following:

- The amount paid (or which would have been paid upon application) under a Canadian provincial health care plan, or
- The total of the deductible and coinsurance amounts (converted to Canadian funds).

Apply the above reduction criteria if the beneficiary did not receive payment under a provincial plan because he or she failed to apply for it. Do not make a reduction in the payment of benefits if the beneficiary had an option to participate in a provincial plan but elected not to do so.

Compute each type of service separately, i.e., inpatient hospital care, skilled nursing care, and home health service. The same deductible and coinsurance amounts apply to both domestic and foreign hospital insurance services.

3.8.9 Review Of Incoming Claims Material

An application must be filed within the regular time limit established for all Medicare claims. The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. Under PPACA, claims starting January 1, 2010, must be filed within one year of the date of service.

Review the Form AA-104 for completeness. If the form is not completed properly, return it to the applicant. Compare the Form AA-104 with the doctor's statement, if any, and reconcile any discrepancies with the beneficiary. When private accommodations are claimed and the beneficiary has not already submitted a doctor's statement of medical necessity, request one.

If the bill does not indicate that it was paid, or a receipted bill was not submitted, inform the claimant that reimbursement cannot be made unless a receipted bill or a bill with an assignment of benefits to the provider is received.

If there is a discrepancy between the amount alleged by the claimant and the amount shown on the receipted bill, reconcile it before forwarding the claims material to WBA.

3.8.10 Role Of Western Benefits Association Of Ontario, Canada

The RRB has designated Western Benefits Association (WBA) of Ontario, Canada to act as its agent in Canada. This organization provides the RRB with the information required to make a reimbursement determination. WBA represents the RRB as an agent and advisor.

In requesting certification of hospital insurance services furnished in Canada, the Medicare Section refers Form AA-104, receipted bills other statements, and Form G-760 to WBA. WBA takes the following actions:

1. Establishes that the services were received;
2. Verifies the total charges;
3. Verifies the amount payable under the Canadian provincial health plan;
4. Verifies the amount paid by the beneficiary;
5. Completes Form G-760 and certifies:
 - a. That the services were provided to the beneficiary;

- b. That the amount charged for services are reasonable costs, with appropriate exceptions listed in "Remarks;"
- c. That the services are covered by the Medicare program with appropriate exceptions listed in "Remarks;" and
- d. That the provider of services is a qualified participant.

When a question arises about any WBA determination, contact them to reconcile the difference. If WBA finds that the provider is not a qualified participant, deny the claim.

3.8.11 Obtaining Certification From WBA

Refer Form AA-104, all receipted bills, except those for Part B services only (a bill may be received for both Part A and Part B services), and Form G-760 to WBA for certification if the services furnished are covered under the Medicare program and the beneficiary is a QRRB. Prepare the referral package as follows:

1. Assemble the Form AA-104 and all attachments including correspondence that reconciles any discrepancy.
2. Prepare Form G-760. Enter the beneficiary's name, RRB claim number, Medicare claim number (if different) and your signature on the Form G-760. WBA will complete the "Certification," including the appropriate dates in item 1.
3. Fax Form G-760, Form AA-104, the receipted bill(s), doctor's statement, etc. to WBA.

If accommodations more expensive than a semiprivate room are claimed and were not certified to be medically necessary, request WBA to determine the rate for a semiprivate room and to base its determination of reimbursable charges on that rate. Also, raise any other questions about the claim or bill that need clarification. These questions should be asked in the "Remarks" section of Form G-760. For example, if the daily rate on the hospital bill appears excessive, question whether it includes the cost of a private room.

4. Maintain the original forms until the completed Form G-760 is returned by WBA. Trace for the completed Form G-760 using the following schedule:
 - Initial request: 45 days
 - Second request: 30 days
 - Third request: 14 days

The third trace should be made by telephone call to WBA.

3.8.12 Using Prior Utilization Data

When the claims specialist releases Form G-760 to WBA, the claims specialist will also review the Common Working File (CWF) to obtain Part A and/or Part B utilization information. Hospital services received in the U.S. are considered along with services received in Canada to determine the amount payable. For example, the benefit period, deductible and coinsurance amounts may be affected.

3.8.13 Who May Receive Payment

Payment of hospital insurance benefits is to be made as follows:

1. The individual who received the services if such individual paid for the services and submits documentary proof that such payment was made, or
2. The provider of services if the beneficiary makes an assignment.

3.8.14 Examples Of Computation Of HI Benefits

Here are some examples showing the computation of HI benefits for services received in Canada. The figures used in the following examples are not actual figures. If payment cannot be made for a particular day, do not count the day as a day of utilization, e.g., a person is hospitalized in a standard ward room and the Canadian provincial plan paid all charges in full. For more information, refer to Part 3 of the Intermediary Manual, section 3107.

- A. Inpatient Hospital - Example - Mr. Jacobs was hospitalized for 90 days in a two-bed room. The daily rate was \$90. The Canadian provincial plan paid the daily rate of \$80 for a standard ward bed. The total cost of services covered under the RRA before exclusion is \$8,100 (90 days x \$90 full daily rate). The \$8,100 total charge must be reduced by the amount paid under the Canadian provincial plan or the amount of the deductible and coinsurance adjusted to Canadian funds, which is more. The amount paid by the Canadian provincial plan is \$7,200. The deductible of \$124 plus the coinsurance amount of \$930 (\$31 x 30 days) is \$1,054. This amount adjusted to Canadian funds (\$1,054 x \$1.07, a hypothetical exchange rate as of the date of the hospital bill) is \$1,127.78. Therefore, we deduct \$7,200 paid under the Canadian provincial plan from the total of \$8,100. This leaves \$900 in Canadian funds to be paid under the RR Act. This amount must be converted to U.S. funds as of the date of payment. \$900 multiplied by a hypothetical U.S. exchange rate of .9346 is \$841.12. This is the amount payable.
- B. Skilled Nursing Care - Example - Mr. Bacon was in a covered nursing home for 100 days. The daily rate was \$30. The Canadian provincial plan pays for no part of this skilled nursing service. The total cost of the skilled nursing services was \$3,000 (100 days x \$30). The coinsurance amount is \$1,326.80 (80 days x

\$15.50 x \$1.07, a hypothetical Canadian exchange rate). The total charge for the skilled nursing services must be reduced by the amount paid under the Canadian provincial plan or the coinsurance amount, whichever is greater. Therefore, the amount payable in Canadian funds is \$1,673.20 (\$3,000 - \$1,326.80). In converting the amount payable to U.S. funds, \$1,673.20 is multiplied by .9346, a hypothetical U.S. exchange rate. The amount payable in U.S. funds is \$1,563.77.

- C. Home Health - Example - Mr. Corley received 100 home health visits in a 1-year period. The home health visits were \$8 each. The Canadian provincial plan paid no benefits. The total cost of the home health services is \$800. There is no deductible or coinsurance for home health services. Therefore, the amount payable in Canadian funds is \$800. This amount must be converted to U.S. funds as of the date of payment. Do this by multiplying \$800 by the U.S. exchange rate on the date the bill was paid (\$800 x .9346, a hypothetical U.S. exchange rate, is \$747.68). The amount payable in U.S. funds is \$747.68.
- D. Inpatient Lifetime Reserve Hospital Days - Example - Mrs. Evans was hospitalized a number of times in the same benefit period and used up her 90 days. Before a new benefit period started, she again was hospitalized. Mrs. Evans decided to use her 60 lifetime reserve days. She was hospitalized in a two-bed room. The daily rate was \$90. The Canadian provincial plan paid the daily rate of \$80 for a standard ward bed. The total cost of services covered under the RRA before exclusions is \$5,400 (90 full daily rate x 60 days). The \$5,400 is reduced by the amount paid or the amount of the coinsurance adjusted to Canadian funds, whichever is the greater amount. The amount paid by the Canadian provincial plan is \$4,800; the coinsurance amount is \$3,720 (\$62 x 60 days). The coinsurance amount adjusted to Canadian funds is \$3,980.40 (\$3,720 x \$1.07, a hypothetical exchange rate). Therefore, \$4,800 paid under the Canadian provincial plan is deducted from the cost of \$5,400. This leaves \$600 in Canadian funds to be paid under the RRA. This amount is converted to U.S. funds as of the date the bill is paid. \$600 x .9346, a hypothetical U.S. exchange rate, is \$560.76. When this is paid, Mrs. Evans 60 lifetime reserve days will have been exhausted.

NOTE: RRB asks the beneficiary if (s)he wants to use lifetime reserve days or keep them for the future.

- E. New Benefit Period – Example - Mr. Halbert had a heart attack and was admitted to the Douglas Memorial Hospital in Ontario, Canada on May 20, 2008. He was released on June 2, 2008 and was transferred to a skilled nursing facility (SNF). He was discharged from the SNF on June 23. Fifteen days later on July 8, Mr. Halbert suffered a stroke and was hospitalized from July 8, 2008 through August 28, 2008. He is considered to still be within his first benefit period because 60 days had not elapsed since his last hospitalization or discharge from a SNF. Mr. Halbert had a relapse and was re-admitted on November 24. He was discharged from the SNF on December 1, 2008. This is considered a new benefit period

because more than 60 days elapsed from the date of his last hospitalization or discharge from a SNF (August 29 through November 23).

- F. Acute Level of Care – Example – Mrs. Williams was hospitalized after suffering severe injuries from a car accident. After a 10-day stay in the hospital, Mrs. Williams was to be transferred to a skilled nursing facility. However, she could not be immediately transferred to the facility. She remained at the hospital for an additional seven days until a bed was available at the skilled nursing facility. Since Mrs. Williams no longer required the level of care normally provided in a hospital, her last seven days in the hospital were billed as ALC (Alternate Level of Care). She submits the bill of \$2,500 to the RRB for payment. RRB will only reimburse her the co-pay for three of the days (the maximum).

3.8.15 Selecting Payee For Claims After Death

If the beneficiary who received the service dies, claims for unpaid benefits are paid as follows:

- A. Bill Was Paid - Pay in the following order of priority:
- The person or persons who paid the bill.
 - The legal representative of the estate if the bill was paid by the deceased enrollee or from funds from his or her estate. When the estate has already been closed, or when there may be an indefinite delay in the appointment of a legal representative, payment may be made to a surviving relative in the priority order listed below.
 - The surviving spouse who was either living in the same household as the enrollee or was entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
 - Child or children of the enrollee who were entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
 - Parent or parents of the enrollee who were entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
 - Surviving spouse who was not either living in the same household as the enrollee or was not entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
 - Child or children of the enrollee who were not entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.

- Parent or parents of the enrollee who were not entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
- Legal representative of the estate of the enrollee if the bill was paid by another person who is now deceased and no relative as described above exists.

Documentary evidence must be submitted to support the entitled person's claim for benefits (i.e., proof of relationship, proof of payment, or proof of appointment).

- B. Bill Was Not Paid - Pay to the provider of services if the provider accepts an assignment.

If no person survives who meets the above requirements, the benefit cannot be paid.

3.8.16 Preparation Of Award Through SURPASS; Completion of Form G-730

- A. Instructional Memorandum No. 07-02 containing instructions for making Canadian Part A benefit payments is no longer accessible through PRISM. A paper copy is available in Policy & Systems until IM 07-02 can be incorporated into this section.
- B. Use Form G-730 to document payment of the claim and the utilization of HI services furnished in Canada. See RCM 3.8, Appendix A for instructions on the preparation and certification of this form.

Because the U.S. foreign exchange rate for a Canadian dollar fluctuates, convert the reimbursable amount into U.S. funds as of the date of the hospital bill was paid and pay the converted amount. If the exact date of payment is not available, use the exchange rate in effect on the billing date. The Medicare Section maintains a listing of exchange rates for this purpose. There are some non-payment situations where an award form should be completed but no utilization charged. e.g., physician refuses to make a required certification or the provider fails to submit needed information.

3.8.17 Completion Of Award Letter

Form RL-340 or Form RL-341 is the award letter used to notify a Canadian beneficiary of entitlement to reimbursement for HI services in Canada. Award letter RL-340 is used when reimbursement will be paid to the beneficiary. Award letter RL-341 is used in assignment cases when reimbursement will be paid to the provider. The letter is released by the authorizer when the Canadian payment has been authorized on SURPASS. Complete the award letter carefully to show all the details. It is used as a record of HI services in Canada.

Complete Form RL-340 or Form RL-341 using RRAILS. Use the data shown on the completed Form G-730 to complete the form.

- A. Heading - The beneficiary's name and address are prefilled. Type in the salutation.
- B. Paragraph 1 - In the first line, enter the Net Amount Paid shown in Item 19 of the Form G-730. Enter the type of service(s), dates covered by the bill and number of health visits included, as shown in Item 6 of the Form G-730. If an RL-341 is being prepared, enter the name of the hospital in the first sentence.
- C. Paragraph 2 - List the exceptions and amounts shown in Items 8 (amount paid by Canadian provincial plan), item 9 (deductible and coinsurance amounts), and item 10 (non-covered services) of the Form G-730.
- D. Paragraph 3 - Enter the number of days or visits used on this bill, used to date, and remaining, as shown in Item 6 of the Form G-730 for each type of service.
- E. Checking RL-340 and RL-341 - Check the correctness of the data entered on the award letter.
- F. Disposition - Route the original and 2 copies of the RL-340 or RL-341, with the Form G-730 and all related documentation to the authorizer. The authorizer will date the original letter and the 2 copies, and release the original letter upon authorizing the SURPASS award. The authorizer will also route a copy of the award letter with copies of all other documents to be imaged. The other copy along with the originals and/or copies of all other documents are to be filed in the Foreign Claims Voucher Book.

3.8.19 Processing Denials

- A. Reasons for Denials - Deny the claim without referral to WBA if the beneficiary does not submit the necessary evidence, or claims only non-covered services. Some examples of non-covered services are:
 1. Private nurse, comfort items, etc.
 2. Inpatient hospital services when the cost is less than the deductible.
 3. Skilled nursing services (SNF) when:
 - Beneficiary did not have a qualifying 3-day hospital stay;
 - Beneficiary did not enter SNF or chronic care facility within 30 days after release from hospital;
 - Nursing care had no relationship to condition requiring hospitalization; etc.

4. Home health services were not provided by an agency participating in Medicare.

After verification of the services by WBA, deny the claim if:

1. A. U.S. intermediary has already paid HI benefits on the claim.
2. The services are not covered.
3. The charges are less than deductible.

NOTE:

A beneficiary has 120 days to file a re-determination request on all Medicare claims.

- B. Disposition of Claims - Prepare an original and 2 copies of the denial letter. Be sure to include the standard explanation of the beneficiary's rights to reconsideration and appeal in the letter. Close out the entry in the Foreign Claims Voucher Book, and route all copies of the letter and all related documents to authorization.

If covered services are involved but the charges are less than the deductible, or the beneficiary does not submit necessary evidence, prepare a "dummy" Form G-730 as described in RCM 3.8.20.

The copies of the letter will be distributed as follows:

- Original - Claimant; the original bills and receipts should be included.
- Copy -To imaging along with copies of the claim and related documentation, i.e. bills and receipts.
- Copy - Foreign Claims Voucher Book along with copies of the claim and related documentation, i.e. bills and receipts.

3.8.20 Report To CMS Of Utilization

HI services furnished in Canada are charged against a beneficiary's utilization record in the same manner as services furnished in the U.S. Form G-730 is used to record utilization information and is sent to the Centers for Medicare and Medicaid Services (CMS). Form G-730 is also used when the claim is not payable but the services are chargeable against the beneficiary's utilization record. The Medicare Section will send a "dummy" Form G-730 to CMS with the words "No Amount Payable" in the remarks section of the form.

Health Enterprises is no longer the intermediary that processes Forms G-730 to update the Common Working File (CWF). All Forms G-730 are to be sent to CMS via email.

After the case is complete, the authorizer will encrypt the Form G-730 Word document, attach it to the email and send it to CMS at the following address:

Richard.Wolfsheimer@cms.hhs.gov

Richard Wolfsheimer is our contact at CMS for processing Forms G-730. His telephone number is (410) 786-6160.

The authorizer should follow this email with a second email to Richard Wolfsheimer providing him the password to open the encrypted file. The same password will be used for all subsequent Forms G-730 encrypted and sent to CMS.

3.8.25 Introduction – Part B Services in Canada

Beginning in 1973, the Social Security Act provides benefits for certain Part B services furnished in Canada. Part B covers physician and ambulance services furnished in connection with and during specific hospital stays. The three situations are:

1. An emergency occurs in the U.S. and the Canadian hospital is closer than the nearest U.S. hospital.
2. Inpatient hospital services are furnished in a Canadian hospital which is closer to, or substantially more accessible to the beneficiary's U.S. residence than the nearest U.S. hospital which can provide adequate care, regardless of whether or not an emergency exists.
3. An emergency occurs in Canada while the beneficiary is traveling without unreasonable delay and by the most direct route between Alaska and another State.

Under this provision payment can be made for the following Part B services:

1. Physicians' services rendered to the beneficiary while he or she is an inpatient.
2. Physicians' services rendered to the beneficiary outside the hospital on the day of his or her admission as an inpatient, provided the services were for the same condition that required emergency treatment. Please note that claims for emergency room visits are not payable if there is no accompanying hospital stay.
3. Ambulance services, where necessary, for the trip to the hospital in connection with the beneficiary's hospitalization.

Even though the hospital stay of a QRRB is covered under the RRA, Part B benefits are payable only when the hospitalization is covered under the SS Act. CMS has authorized the RRB to make coverage determinations under the SS Act for QRRBs claiming Part B benefits.

3.8.26 Claims Development

- A. General - Part B claims may be received from Palmetto GBA, directly from the beneficiary or indirectly through RRB field offices. A claim should be made on Form CMS-1500. (Claims submitted using obsolete Forms G-740s or HCFA-1500 are also acceptable.) The claim must be filed within the regular time limit established by law. Enter each incoming claim in the foreign Part B log book.

Each claim must include the beneficiary's residence, where the services were rendered, the type of services, and the nature of the illness or injury. If the claim lacks sufficient information to make a coverage decision, request the appropriate district office to develop the required information. If a claim for hospital insurance benefits has not been filed, have the district office secure a completed Form AA-104. Wait for the certification from WBA before making a determination on the Part B claim. WBA will determine whether the hospital is a "qualified" institution and whether benefits have already been paid by CMS.

- B. Coverage Determination - In determining whether Part B benefits are payable, the Medicare Section claims specialist first determines whether Part A hospital benefits are payable under the SS Act. The claims specialist applies the provision of the SS Act regarding:

- accessibility of the Canadian hospital,
- residency requirement,
- Canadian travel requirements, (Use MapQuest or a similar application to determine if the beneficiary used the shortest practicable route traveling between Alaska and another state.
- whether physician and ambulance services furnished in Canada were furnished in connection with covered inpatient services, and
- whether the claim was filed within the time limit.

3.8.27 Emergency Hospital Admissions

- A. Emergency Provision - An emergency will be considered to have occurred within the United States if the individual was physically present in the United States when the need for emergency inpatient hospital services arose and the individual's reason for departure from the United States was to obtain treatment at the foreign hospital. Thus, a person who becomes ill while enroute to a foreign country by ship or airplane and receives hospital services in the foreign country does not qualify to have payment made for these services.

The emergency requirement will be established based upon the statement of the physician who attended the patient at the hospital. The statement must describe

the nature of the emergency, furnish any relevant clinical information about the patient's condition, and also state that the services rendered were required as emergency services. The statement must include the date when, in the physician's judgment, the emergency ceased. Photocopies of hospital records can be used to substantiate the emergency nature of the situation.

B. Accessibility Determination.

1. Emergency Occurs Within the U.S. - If the emergency occurred within the U.S. determine from the criteria below whether the patient was admitted to the nearest or most accessible hospital from the site of the emergency.

- a. Participating Hospital 15 or Fewer Miles Farther From the Location of the Emergency Than the Admitting Canadian Hospital.

If the distance from the location of the emergency to the nearest participating hospital with available beds or adequate emergency facilities is 15 or fewer miles greater than is the distance to the admitting Canadian hospital, accessibility is provisionally not met, but there must be a physician review to determine whether the nature of the emergency required immediate transportation to the Canadian hospital.

If the review indicates that the nature of the emergency would have allowed the additional transportation time needed to take the patient without hazard to the U.S. hospital, the accessibility requirement shall be deemed not met unless evidence established the necessity for taking the patient to the Canadian hospital e.g., unusual medical circumstances; needed equipment and/or personnel unavailable in the U.S. hospital.

Factors involving selection of a hospital which reflect the personal preference of the individual or physician does not have staff privileges at the participating hospital, nearness to beneficiary's residence, religious affiliation, presence of previous medical records at the nonparticipating hospital, cost, type of accommodations available, etc. are not considered in the accessibility determination.

- b. Participating Hospital More than 15 Miles Farther from the Location of the Emergency than the Admitting Nonparticipating Hospital.

If the nearest participating hospital is more than 15 miles farther from the location of the emergency than is the admitting nonparticipating hospital the accessibility requirements shall be deemed met.

Request the field office to secure a statement from the beneficiary describing the circumstances of the illness or injury, when the emergency occurred and why the Canadian hospital was chosen. Ask the field office to determine the distances between the emergency site and:

- the closest U.S. hospital,
- the Canadian hospital that admitted the beneficiary.

2. Emergency Occurred In Canada - If the emergency occurred while the beneficiary was traveling in Canada between Alaska and another State, the accessibility requirement is considered met where the emergency occurred more than 15 miles from the U.S. border and the other Canadian travel provisions are met. If the emergency occurred within 15 miles of the U.S. border, apply the accessibility criteria described in B. 1. above.

- C. "Canadian Travel" Provision - An emergency will be considered to have occurred while the beneficiary was traveling without unreasonable delay and by the most direct route between Alaska and another State if the emergency occurred while the beneficiary was enroute between Alaska and another border State by the shortest practicable route, or while making a necessary stopover in connection with such travel. To make this determination, secure a detailed itinerary from the beneficiary and apply the criteria below. The examiner may also use MapQuest or a similar application to determine the shortest practicable route possible.

1. Shortest Practicable Route - Ordinarily the "shortest practicable route" is the one that results in the least travel in Canada, between the point of entry into Canada and the intended point of departure. The amount of travel in the United States prior to entering Canada is not pertinent. A route involving greater travel within Canada may be considered the "shortest practicable route" if the additional travel would result in a savings of time or was necessary because of road or weather conditions, the age, health, or physical condition of the traveler, to make suitable travel arrangements, obtain acceptable accommodations, etc.

However, the individual would be considered to have deviated from the "shortest practicable route" if the detour was unrelated to the purpose of reaching his or her destination (e.g., for the principal purpose of sightseeing or vacationing).

2. Necessary Stopover - The term "necessary stopover" means (a) a routine stopover for rest, food, or servicing of the travel vehicle, and (b) a non-routine stopover (even though of significant duration) caused by unsuitable road or weather conditions, the age, health, or physical condition of the traveler, the need to make suitable travel arrangements, or to obtain acceptable accommodations.

3.8.28 Services Furnished In Canadian Hospital Nearest To Beneficiary's U.S. Residence

In determining whether a U.S. border resident can qualify for Part B benefits, two criteria must be established: the beneficiary's "residence" and the accessibility of the Canadian hospital.

- A. Residence - "Residence" means the beneficiary's fixed and permanent home to which he or she intends to return whenever he or she is away or a dwelling where the beneficiary periodically spends some time (e.g., a summer home).

Residence will normally be determined from the address listed on the claim form.

- B. Accessibility - The accessibility requirement will be deemed met if the Canadian hospital is closer to the beneficiary's U.S. residence than is the closest U.S. participating hospital. If the Canadian hospital is farther from the beneficiary's residence than is a U.S. participating hospital, accessibility will not be met unless the facts show that the U.S. hospital had no bed available, would not accept the patient, did not have the necessary equipment or personnel, or was inaccessible for some other reason.

The personal preference of the beneficiary, his or her physician, or others in the selection of a hospital, the type of accommodations available, or the non-availability of staff privileges to the attending physician are not considered in determining whether a Canadian hospital is more accessible than a participating hospital.

Request the field office to determine the distances between the beneficiary's residence and:

- the closest U.S. hospital,
- The Canadian hospital that admitted the beneficiary.

If the admitting Canadian hospital is farther than the closest U.S. hospital, ask the field office to secure a statement from the beneficiary explaining why the Canadian hospital was chosen.

3.8.29 Disposition Of Part B Claims

- A. Claim Meets Coverage Requirements - Prepare a letter to Palmetto GBA authorizing payment of the Part B claim. Briefly explain the basis for the favorable determination. Use the letter as a transmittal for the Part B claim, related material, and copy of the Form AA-104. Address all correspondence to:

Octavia Huff
Palmetto GBA

Post Office Box 1066
Augusta, Georgia 30999-001

Her telephone number is (706) 855-3382.

Route the letter and all related documents to the authorizer. The authorizer will date the letter and all copies, and release the original letter upon authorizing the determination. The authorizer will also route a copy of the letter with copies of all other documents to be imaged. The other copy along with the originals and/or copies of all other documents are to be filed in the Canadian Voucher Book.

- B. Claim Does Not Meet coverage Requirements - Prepare a letter to the beneficiary (with a copy to Palmetto GBA if they referred the claim to us.) Explain the coverage requirements and include the Medicare appeals paragraph.

Route the letter and all related documents to the authorizer. The authorizer will date the letter and all copies, and release the original letter upon authorizing the determination. The authorizer will also route a copy of the letter with copies of all other documents to be imaged. The other copy along with the originals and/or copies of all other documents are to be filed in the Canadian Voucher Book.

If the beneficiary protests the denial, consult with your supervisor.

NOTE:

A beneficiary has 120 days to file a re-determination request on all Medicare claims.

3.8.35 Medicare Benefits In Mexico

Claims for Medicare services furnished in Mexico are handled by the Centers for Medicare & Medicaid Services (CMS). When a claim for inpatient hospital benefits is received, the Medicare Section claims specialist forwards it to the appropriate regional office of CMS. The CMS regional office makes the coverage determination and:

- sends the Part B claim to Palmetto GBA for payment, or
- prepares and releases a denial letter.

The claims specialist answers general questions about Mexican coverage.

All claims for inpatient hospital services furnished in Mexico are sent to the appropriate CMS regional office. Claims for other services furnished in Mexico should be forwarded to Palmetto GBA in Augusta, Georgia. The geographic location of the hospital furnishing the inpatient services determines which regional office handles the claim. If the examiner cannot determine the Mexican state the hospital is located in from any of the documentation provided, he or she can use Google or MapQuest to assist in making a determination.

The following is a listing of all 31 Mexican states: Aguascalientes, Baja California, Baja California Sur, Campeche, Chiapas, Chihuahua, Coahuila de Zaragoza, Colima, Durango, Guanajuato, Guerrero, Hidalgo, Jalisco, Mexico, Michoacan de Ocampo, Morelos, Nayarit, Nuevo Leon, Oaxaca, Puebla, Queretaro de Arteaga, Quintana Roo, San Luis Potosi, Sinaloa, Sonora, Tabasco, Tamaulipas, Tlaxcala, Veracruz-Llave, Yucatan, Zacatecas

State	Regional Office
Baja California (B.C.)	Centers for Medicare & Medicaid Services Regional Office – Region 9 90 Seventh St, Suite 5-300 (5W) San Francisco, CA 94103-6706
Nayarit (NAY.)	
Sinaloa (SIN.)	
Sonora (SON.)	
All Others	Centers for Medicare & Medicaid Services Regional Office –Region 6 1301 Young St., Suite 714 Dallas, TX 75202

Appendices

Appendix A - Form G-730, Determination of Award

Form G-730 (6-86) - Determination of Award - Hospital Insurance Benefits for Services in Canada. If benefits are payable for more than one type of service (e.g. inpatient hospital, chronic care, home health, or skilled nursing facility), a Form G-730 should be prepared for each type of service.

Use

Used by the Medicare Section to reimburse a QRRB for HI services received in Canada.

Completion

Item	Entry
1	Enter the beneficiary's RRB claim number, including payee symbol (if any), claim number prefix.

2	Enter the employee' SS number.
3	Enter the beneficiary's pseudo number, if there is one.
4	Enter the name of the beneficiary who received the hospital insurance services.
5	Enter the beginning date of the benefit period. This is the first day the beneficiary received covered services in the current benefit period.
6	<p>Check the box to indicate the type of service. If there is inpatient hospital and some other type of service on the same bill, prepare a separate Form G-730 for each type of service.</p> <p>Enter the dates covered by the bill unless the bill covers services before the effective date of coverage. In the latter event, enter only the period covered by the bill beginning with the effective date of coverage. Enter the number of days used or visits made and the number of days or visits remaining.</p>
7	Enter the total charges (in Canadian funds) for the services provided to the beneficiary during the period covered. This may include services not covered under the RRA. This should be the total charges as shown in item 1 of the Form G-760 completed by Western Benefits Association (WBA) unless the bill covers services before the effective date of coverage. In the latter event, enter only the total charges for the period beginning with the effective date of coverage.
8	Enter the amount (in Canadian funds) payable to the provider under the Canadian provincial plan. This is the amount shown in item 2 of the Form G-760 completed by WBA unless the bill covers services before the effective date of coverage. In the latter event, enter only the total charges for the period beginning with the effective date of coverage. If none, leave this item blank.
9	Add the deductible and/or the coinsurance together, if applicable, divide that amount by the exchange rate and enter the total amount as converted to Canadian funds as of the date(s) the bill(s) was(were) processed paid in the "\$" field. Enter the amount by which item 9 exceeds item 8 in the column next to the arrow. If item 8 is greater, enter 0.
10	List the type of services not covered and the cost in Canadian funds of each type and enter the total in Canadian funds in the "\$" column. This information will be listed as exceptions under "Remarks" of the completed Form G-760. If none, leave this item blank.
11	Enter the amount of Canadian funds previously paid for the services covered

	by the bill as listed in item 6 of the Form G-730. This is the amount of Canadian funds shown in item 14 of any previous Form G-730 completed for the same services. If none, leave this item blank.
12	Enter the unpaid amount of Canadian funds for the services covered by the bill as listed in item 6 of the Form G-730.
13	Add items 8 through 12 and enter the total here.
14	Subtract the total shown in item 13 from the total charges shown in item 7. Enter the result here.
15	Under date, enter the date the bill was paid. Under U.S., enter the exchange rate for the Canadian dollar.
16	Multiply the amount in item 14 by the exchange rate in item 15 and enter the result here.
17	Use this item to include any additional information that would be useful in explaining the award.
18	Enter the name and address of the payee. Follow the rules in RCM 8.1, Appendix A, except do not use a group mark.
19	Under "Net Amount Paid," enter, in U.S. funds, the total amount to be paid to the payee in item 16.

Signature And Disposition

The Medicare Section specialist signs his or her name and enters the date on which he or she completed the form. The authorizer will sign his or her name and enter the date on which he or she authorized the completed Form G-730.

Route the completed Form G-730 with all related documents to the authorizer. Once the authorizer has authorized the Form G-730 and related SURPASS award (if any), a copy of the Form G-730 and related documentation will be routed for imaging, and a copy will be filed in the Foreign Claims Voucher Book. The original Form G-730 will be sent to CMS as an encrypted document via an email. Refer to section 3.8.20 for further information.

3.9.1 Scope Of Chapter

This chapter covers the handling of overpayments of Medicare benefits. The procedure for investigating the possible forgery of a Medicare benefit check is also included.

For further information on Medicare overpayments refer to:

Part A Intermediary Manual - Section 3700.

Part B Intermediary Manual - Section 6400.

Social Security Claims Manual - Section 5500.

Medicare Overpayments - General

3.9.5 Medicare Overpayments Defined

- A. HIB (Part A) Overpayment - A hospital insurance overpayment occurs when more than the correct amount has been paid in hospital insurance benefits to:
 - 1. A "provider of services" (a hospital, skilled nursing facility, or home health agency) for items or services furnished an individual; or
 - 2. An individual who received the benefit of the items or services.
- B. SMI (Part B) Overpayment - A medical insurance overpayment occurs when more than the correct amount has been paid in medical insurance benefits to:
 - 1. A physician or supplier of medical services for items or services furnished an individual; or
 - 2. An individual who received the benefit of the items or services.

3.9.6 General Handling

- A. Overpayments in the U.S. - These instructions cover the handling of HI overpayments made to or on the behalf of individuals living in the United States.
- B. HIB Overpayment in Canada - A hospital insurance overpayment made to an individual living in Canada is to treated as though it were a railroad retirement annuity overpayment. The instructions in RCM 6.6 apply except that any case involving such an overpayment, regardless of the amount, is to be referred to MS.
- C. SMI Overpayment in Canada - A medical insurance overpayment for a resident of Canada will be handled as though the individual were a resident of the United States.

3.9.7 Liability For Medicare Overpayments

- A. Provider of Service, Physician, or Supplier Liable - A provider of services, physician, or supplier is deemed to have knowledge of the laws and regulations which apply to the payment of Medicare benefits. Therefore the provider or other person is liable for an overpayment made to him if:
1. The overpayment was caused by a mathematical or clerical error.
 2. The overpayment was due to a duplicate payment which was retained by the provider or other person.
 3. The beneficiary did not receive the services (or items) paid for.
 4. The provider or other person accepted payment for services (or items) which he knew or should have known were not reasonable or necessary for treatment.
 5. The overpayment resulted from a charge in excess of the reasonable charge.
 6. A provider or other person, not qualified under SSA regulations to perform services (e.g., an immediate relative or member of the beneficiary's household), accepted payment for services.
 7. A physician or supplier collected a payment on the basis of an assignment without disclosing that he had already been paid by the beneficiary (see SSCM section 10603.5).
- B. Beneficiary Liable - A beneficiary is liable for repayment of overpayments made direct to him. He is also liable for overpayments made to a provider of services, supplier, or physician on his behalf if he received the services, the services were necessary, the charges were reasonable and:
1. The overpayment resulted from failure to properly apply the deductible or coinsurance; or
 2. The overpayment resulted from benefits paid to the provider of services under the guarantee provision of section 1814(e) of the SS Act (see Part A Intermediary Manual - Section 3714 to 3714.3); or
 3. The overpayment resulted from some other cause (e.g., non-entitlement or non-coverage) and the provider or other person acted reasonably in filing for and accepting Medicare payments. The provider or other person will be considered to have acted reasonably if he:

- a. Had no basis for questioning entitlement or coverage or, if he did, brought it promptly to the attention of the intermediary or carrier, and
 - b. Complied with all pertinent regulations and had reason to believe the services were covered.
- 4. The provider or other person was without fault in causing the overpayment (effective with notices of payment sent after 10-30-72).
- C. Dual Liability - The provider, physician or supplier and the beneficiary are jointly liable for an overpayment, provided the overpayment was made to the provider or other person for services which the beneficiary received, if:
 - 1. The overpayment was caused by an error regarding entitlement or coverage of services and the provider or other person did not act reasonably and with due care in filing for and accepting the payment; or
 - 2. The provider or other person received duplicate payments and turned one payment over to the beneficiary.
- D. Limitation on Beneficiary Liability - A beneficiary who was without fault (i.e., did not know and could not be expected to know that the services were not covered) and whose claim under Part A or Part B has been disallowed because the services were not reasonable or necessary for the diagnosis or treatment of an injury or illness or because the care was a non-covered level of care (i.e., custodial care), shall not be liable for payment.

If the provider or other person in such a case also exercises due care (i.e., did not know and could not be expected to know non-covered services were involved), the Medicare program will make payment as if the services were covered. When payment is made, the provider and patient will be put on notice so that they cannot again claim lack of knowledge in subsequent claims involving similar situations.

If the provider did not exercise due care and the beneficiary was without fault, the provider would be liable for the services but could appeal both the determination as to coverage and "due care." If the provider did not exercise due care and collected from the beneficiary, the program would, upon application, reimburse the beneficiary. The payment would then be treated as an overpayment to the provider.

This provision applies only to Part A bills and assigned Part B bills for items or services provided after 10-30-72.

3.9.15 Intermediary's Or Carrier's Responsibility

- A. When the Provider of Services, Physician or Supplier Is Liable - The intermediary or carrier will notify the provider or other person of the overpayment, will offset the overpayment against any future benefits due the provider or other person and, if necessary, will ask for a refund. If recovery of an HIB O/P cannot be made from the provider of services, the intermediary will refer the case to SSA, Bureau of Health Insurance. If recovery of an SMI O/P cannot be made from a physician or supplier, the Part B carrier will refer the case to RRB.
- B. When the Beneficiary Is Liable - The intermediary or carrier will notify the beneficiary of the overpayment, will offset the overpayment against any future unassigned payments due the beneficiary and, if necessary, will ask for a refund. If an HIB O/P is not recovered from the beneficiary, the intermediary will refer the case to SSA, Bureau of Health Insurance. If an SMI O/P is not recovered from the beneficiary, the Part B carrier will refer the case to RRB.
- C. Dual Liability - The intermediary or carrier will send an overpayment letter first to the provider of services, supplier or physician. If the overpayment is not recovered within 60 days, the intermediary or carrier will ask the beneficiary for a refund. Any payments due the beneficiary will be withheld pending recovery from the provider of services or other person. If recovery of an HIB O/P cannot be made from either the provider of services or the beneficiary, the intermediary will refer the case to the Bureau of Health Insurance. If recovery of an SMI O/P cannot be made from either the supplier or physician or the beneficiary, the Part B carrier will refer the case to RRB.
- D. What the Overpayment Letter Should Contain - The overpayment letter sent by the intermediary or carrier to the provider of services, physician, supplier or beneficiary should:
1. Clearly identify the overpayment by showing the name and address of the provider or other person, the dates of services, the nature of the services, the date and amount of the check(s) and to whom it was paid, and the amount of the overpayment.
 2. Clearly explain why the payment was incorrect.
 3. Identify and advise the amount of any Medicare benefits withheld.
 4. Request a refund.
 5. Notify the beneficiary that unless a refund is made, the overpayment may be deducted from his monthly annuity.
 6. Inform a beneficiary of his right to a reconsideration or review of the overpayment decision.

7. Include an explanation of the waiver provision.

See Exhibit 2 for a sample overpayment letter.

- E. When the Beneficiary Requests That Recovery Be Waived - If a beneficiary requests that a Medicare O/P be waived or states conditions that might qualify him for waiver, the intermediary or carrier should refer the case to the Bureau of Health Insurance or RRB immediately.
- F. When Beneficiary or Physician Is Deceased.
 1. Beneficiary Liable - The intermediary or carrier should withhold the overpayment from any amount payable on the beneficiary's account to a relative or to the beneficiary's estate. If an amount is payable on the beneficiary's account to any other person or organization, that amount cannot be withheld.
 2. Physician Liable - the Part B carrier should withhold the overpayment from any other Medicare payment due the physician's estate. If the O/P cannot be recovered by withholding, the carrier should refer the case to RRB immediately with any information received about an estate.
- G. When the Beneficiary Is Entitled to Welfare Payments - The intermediary or carrier will contact the State Welfare Department, to determine whether that agency will refund an overpayment for which a beneficiary receiving or entitled to welfare is liable, if:
 1. An HIB overpayment was caused by:
 - a. Failure to properly assess the deductible or coinsurance;
 - b. Payment for non-covered services; or
 - c. Payment for services after benefits have been exhausted.
 2. An SMI overpayment was caused by failure to properly assess the deductible.

If the State Welfare Department will not refund the overpayment, the intermediary will refer the case to SSA, Bureau of Health Insurance, or the Part B carrier will refer the case to RRB without taking any further recovery action. A record of any contact made with the welfare department should be included with the material referred to SSA or RRB.

3.9.16 Responsibility Of SSA

- A. HIB O/P - SSA will receive all cases in which an overpayment of HIB benefits has not been recovered by the intermediary from a provider of services or

beneficiary. After determining who is liable for the overpayment, SSA will handle to completion all cases in which the provider is solely liable.

If a QRRB or DQRRB is liable for repayment of the overpayment, SSA will refer the case to RRB for consideration of waiver or recovery from benefits payable under the RR Act.

- B. SMI O/P - SSA will not handle SMI O/P for QRRB's or DQRRB's unless RRB requests that recovery be made from benefits payable by SSA, because the annuity is not in current pay status (see sec. 3.9.45). However, all cases in which a physician or supplier of services is liable for repayment should be sent to SSA for handling.

3.9.17 Responsibility Of RRB

The chances of recovering a Medicare overpayment are better if recovery action is taken soon after the notice of overpayment is received. Therefore, Medicare overpayment cases should be given preferred handling.

- A. General - RRB is responsible for the waiver or recovery of an HI O/P in any case in which the beneficiary is liable for repayment. RRB will have complete jurisdiction over such overpayments. However, if waiver is not applicable, RRB cannot recover the O/P because the annuity is not in current pay status, and the beneficiary is receiving social security benefits, the case may be referred to SSA for recovery from the benefits payable by that agency (see sec. 3.9.45).
- B. Responsibility of the Medicare Section (MS) - MS will take the following actions in cases referred to RRB:
 1. Review alleged overpayments of Medicare benefits to determine whether.
 - a. The amount of the overpayment is correct;
 - b. Recovery efforts have been directed to the person actually liable for the overpayment; and
 - c. The intermediary or carrier has taken all necessary action for which it is responsible.
 2. Clear up any problems or questions concerning a SMI overpayment with the Part B carrier and a HIB overpayment with CMS or the intermediary who handled the case.
 3. Ask CMS to contact the State Welfare Department in any case in which a beneficiary, who is or may be entitled to welfare payments, is liable for an overpayment caused by failure to properly apply the deductible. Send the overpayment material with a transmittal letter to the Centers for Medicare

& Medicaid Services, Overpayment Section (see RCM 10.6, Item 27). In the transmittal, include the following information:

- a. the overpayment was caused by failure to properly apply the deductible and the beneficiary is or may be entitled to welfare payments, and
 - b. a statement of what evidence shows that the beneficiary is or may be entitled to welfare and any identification number, etc., to be used in the contact with the welfare department, and
 - c. any unusual or unclear facts concerning the overpayment, such as the fact that the Part B carrier recovered part of it.
4. Send to the appropriate CMS regional office (see RCM 10.6, item 27a), cases in which the provider, supplier or physician is solely liable for the overpayment. Provide CMS with the name, address of the provider, supplier or physician and the reason why that person is liable for the overpayment in the transmittal letter.
 5. Refer all other overpayment cases which are not under the jurisdiction of the Board to the Centers for Medicare & Medicaid Services, Overpayment Section (see RCM 10.6, item 27). This includes cases in which CMS has jurisdiction for the payment of survivor benefits. Provide the name, address and social security number of any survivor, or a statement that we have no record of a survivor in the transmittal letter. Include any information concerning an estate, if available.
 6. In SMI overpayment cases only, send a carbon copy of the letter to the Part B Carrier.
 7. Check for evidence of fraud or abuse.
 8. If items 3, 4, 5 and 8 do not apply after completing actions 1, 2 and 9, prepare RL-390.
 9. Notify the overpaid person of a decision to recover the overpayment (see sec. 3.9.44), or ask the adjudication unit that suspends the annuity to do so.
 10. If the overpayment cannot be recovered from a railroad retirement annuity because the annuity is not in current pay status, the beneficiary is receiving social security benefits, refer the case to the controlling SSA Program Center for recovery.
 11. File a proof of claim against the estate of a beneficiary who is liable for an overpayment, whose overpayment has not been recovered, and whose estate is still open (see sec. 3.9.53).

12. Transfer overpayments which cannot be recovered to uncollectibles and to GAO, if appropriate (see sec. 3.9.53).
 13. Notify SSA of the disposition of all Medicare overpayments. Notify the Part B carrier of the disposition of SMI overpayments. (See sec 3.9.80 and 3.9.81).
- C. Responsibility of Debt Recovery Division (DRD) - DRD will take the following actions in cases referred to RRB:
1. Determine whether to waive or recover all HI overpayments in which the beneficiary is liable.
 2. Determine the method of recovery if waiver is not applicable.

3.9.25 When Recovery May Be Waived

Recovery of a Medicare overpayment from a beneficiary or from any survivor eligible for benefits on his earnings record may be waived if:

- A. The individual against whom the recovery would be made was without fault in causing the overpayment; and
- B. Recovery would:
 1. Defeat the purpose of Title II of the SS Act, or
 2. Defeat the purpose of Title XVIII of the SS Act, or
 3. Be against equity and good conscience in accordance with Section 1870(c) of the SS Act.

Prior to the 1972 amendments (waiver actions considered before 11-1-72), an overpayment made to a deceased beneficiary who was at fault in causing an overpayment had to be recovered from any survivor eligible for benefits on the deceased beneficiary's earnings record. The overpayment could not be waived even if the surviving beneficiary was without fault in causing the overpayment.

3.9.26 Without Fault

- A. General - Since a finding of without fault is required in all cases before waiver may be approved, resolve this issue first. If "without fault" is not established, do not develop whether recovery would either defeat the purpose of Title II or Title XVIII of the SS Act or be against equity and good conscience.

The term fault as used in "without fault," applies to the overpaid person (beneficiary, provider of services, supplier, or physician) and to the individual from whose benefits the overpayment is to be recovered (a survivor entitled to

benefits on a deceased beneficiary's wage record). The fact that the overpayment may have been caused by an administrative error will not, in itself, establish "without fault." The fault need not necessarily involve fraud. However, there are certain cases in which information in file will establish "without fault" without further investigation.

If a provider of services, supplier or physician is found to be without fault in causing an overpayment the overpayment must be recovered, unless waiver applies, from any benefits payable on the earnings record of the beneficiary on whose behalf the pseudo number was made.

In order to support a without fault finding, the evidence must show that the overpaid person exercised a high degree of care in determining whether he was entitled to the incorrect payment. However, the complexity of the circumstances which caused the overpayment and the capacity of the individual to realize that he was overpaid must be considered in determining the degree of care expected in a particular case.

EXAMPLE: If a beneficiary receives two identical checks within a short period of time based on the same claim, no payments are due based on additional claim, and the beneficiary appears to have reasonable intelligence and education, without fault will probably not apply. If, however, a duplicate payment is made in two checks of differing amounts, payments are due based on additional claims, and/or the beneficiary is of low intelligence or educational level, without fault may apply, depending on the circumstances in the case.

The following guidelines may be followed in determining whether a beneficiary is without fault in causing an overpayment:

1. A beneficiary is not expected to maintain a personal record of utilization.
2. A beneficiary is not usually expected to know the correct deductible amount.
3. A beneficiary is not usually expected to know which services are not covered by Medicare, unless he has been advised in writing that a service is not covered (see sec. 3.9.7, item D).

B. When an Overpaid Person Is at Fault - The person liable for an overpayment is usually at fault when the overpayment resulted from:

1. An incorrect statement by the person that he knew or should have known was false; or
2. Failure of the person to give information that he knew or should have known was material; or

3. Acceptance by the person of a payment that he knew or should have know was incorrect.

C. When an Overpaid Person Is Without Fault.

1. Reliance on Misinformation From an Official Source - The person liable for the overpayment will be found to be without fault if the overpayment occurred solely because the individual relied on misinformation from an official source. If the overpaid person is found to be "without fault" because of reliance on misinformation from an official source, recovery of the overpayment will be deemed to be against equity and good conscience.

Generally, reliance on misinformation may involved in overpayments resulting from payment for supplies or services which are not covered by Medicare. Reliance on the advice or information given to the individual must have some reasonable basis and must be restricted to information from an agent or agency of the U.S. Government, including intermediaries and carriers.

Generally, misinformation is not considered to be involved when duplicate checks are issued on the basis of the same claim or if information is provided on the basis of erroneous or incomplete records which the individual did not question. However, an individual may sometimes be found to be without fault in such circumstances.

2. Overpayment Discovered More Than Three Years After Notice of Payment Sent - In the absence of evidence to the contrary, the provider of services, supplier, or physician is deemed to have been without fault in causing an overpayment if the overpayment was discovered more than 3 years after the year in which the notice of payment was sent.

For examples of when "without fault" applies see SSCM 5589.2.

3.9.27 Defeat The Purpose Of Title II

- A. General - Recovery of an overpayment would "defeat the purpose of Title II of the Social Security Act" (be contrary to the purpose and intent of the Act), if it would deprive the overpaid person of income that is reasonably necessary for ordinary living expenses.

Request the field to obtain a completed DR-423 from the debtor if the individual claims it would be a hardship to repay the Part B. Assume that recovery would defeat the purpose of Title II, without developing a DR-423, if there is an indication that the beneficiary is receiving or entitled to welfare payments.

- B. When "Defeat the Purpose of Title II" Applies - Recovery of an overpayment will generally defeat the purpose of Title II if:
1. The person needs substantially all of his current income to meet his current ordinary and necessary living expenses; and
 2. Recovery of the overpayment would reduce the person's total assets, not including household furnishings, wearing apparel, an automobile and a home of reasonable value in which the overpaid person lives, to:
 - a. below \$3,000 for a person without dependents; or
 - b. below \$5,000 for a person with one dependent. Allow an additional \$600 in assets for each additional dependent.

If the overpaid person has assets which exceed \$3,000, \$5,000, etc., by less than the amount of the overpayment, it is possible to apply waiver to only part of the overpayment and to recover the balance.

EXAMPLE: A Medicare beneficiary was overpaid \$1,850.00. He and his wife have assets of \$6,000, excluding those outlined above. Their total income barely meets their ordinary and necessary living expenses. Assuming that the beneficiary was without fault in causing the overpayment, \$850 of the overpayment can be waived and \$1,000 can be recovered, leaving assets of \$5,000.

Waiver of recovery against an estate may not be considered on the basis of defeat the purpose of Title II, even though waiver would have been proper on that basis during the lifetime of the overpaid person. The estate cannot be considered to need income for ordinary and necessary living expenses.

For further information concerning "Defeat the Purpose of Title II," see SSCM 5550 through 5552.4.

3.9.28 Defeat The Purpose Of Title XVIII

Recovery of the overpayment would "defeat the purpose of Title XVIII" (be contrary to the purpose and intent of that title of the Act), if it would deprive the person of funds needed within a year for hospital or medical care reasonably necessary for his health. If recovery would not deprive the individual of a subsistence income (i.e., defeat the purpose of Title II), but would deprive him of necessary hospital or medical care, such recovery would defeat the purpose of Title XVIII. However, if recovery would obviously defeat the purpose of Title II, only that one element need be developed.

The need for hospital or medical care must be real and tentatively planned to occur within a year (as distinguished from conjectural or in the distant future), and the commitment of the funds must be real and not conjectural, to be considered in determining whether

adjustment or recovery would "defeat the purpose of Title XVIII." The individual need not have begun the needed treatment or care, but he must have made the necessary plans to do so. He may have arranged for the treatment when it is medically appropriate or when he has accumulated the necessary cash to defray the expenses. A statement (1 or 2 sentences long) from the physician in charge or from a similarly authorized medical source is needed to indicate (a) whether the treatment and/or care is needed and (b) the estimated cost. Note that expenses already incurred for medical care, hospitalization, etc., are taken into consideration in determining whether recovery would defeat the purpose of Title II. No expense may be counted twice in determining whether recovery would defeat the purpose of Title II. No expense may be counted twice in determining whether recovery would defeat the purpose of Title II or XVIII.

3.9.29 Against Equity And Good Conscience

- A. General - Under the SS Act, recovery of an overpayment will be considered to be against equity and good conscience where the beneficiary, relying on benefit payments or on a notice that such payments would be made, relinquished a valuable right or changed his position for the worse. In reaching such a determination, the individual's financial circumstances are irrelevant.
- B. When "Against Equity and Good Conscience" Applies - Recovery of an overpayment will be deemed to be "against equity and good conscience" if the overpaid person is found to be "without fault" because of reliance on erroneous information from an official source (see RCM sec. 3.9.26).

Recovery of an overpayment from a beneficiary who is without fault is also deemed to be against equity and good conscience if:

1. The overpayment was made for items or services not medically necessary or for the expenses of custodial care; and
2. The overpayment was discovered more than 3 years after the year in which the notice of payment was sent.

In addition, a provider under Part A, or a physician or other supplier who accepted assignment under Part B cannot, after refunding a Part B for medically unnecessary or custodial care services, charge the enrollee who is without fault after 3 years have expired.

For further information concerning "Against Equity and Good Conscience," see SSCM 5553 through 5553.4 and 5589.2.

3.9.40 When To Recover

Recover the overpayment from the beneficiary or, if he is deceased, from a survivor entitled to benefits on his earnings record if:

- A. Tolerance does not apply (see sec. 3.9.41); and
- B. The beneficiary is liable for the overpayment; and
- C. The overpayment cannot be waived; and
- D. The intermediary or carrier was unable to recover the overpayment.

3.9.41 When Tolerance Applies

- A. Overpaid Person Alive.
 - 1. Benefits in Current Pay Status to the Overpaid Person - Offset against benefits currently payable unless the amount of the overpayment is \$5.00 or less.
 - 2. Benefits Not in Current Pay Status - Do not request a refund or take any further recover action if the amount of the overpayment is \$15.00 or less, even if setoff may be possible against benefits payable to the overpaid person in a subsequent month or if immediate setoff action is possible against benefits payable to an individual other than the overpaid person.
- B. Overpaid Person Deceased.
 - 1. Benefits in Current Pay Status to a Survivor - Offset against benefits currently payable unless the amount of the overpayment is \$5.00 or less.
 - 2. Benefits Not In Current Pay Status.- Do not request a refund or take further recovery action if the amount of the overpayment is \$15.00 or less.

Although no recovery action will be taken when tolerance applies, any voluntary refund by a beneficiary will be accepted.

If tolerance applies, file the overpayment notice in the folder marked: "NAN; O/P under \$15.01; No Monthly Benefits." Do not set up a program accounts receivable record. If an accounts receivable record was set up, close it out by entering code 88 in the "cause" columns (cols. 52-53) of the. Prepare Form RL-391 with a check in the "Determined Uncollectible" box and add: "Tolerance applied - No Monthly Benefits." If a SMI benefit was overpaid, send a copy of the RL-391 to Travelers. See secs. 3.9.80 and 3.9.81.

3.9.42 Methods Of Recovery

The overpayment can be recovered by one of the following methods in the order of preference listed:

- A. Cash refund in one lump sum.

- B. Set off against RR or SS Act benefits:
1. During the lifetime of the overpaid person, against RR or SS Act benefits to which he may be entitled, whether based on his own earnings record or the earnings record of another person; or
 2. After the overpaid person's death, against RR or SS Act benefits or lump-sum payments payable to survivors on the overpaid person's earnings record.

The overpaid person is liable for the overpayment during his lifetime. Only upon his death can the overpayment be set off against benefits for other persons on the same earnings record.

- C. Cash installments, provided the payments are made regularly and are substantial enough to liquidate the overpayment within a reasonable period of time.
- D. Temporary Withholding (partial adjustment). (See sec. 3.9.43.)
- E. Civil action against a beneficiary's estate (see sec. 3.9.53).

NOTE: An actuarial adjustment cannot be used to recover an overpayment of Medicare benefits.

3.9.43 Temporary Withholding

- A. General - Temporary withholding (partial adjustment) consists of withholding part of a monthly benefit each month until the overpayment is recovered in full.

Temporary withholding may be offered if evidence indicates that the beneficiary is dependent on part of his monthly benefits for ordinary and necessary living expenses and recovery of the overpayment by any other method would cause financial hardship.

Temporary withholding is never permitted:

1. If the overpayment was caused by intentional false statements or misrepresentations by the person against whose benefits offset is being made, or by his willful concealment of, or deliberate failure to furnish, necessary information; or
 2. In amounts of less than \$10.00 a month; or
 3. In other than even dollar amounts.
- B. Beneficiary Without Fault - If waiver depends upon a finding of "Defeat the Purpose of Title II" and the DR-423 indicates that the beneficiary needs only part of his monthly benefit for ordinary and necessary living expenses, temporary

withholding should be granted. However, if other conditions for waiver are present and it would be necessary to withhold less than \$10.00 a month to insure the beneficiary of income needed for his ordinary and necessary living expenses, waiver, not temporary withholding, should be granted.

If the overpayment cannot be recovered by temporary withholding, before termination of entitlement, without depriving the beneficiary of needed income:

1. Withhold from the beneficiary's monthly benefits the maximum amount possible without depriving the beneficiary of needed income; and
 2. After the benefits are terminated, consider waiving recovery of the balance of the overpayment. No further without fault development will be needed. It will be necessary, however, to determine whether recovery of the remainder of the overpayment will defeat the purpose of Title II of the SS Act at that time.
- C. Beneficiary Not Without Fault - If the beneficiary is not without fault in causing the overpayment, the temporary withholding must be set at a rate which will permit recovery of the overpayment before the expected last month of entitlement or within a 36 month period, whichever is earlier. If no monthly withholding amount is suggested by the beneficiary, withhold one-half of the monthly benefit, if this will result in recovering the overpayment within a 36-month period.

If the overpayment is not recovered before termination of entitlement, use all available means to recover the balance of the overpayment.

For further information, see SSCM 5516 TO 5520.6.

3.9.44 Notice To Individual

- A. Request for Refund - The intermediary or carrier is responsible for sending a request for refund, similar to that shown in Exhibit 2, to the beneficiary. If a satisfactory letter was not sent, HB should return the overpayment material to the Part B carrier or the intermediary, as shown in sec. 3.9.17.

In certain unusual cases, MS will send an initial request for refund. See Exhibit 2 for a sample letter to be used as a guide. Send a copy of the letter to the field office.

- B. Recovery Notice - MS will send a case to an adjudication unit for suspension of the annuity and a letter informing the individual of recovery action if:
1. The overpaid person is alive,
 2. A previous letter was sent to the overpaid person, notifying him of his rights to reconsideration and waiver,

3. The overpayment is less than \$200.00, and
4. The overpayment can be recovered from one month's annuity.

A G-167 must be prepared to notify the adjudication unit of the recovery action to be taken.

MS will prepare and send a recovery notice in any case not handled by an adjudication unit. Include in the letter:

- The amount of the overpayment and how and when it occurred,
- An explanation of how the overpayment will be recovered, including the option of refunding the overpayment in cash,
- The right to request reconsideration or review of the overpayment determination, if this right was not explained in a recent letter, and
- An explanation of the waiver provision of the law, if not given in a recent letter.

If the overpayment is \$200 or more or there is an indication that waiver may apply, send the overpayment letter to the district office for in-person delivery. Use Form G-421b as a cover memo.

See Exhibit 3 for a sample letter to be used as a guide. Send a copy of the letter to the field office.

3.9.45 Requesting SSA To Recover From SS Act Benefits

If recover from RR Act benefits is not possible because an annuity is not in current pay status, and there is an indication that the beneficiary is entitled to SS Act benefits, request the SSA program center to recover the overpayment. Ask the program center to advise when their recovery action is completed. Include the following information in the letter:

- A. Name and address of the beneficiary or survivors;
- B. SSA claim number;
- C. Amount of the overpayment;
- D. Cause of the overpayment; and
- E. Reason recovery is not possible from RR Act benefits.

Send a copy of the letter to SSA Reconsideration Branch (see RCM 10.6, item 27), and the local carrier's office which notified RRB of the overpayment. It is not necessary to

notify the beneficiary or the survivors of the referral to SSA unless an inquiry is received. Establish a six-month tickler call up for control purposes. If, after the expiration of the call up, SSA has not recovered the entire overpayment, trace the program center "Attention: Recovery Unit" to request the status of the recovery action.

3.9.46 Reinstatement Of Payments By Adjudication Units

When sufficient monthly annuity payments have been withheld to offset the erroneous Medicare payment, complete the award form and withhold the amount due in the normal manner. Enter the amount recovered on Form G-376. Instruct the coding clerk to route the folder to "Accts. Rec." after vouchering.

Complete Form G-240 requesting the Medicare Section (MS) to transfer the amount of the overpayment from the RR account to the appropriate Medicare account. Control the folder to send to MS.

3.9.50 Survivor Benefits Payable At RRB

After the overpaid person dies, consider waiver or recovery of the overpayment from monthly benefits or lump-sum death payments due a survivor on the earnings record of the overpaid person. See Sec. 3.9.25 through 3.9.46.

3.9.51 Survivor Benefits Payable At SSA

If there is an annuity due and unpaid at death, MS will refer the case to an adjudication unit for offset. Transfer the balance of the overpayment, along with a letter of explanation and all material concerning the overpayment, to SSA, Program Review Section (see RCM Part 10.6, item 27a). See Exhibit 1 for a sample letter. Be sure to show all SSA claim numbers in the letter.

Do not set up an accounts receivable record for an overpayment being transferred to SSA. Close out any accounts receivable record previously set up by entering code 88 in the "Cause" columns (cols. 52-53) of the G-376.

3.9.52 No Further Benefits Payable At SSA Or RRB

If an overpaid person is deceased and recovery is not possible from any other source, liability rests with the estate of the deceased. If no further benefits are payable on the employee's earnings record, the overpayment is less than \$100.00, and evidence of an estate is not available, terminate collection action as shown in sec. 3.9.61.

If the name and address of the administrator or attorney of the estate is in file, write a letter to that person, asking for a refund of the overpayment. If a refund is not received and the overpayment is less than \$100.00, terminate collection action.

If the overpayment is \$100.00 or more, develop for information concerning an estate as shown in sec. 3.9.53, whether or not the file contains evidence that an estate exists.

3.9.53 Recovery From Estate

To develop for an estate, ask the D/O to check with the probate court in the area where the overpaid person died or with the nearest relative to determine whether an estate has been opened and, if so, the name and address of the administrator of the estate, the identity and location of the court of jurisdiction, the expected closing date of the estate and the assets and liabilities of the estate. If the estate is closed or was not administered, the D/O should check to see who received the assets of the estate and the amount of those assets.

After developing for the existence of an estate, handle as follows:

- A. No Evidence of an Estate - Transfer the overpayment to uncollectible (see sec. 3.9.60).
- B. Estate Open. - File a proof of claim (see Exhibit 4) against the estate when there are sufficient assets to settle the indebtedness of the Board. File the original of the Proof of Claim and Statement of Indebtedness with the clerk of the court in which the estate is to be probated. File a duplicate original copy with the legal representative. Send copies of both documents to the D/O having jurisdiction of the area in which the court is located.

Some references to the SS Act for use in preparing a proof of claim are:

Section of SS Act	Type of Overpayment
Title XVIII, Part A, Section 1812(a) (U.S.C. 1395d)	Exhaustion of benefit days
Title XVIII, Part A, Section 1813 (U.S.C. 1395e)	Failure to apply deductible or coinsurance
Title XVIII, Part A, Section 1814 (U.S.C. 1395f)	Payment for non-covered services
Title XVIII, Part B, Section 1833(a) (U.S.C. 1395(1))	Payment of 100%, rather than 80%
	Charges exceeding reasonable charge
Title XVIII, Part B, Section 1833(b) (U.S.C. 1395(1))	Failure to apply deductible
Title XVIII, Part B, Section 1834(a) (U.S.C. 1395m)	Exhaustion of benefit days for home health services

Title XVIII, Part C, Section 1862(a) (U.S.C. 1395y)	Payment for non-covered services (Part A and B)
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- C. Estate Closed or Will Not Be Administered - When the assets of an estate have been distributed, a distributee may be liable for the refund if he still has the proceeds of the estate, or property resulting from the proceeds, in his possession. The liability of each distributee is proportionate to the share received. Therefore, request a refund from each distributee. If a distributee with substantial assets refuses to refund the portion of the overpayment for which he is liable and that portion is \$200.00 or more, refer the case to GAO.

3.9.60 When To Classify A Medicare Overpayment As Uncollectible

Classify a Medicare overpayment as uncollectible when complete recovery or a reduction in the overpayment balance cannot be made by:

- A. Waiver
- B. Setoff against a current benefit accrual under the RR or SS Act; or
- C. Further collection efforts.

3.9.61 Processing Uncollectible Cases

Uncollectible cases under the jurisdiction of RRB should be handled by one of the following methods:

- A. Suspending Collection Efforts - Collection action may be suspended temporarily (establish a call up for future collection action) when:
 - 1. The overpaid person is still entitled to benefits but offset is not possible and requests for refund have not been honored; or
 - 2. The overpaid person will become eligible for benefits within 6 months following the month in which recovery action is discontinued; or
 - 3. The debtor cannot be located after diligent effort but there is reason to believe that future collection action may be productive enough to justify periodic review; or
 - 4. The debtor is unable to make current payments but his future prospects justify periodic review and recovery action.
- B. Terminate Collection Efforts - Collection efforts should be terminated (transfer the overpayment to the uncollectible account on PARS when:
 - 1. Substantial payments cannot be collected by any method; or

2. The debtor cannot be located and future collection prospects are remote; or
3. Cost of collection efforts will exceed the amount of the overpayment; or
4. The overpayment is less than \$200.00.

When efforts to collect an overpayment are terminated, MS will prepare Form G-270 giving the reasons.

- C. Compromise Settlement - See RCM 6.6.150 through 6.6.156 and SSCM 5537 through 5538.
- D. Refer to GAO - See section 3.9.62 for when and how to refer an overpayment to the General Accounting Office.

3.9.62 Referral To GAO

- A. When to Refer a Case to GAO - An uncollectible overpayment should be referred to GAO for further collection action when the overpayment is \$200.00 or more and there is an indication of fraud or misrepresentation or the overpaid person appears to have the means to repay the debt.
- B. Information Required - Before referring to GAO a case in which a beneficiary is liable for an overpayment, request the F/O to develop DR-423 or another statement of the debtor's financial condition, if such a statement is not in file.

Refer the case to GAO on GL-14 (see Exhibit 5) and include the following information:

1. The name of the overpaid person and the person liable for the overpayment.
2. The last known address of the person from whom recovery should be made.
3. The debtor's date of birth, RRB No., and SSA No.
4. A complete explanation of the overpayment.
5. A summary of collection action taken.
6. Evidence showing the debtor's ability to repay.

See sec. 3.9.71 for the entries to be made in part 2 of Form GL-14. When releasing the GL-14, transfer the overpayment to the uncollectible account.

3.9.70 Entering Medicare Overpayments In Accounts Receivable

All Medicare overpayments under RRB jurisdiction, except those in which tolerance applies, will be entered by HB on Form G-376 according to the instructions in RCM Part 11. After preparing the G-376, route the case to "Acct's Rec."

Overpayment in which tolerance applies or which are under the jurisdiction of SSA should not be entered on PARS. If such an overpayment is inadvertently entered in PARS, the entry should be closed out.

3.9.71 Code Designation And Appropriation Number For HI Overpayments

Separate accounts receivable have been established for overpayments of hospital and medical insurance. The codes to be entered in the overpayment type on PARS are as follows:

Type Code	Type of Overpayment
520	Medical Insurance Overpayments (Palmetto GBA)
540	Hospital Insurance Overpayments (USA)
550	Hospital Insurance Overpayments (Canada)

The appropriation numbers and trust fund titles shown below are used in preparing Forms GL-14 (see Exhibit 5).

Appropriation	Trust Fund Title
75-20X8004	Federal Supplementary Medical Insurance Trust Fund
75-20X8005	Federal Hospital Insurance Trust Fund

3.9.72 Responsibility For Posting Waiver And Recovery Actions

Responsibility for posting waiver or recovery action on PARS depends on the action taken. If the overpayment is:

- A. Waived - MS GS-08 examiners will post the waiver actions. This action is authorized by GS-09 examiners.

- B. Recovered from RR Act benefits - MS will post the recovery at the time of reinstatement, if the overpayment is recovered from one months annuity, after recovery if recovery takes more than 1 month. The adjudicative units will return the files to MS for posting to PARS after recovery.
- C. Recovered by cash refund - MS premiums collections clerk will post the recovery.

3.9.80 Notifying SSA

Notify SSA of the disposition of every valid overpayment that has been referred to RRB. Send RL-391 and, if pertinent, a copy of the G-270 to CMS.

3.9.81 Notifying Palmetto GBA

When an SMI benefit overpayment is involved, send RL-391 and, if pertinent, a copy of the G-270 to the Railroad and Medicare Division, Palmetto GBA. A carbon copy of the letter to CMS may be used. In such cases, show the following information on the carbon:

cc: Railroad and Medicare Division

Palmetto GBA

3.9.90 Forged Medicare Benefit Checks

When the payee of a SMI benefit check alleges that he did not endorse the check, the Medicare Part B carrier will develop the forgery claim and route it to the CMS regional office for investigation. Any unresolved SMI benefit check forgery claims on hand should be routed to the chief of Medicare programs who will forward them to the appropriate destination.

If a Canadian HI check forgery claim is received, forward it to CPPS for handling.

3.9.93 Handling After Report By U.S. Secret Service

The U.S. Secret Service will report the results of its investigation to RRB. MS will transmit the report to the Part B carrier. If the report is that the endorsement was forged, the Part B carrier will issue a new check to the payee, with an explanation stating that the U.S. Secret Service has assumed jurisdiction of the forgery, and will enter into reclamation proceedings with its bank.

If the U.S. Secret Service reports that the endorsement was not forged, the Part B carrier will notify the payee of that fact.

Request For Refund Of Medicare Benefit Overpayment

Dear:

Our records show you received \$ ____ more in Medicare benefits than you should have. (Include an explanation which explains in simple, non-technical language how and when the incorrect payment was made.)

You are asked to refund by check or money order made payable to the Railroad Retirement Board and sent to our Payment Records Section at the address shown in the heading of this letter. If you do not repay this amount within 30 days of the date of this letter, it will be deducted from the annuity you are receiving under the Railroad Retirement Act.

If you believe that this determination is not correct, you may request that your case be reexamined. If you want this reconsideration, you must request it no later than 6 months from the date of this notice. You may make such a request through the nearest district office of the RRB. If additional evidence is available, you should submit it with your request.

The law requires that an overpayment must be paid back, unless both of the following conditions are met:

1. You were not responsible in any way for causing the overpayment. (If the payment was made to the beneficiary, rather than to the provider, add: "and you cashed the check(s) believing that the payment was correct"); and
2. Paying back the overpayment would keep you from paying your necessary living expenses, including current or planned medical expenses, or would be unfair for some other reason. If repayment would cause you serious financial hardship, it will be necessary for you to submit a statement of your income from all sources as well as your expenses and other debts.

If you believe both of the above conditions apply in your case, you should write the Railroad Retirement Board within 30 days from receipt of this letter. Unless we hear from you within 30 days, the overpayment will be recovered from your annuity.

Notice Of Recovery Of Medicare Benefit Overpayment

Dear:

(Explain in simple, non-technical language how and when the incorrect payment was made.)

The following methods of repayment are for your consideration:

1. Cash refund of ____ by check or money order made payable to the Railroad Retirement Board and sent to our Payment Records Section at the address shown in the heading of this letter.
2. Withholding your annuity from ____ through ____ The partial payment due for ____ would be released to reach you soon after the end of that month.

(Add the following item if information in file indicates that recovery by one of the above methods would cause financial hardship.)

- Temporary withholding. This means that ____ per month would be withheld from your annuity for ____ months from ____ through ____.

Please advise which of the methods you select to refund the overpayment.

(Include the following paragraphs if the individual has not previously been informed of his rights to reconsideration or waiver).

If you believe that this determination is not correct, you may request that your case be reexamined. If you want this reconsideration, you must request it no later than 6 months from the date of this notice. You may make such a request through the nearest district office of the RRB. If additional evidence is available, you should submit it with your request.

The law requires that an overpayment must be paid back unless both of the following conditions are met:

1. You were not responsible in any way for causing the overpayment, and
2. Paying back the overpayment would keep you from paying your necessary living expenses, including current or planned medical expenses, or would be unfair for some other reason.

If you believe that both of the above conditions apply in your case, you should write to the Railroad Retirement Board within 30 days of the date of this letter. If the conditions do not apply, you must arrange to refund the overpayment.

Unless we hear from you within 30 days of the date of this letter, your annuity will be suspended to recover the overpayment by withholding, as shown above.

If you have any questions about this letter, please contact the nearest district office of the RRB.

Statement And Proof Of Claim State Of Texas

The Probate Court of Wichita County Estate of John L. Doe, Deceased

To: Cleo M. Doe, Executrix
Estate of John L. Doe
305 Collins Street
Wichita Falls, Texas 76301

Overpayment of hospital insurance benefits under Section 7(d) of the Railroad Retirement Act as amended through 1974 (45 U.S.C. 231f) from 7-27-68 through 11-4-68 per attached statement.

\$847.02

STATE OF ILLINOIS) vs

County of Cook)

I, Donald M. Smith, Director of Retirement Claims of the Railroad Retirement Board, a duly authorized agent for the United States in this behalf, being duly sworn, depose and say:

1. That the estate of John L. Doe, deceased, is justly and truly indebted to the United States in the sum of \$847.02.
2. That the nature of said debt is set forth in the attached statement.
3. That the attached statement is a true and correct statement of account against the estate of John L. Doe, deceased.
4. That no part of said debt has been paid, but that the sum is now due and payable.
5. That there are no set offs or counter claims to said debt.
6. That said debt has priority and must be paid in full in advance of distribution to creditors, as and to the extent provided in Section 3466 of the Revised Statutes (31 U.S.C. 191) or other applicable provisions of law. Attention is also called to the provisions of Section 3467 of the Revised Statutes (31 U.S.C. 192) with respect to the personal liability of every executor, administrator, assignee, or other person who fails to pay the claims of the United States in accordance with their priority.

Subscribed and sworn to before me _____ Dated this _____ day of
this _____ day of January 1975 _____ January 1975

Notary Public, Cook County, Illinois J. R. Feldhiem

My Commission expires _____ 19 _____ Director of Disability and Medicare Operations

Railroad Retirement Board

Chicago, Illinois

Statement Of Indebtedness John L. Doe, Deceased

John L. Doe became entitled to hospital insurance benefits under Section 7(d) of the Railroad Retirement Act of 1974 on 7-1-66. Section 7(d) of the Railroad Retirement Act (45 U.S.C. 231f) provides that:

"The Board shall...have the same authority to determine the rights of individuals...to have payments made on their behalf under section 226, and Parts A and C of Title XVIII of the Social Security Act as the Secretary of Health, Education, and Welfare..."

Mr. Doe entered Madison North Convalescent enter on 2-28-68. Benefits were paid on his behalf under Part A, Title XVIII of the Social Security Act for 27 days from 2-28-68 through 3-26-68. He was a patient at Cedar Rest Haven, a skilled nursing facility, from 3-26-68 through 7-15-68. No benefits were paid during this period. Mr. Doe was transferred to Deaconess Hospital for the period from 7-15-68 through 7-27-68. Benefits of \$760.16 were paid during that period. He entered Madison South Convalescent Center on 7-27-68. Benefits totaling \$2,527.69 were paid on his behalf for 100 days from 7-27-68 through 11-4-68.

Section 1812(a) of Part A, Title XVIII of the Social Security Act (42 U.S.C. 1395d) provides:

"The benefits provided to an individual...shall consist of entitlement to have payment made on his behalf...for post-hospital extended care services for up to 100 days during any spell of illness..."

Section 1813(a) of Part A, Title XVIII of the Social Security Act (42 U.S.C.1395e) provides:

"The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount...for each day...on which he is furnished such services after such services have been furnished to him for 20 days during such spell..."

Section 1861(a) of the Social Security Act (42 U.S.C. 1395x) status:

"The term 'spell of illness' with respect to any individual means a period of consecutive days..(1) beginning with the first day...on which such individual is furnished inpatient hospital services or extended care services...and (2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or an inpatient of a skilled nursing facility..."

When benefits were paid on Mr. Doe's behalf for the period from 7-27-68 through 11-4-68, the intermediary was unaware of the benefits paid on his behalf for 2-28-68 through 3-26-68. Therefore, benefits were paid for the entire 100 days, rather than for 73 days.

Benefits were also paid without deducting the coinsurance amount \$5.00 per day for the 20-day period from 7-27-68 through 8-15-68.

Mr. Doe was overpaid a total of \$100.00 because of the failure to apply the coinsurance and \$747.02 for 27 days after his coverage period was exhausted. The total overpayment is \$847.02.

Report Of Alleged Forgery

TO: District Manager

FROM: Chief, Waiver, Recovery and Penalty Section

Bureau of Retirement Claims

A Name

Address

SUBJECT: Alleged Forgery of Medicare Check

Health Insurance Claim No.

Claimant:

The (name of carrier) recently referred to the RRB the matter of an alleged forgery of a Medicare benefit check for \$ _____ issued on _____ to _____. It is our responsibility to submit such cases to the U.S. Secret Service for investigation and determination.

Attached is an original plus two tissue copies of our letter to the Special Agent in Charge of the _____ Secret Service Office. It is requested that a representative of your office contact that Secret Service Agent to deliver the original and first tissue copy of the letter and the attached exhibits.

Please advise us when the letter and exhibits have been delivered. Include in the written report any comments which the Special Agent may have concerning the content of our letter or the exhibits.

The additional copy of our letter to the Secret Service is for your file.

Report Of Alleged Forgery

Special Agent in Charge
United States Secret Service

In reply refer to

RRB No.

Health Insurance Claim No.

Alleged Forgery of Medicare

Check

In the amount of

Claimant:

Dear Sir:

Palmetto GBA, the Railroad Retirement Board's intermediary for Part B Medicare benefits to our annuitants, recently advised us of a claim of forgery on a Medicare payment check issued to _____. Benefit payments of this type are drawn by Medicare intermediaries from United States funds under Title XVIII of the Social Security Act.

The check in question was issued by Palmetto GBA, Augusta, Georgia, on _____, drawn on the Chase Manhattan Bank, New York, against the Federal Supplementary Medical Insurance Trust Fund. That check, numbered _____, was payable in the amount of _____ to _____ (name) (address) _____.

With their referral of this case, Palmetto GBA forwarded to us the original and four photocopies of the Medicare check in question, together with the forgery affidavit from the payee, _____.

Because the alleged forgery in this case involved a check representing funds of the United States, we are submitting this matter to your office for further handling and appropriate action. You will find enclosed copies of the following documents:

1. The original and four photocopies of the above described health insurance benefit check for _____, issued on _____ to _____ by Palmetto GBA.
2. Three photocopies of the forgery affidavit by _____ name _____ address _____, given to Palmetto GBA on _____.
3. Three photocopies of _____, signed on _____ by _____.
4. Three copies of _____, signed on _____ by _____.

After you have completed your investigation, please advise us of your recommendation or determination in this matter. We, in turn, will notify Palmetto GBA of your decision. If the forgery claim is substantiated, and if it is otherwise appropriate in this case, we will request Palmetto GBA to issue a replacement check to _____. If possible, please

return the original of the enclosed Medicare check, because we may be required to return it to Palmetto GBA for their records.

You may indicate the status or disposition of this case by checking the appropriate items on the next sheet and returning it to us at the address shown in the heading of this letter.

Very truly yours,

J. R. Feldheim

Director of Disability and Medicare Operations

Enclosures

Report Of Alleged Forgery (Status)

To: U.S. Railroad Retirement Board
Operations
RMS Section
844 North Rush Street
Chicago, Illinois 60611

Agency File:

Beneficiary:

Check No.

Claimant:

The status of our file on this case is as follows:

// Payee's claim of forgery substantiated // Settlement recommended.

// Payee's claim of forgery withdrawn. // Signed statement attached.

// Restitution was made or is expected by. _____

(Date)

// Other _____.

// Original check returned herewith.

Special Agent

Special Agent in Charge

3.10.1 Scope of Chapter

This chapter provides information and instructions about Part B premium collection activities. The Medicare and Payment Services Section (MPSS), which includes the Medicare Unit (MU) and Tax, Clerical and Imaging Unit (TCIU), handles all Part B collection activities. This includes:

- the screening of premium notices;
- the collection of premium payments through the lockbox (US Bank is the current lockbox operator. The lockbox address is U.S. Railroad Retirement Board, Medicare Premium Payments, P.O. Box 979024, St. Louis, MO 63197-9000.)
- the control and deposit of premium payments ;
- the crediting of premium payments to advance the paid thru date on MIRTEL ;
- the crediting of payments to debts on PAR records ;
- the handling of routine correspondence pertaining to these matters ;
- the handling of premium payment rejects and alerts ; and
- the various funds transfers involving Part B premiums, with detailed instructions on how to process the Death Transfer listing, page 13 of the MIRTEL statistics and PAR report 4693 .

3.10.2 Types of Premium Notices (RL-800/G-800)

Forms RL-800/G-800 are the premium due notices mailed to beneficiaries who are on direct bill for their Part B premiums. Form G-800 is printed at the bottom of Form RL-800, and is to be returned by the beneficiary with his or her payment. Form G-800 has coded billing information that the lockbox operator enters for the electronic updating of MIRTEL.

A. Initial and Recurring

1. Form RL-800/G-800, Initial Notice - The due date shown is the fifth day of the month following the month of preparation. The period covered is the month of the due date, plus the two following months. Retroactive premiums for the current enrollment period are also included.
2. Form RL-800/G-800, Recurring Notice – After the initial bill is paid, recurring premium notices are prepared for a 3-month period (not necessarily a calendar quarter) until billing is stopped or coverage is terminated.

3. Form RL-800/G-800, Second Notice – If an initial or recurring notice is not returned with a payment within two months, a second notice is generated. The words “SECOND NOTICE” appear in the upper right hand corner of the bill for identification.
4. Form RL-800/G-800, Termination Notice – If an initial, recurring or second notice is not returned by the beginning of the termination month, a termination notice is generated. The word “TERMINATION” appears in the upper right hand corner of the bill for identification.

B. Year-End Bills (released only in January, March and April)

The year-end notices are sent to beneficiaries whose payments are in a suspended status. These notices cover unpaid premiums for the prior calendar year, and January through April of the current year. The words “YEAR-END” appear in the upper right hand corner of the bill for identification. The termination date is always April 30.

1. Around January 1 of each year, Form G-800 initial year-end notices are generated.
2. If no payment is received by March, then a second notice is released in March.
3. Termination Year-End Notices – In April, if the beneficiary has not paid his or her premiums, a third notice is produced. This notice is identified by the words “TERMINATION YEAR END” in the upper right hand corner of the notice.

3.10.3 Screening Initial and Recurring Premium Notices

Forms RL-800/G-800 are mailed to approximately one-third of the beneficiaries on direct bill each month. The premium notices that are to be mailed are forwarded to the MPSS/MU after the monthly billing run is completed on the first work day of the month. If the premium notices are not received by noon of the day after the billing run, the MU clerk should notify the supervisor to contact the designated P&S staff to initiate an investigation. Upon receipt of the premium notices, the MPSS/MU is responsible for taking the following actions:

- A. Review notices for missing or incomplete name and address information.
 1. P&S releases an e-mail to the MU with Monthly Billing Run data. Included in the data are claim numbers for notices with missing name and address information. Sort through the Forms RL-800 to locate the cases mentioned in the e-mail from P&S.
 2. While sorting through the premium notices, additional premium notices with missing information may be found. Remove all premium notices that contain

missing or incomplete name or address information. Use MOLI or DATA-Q to obtain correct name and address information.

3. Manually complete a Form RL-800 on RRAILS with the correct address information. Include the billing information printed on the incomplete Form RL-800. Cut off the bottom of the incomplete RL-800 that contains the coded billing information and tape it to the bottom of the form manually created. Make a copy of the form to create a neat document with the coded billing information and release it to the beneficiary. It is important to handle these letters on the date of receipt, so that the beneficiary does not miss submitting a payment on time. The original Forms RL-800 with incomplete or missing name/address information should be destroyed.
- B. Remove all premium notices for amounts exceeding \$1,200. Refer the notices to the Senior Assistant to the Chief of MPSS (SACM) for review. The SACM will determine if the notices are correct. The SACM will release the correct notices and shred the incorrect notices. During October through December, be sure to include a Form T-800 with each notice if it is determined that the notice should be released.
- C. Termination Notices:

The MPSS staff will make a copy of each termination notice, front and back. The copy will be released to the Field Office, as outlined below. The original notices will be released directly to the beneficiary from the mailroom on the day of receipt of the computer-generated notice.

1. Determine which Field Office services each beneficiary. This information is pre-printed on the notice. Group together the notices for each Field Office.
 2. Complete a Form G-833 (Form RL-800/G-800 Contact-Third Notice of Medicare Part B Premiums Due) for each Field Office. The G-833 is found on RRAILS.
 3. During the months of October through December, include one Form T-800 for each notice. Form T-800 gives beneficiaries information about Medicare premium rates and deductibles for the upcoming year.
 4. Enclose the Form G-833 and the termination notices (and Forms T-800, if any) in a letter-size envelope for each Field Office. Show the Field Office name on the front of the envelope.
- D. Deliver to Mailroom – Take all of the envelopes for the Field Offices to the mailroom for enclosing and mailing. The mailroom will put an address label for the Field Office on the envelope and enclose a return “lockbox” envelope pre-addressed to U.S. Railroad Retirement Board, Medicare Premium Payments, P.O. Box 979024, St. Louis, MO 63197-9000 for each notice.

3.10.4 Screening Year-End Bills

When an annuity goes into suspense the record status on MOLI changes to 23 for year-end billing. The year-end bills are printed and sent to the MPSS for sorting and handling. Follow these steps when processing year-end bills:

- A. Check the beginning date of the period for which premiums are due on each notice. If the beginning date is January through July, a MU examiner will check for utilization for an equitable relief determination before a decision is made on whether to release the notice. Move to step B if the beginning date is August or later.
- B. Address Review – Review name and address information on the notices to make sure the notices contain complete information. If any information is missing, use MOLI or DATA-Q to obtain correct name and address information. Manually complete a Form RL-800 on RRAILS with the correct address information and include the billing information printed on the incomplete notice. Cut off the bottom of the incomplete RL-800 that contains the coded billing information and tape it to the bottom of the form manually created. Make a copy of the form to create a neat document with the coded billing information and release it to the beneficiary. Include the manually prepared Forms RL-800 with the other Forms RL-800 to be delivered to the mailroom.
- C. Third Year-End Bill to Field Office – Separate notices marked “TERMINATION YEAR END” and release to the Field Office printed on the notice. Follow these steps when processing third year-end bill notices:
 1. Determine which Field Office services each beneficiary. This information is pre-printed on the notice. Group together the notices for each Field Office.
 2. Complete a Form G-833 (Form RL-800/G-800 Contact-Third Notice of Medicare Part B Premiums Due) for every Field Office. The G-833 is found on RRAILS.
 3. During the months of October through December, include one Form T-800 for each notice. Form T-800 gives beneficiaries information about Medicare premium rates and deductibles for the upcoming year.
 4. Enclose the Form G-833 and the termination notices (and Forms T-800 if any) in a letter-size envelope for each Field Office. Show the Field Office name on the front of the envelope.
- D. Deliver to Mailroom – Take all of the envelopes for the Field Offices to the mailroom for enclosing and mailing. The mailroom will put an address label for the Field Office on the enclosed envelope and enclose a return “lockbox” envelope pre-addressed to U.S. Railroad Retirement Board, Medicare Premium Payments, P.O. Box 979024, St. Louis, MO 63197-9000 for each notice.

3.10.8 Picking up the Lockbox and Lockbox Content

Background

Medicare premium payments are processed through Treasury's general lockbox network by selected financial institutions. Effective February 2005, US Bank receives SMI premium payments at U.S. Railroad Retirement Board, Medicare Premium Payments, P.O. Box 979024, St. Louis, MO 63197-9000. US Bank also receives the IRMAA D premium payments at U.S. Railroad Retirement Board, Medicare Premium Payments, P.O. Box 979021, St. Louis, MO 63197-9000. The lockbox operation deposits all payments into the Medical Insurance Premium Aged account (75x8004.5). Payments received with a G-800 are electronically transmitted to the RRB on the bank file and processed into the Medicare Information Received, Transmitted, Edited and Logged (MIRTEL) system. If a G-800 is not submitted with a payment, MIRTEL is not automatically updated. US Bank forwards all payment information processed and correspondence received through the lockbox. This includes premium payments that the lockbox could not include on the bank file and payments submitted for arrearages on PAR. The entire package is delivered to the RRB mailroom and picked up by a MU staff member.

Picking Up the Lockbox

The MU staff member is responsible for going to the mailroom daily to pick up the package sent from US Bank. The package is usually delivered by 10:00 a.m. The US Bank will send an email to designated staff and supervisors in the MPSS and designated P&S staff if they do not send a bank file or lockbox. There are two possibilities where the bank would be sending the RRB an email.

1. There is a lockbox and no bank file.
2. There is neither a lockbox nor a bank file.

One email can be sent, to the designated RRB employees, indicating that there is a lockbox but not a bank file, or neither. Even if the bank notifies the RRB that there is not a lockbox or a bank file, the MU staff member should still go to the mailroom to check if a package has been delivered. If no package from the bank was in the mail room by 10:00 a.m., the MU staff member should check later the same day, around 2:00 p.m. If no package was delivered all day, the clerk should notify the SACM and indicate so by writing "No Lockbox" on the "Record of Incoming and Outgoing Work" log.

Contents of the Lockbox

The contents of the package received from the lockbox operation are as follows:

- Computer listing of processed Forms G-800, payments, credits, and deposit information,

- Processed Forms G-800 batched together with copies of original payments,
- Unprocessed Forms G-800 with copies of original payments (These payments will eventually be eliminated after the clerks follow the new cut and paste method when processing G-800s without an address.),
- Correspondence with a processed G-800 batched together with copies of original payments,
- Correspondence without a processed G-800 batched together with copies of original payments ,
- Checks or coins (without a G-800/G-145 PAR notice) not deposited (Example: a check made out to the wrong organization),
- Forms G-145 with a copy of a payment attached,
- Forms G-145 without a copy of a payment attached (Example: a request for partial withholding),
- Foreign remittances,
- Checks returned with a stale date or checks that are pre-dated,
- Credit or Debit Vouchers,
- If there is a compact disc inside the Fed-Ex envelope, it should be walked to the SACM. The RRB receives a CD once a month at the beginning of the month. The CD contains payment information for the previous month.

3.10.9 Batches of G-800s

Premium payments submitted with a G-800 are grouped together and bundled in batches in each lockbox package. Each batch contains 50 or fewer payments and is numbered and labeled with a sheet called the Transaction Detail. The batch number is located in the upper left hand corner. The majority of the batches in the lockbox have G-800s and have therefore been included on the bank file for mechanical crediting of their paid thru date on MIRTEL. The MU staff member is responsible for crediting unprocessed payments to beneficiary records. See RCM 3.10.10 for instructions on handling payments not credited to an account.

- A. Credited G-800s – Upon receipt of the credited G-800s, the MU is responsible for taking the following actions:
1. Verify that the Premium Payment listing matches the Advice of Deposit lockbox listing. See RCM 3.10.16 for a description of how to compare these forms.

2. Scan through a few of the forms in the batch to make sure they belong in that batch. Compare the Deposit Detail print-out to a few of the forms. The serial number column on the print-out matches with check numbers in that batch. If there is a discrepancy, notify the SACM who will contact P&S by email to report the discrepancy.
3. Check MOLI to make sure that the paid thru date was advanced mechanically. Get at least two claim numbers from each batch and check them on the MOLI (SC) screen to be sure the payments were processed. The LAP should be a 40 and the LAP date should be that of the last run. If MOLI does not indicate the payment was applied, check MEDREF for a Premium Payment referral. If there is not a Premium Payment referral with the date of the batch you are checking, notify the SACM who will contact P&S.

Note: Some spouses, widows and disabled children have pseudo-numbers. If the MU staff member checks MOLI for the claim number and does not find a record, he/she should check for a pseudo-number. Type "3" in the "CD" field on MOLI, enter the appropriate prefix and then the claim number provided.

Note: Some spouse records have a prefix other than MA. A spouse record on MOLI might also have XA, TA, or KA as a prefix. Always check the names on these records to make sure you are handling a payment for the correct spouse.

Note: During the dark days, MIRTEL does not run so the MOLI records will not be updated. However, lockbox packages could still come in on those days. Check the batches on the first day after dark days to make sure these payments were credited. If the paid thru date on MOLI has not been updated, notify the SACM who will send an email to notify designated P&S staff.

4. Place the batches in the appropriate boxes organized by date.
- B. Unprocessed Forms G-800 – In some instances, the bank may not be able to process Form G-800, but the payment was deposited. In this situation, the bank will write the paid amount on the G-800 and forward the G-800 to the RRB in the lockbox package. The MPSS/MU staff member will update the MOLI record with the payment information. See RCM 3.10.11 for instructions for advancing the paid thru date for unprocessed G-800s.

3.10.10 Batches without G-800s

One of the batches in the lockbox will contain Medicare premium payments without a G-800. These batches should have a number that is not sequential with the rest of the batches. If a beneficiary sends in a Medicare payment without a G-800, the payment will be credited by the bank, but MOLI will not be mechanically updated. The MU staff member will follow the steps below to process batches without G-800s.

1. Make sure each item belongs in the batch. If there is a discrepancy, contact the designated staff member in P&S.
2. If there is not a claim number or name verify the check is made out to an acceptable payee (Retirement Medicare Section; Office of Programs; Medicare; Medicare Insurance; Medicare Premiums; Medicare Programs Section; Railroad Medicare; Railroad Retirement Board; US Railroad Retirement Board; USRRB; US Railroad Retirement Board Medicare Payments; or US Treasury). If it is made out to an acceptable RRB Medicare name, forward the payment to the MU on a G-115F. If the check is not made out to an acceptable RRB Medicare name, the bank deposited the funds in our lockbox in error. Make a copy of the check and return it to the bank with a note saying, "Not a RRB Medicare Payment". The bank will correct the error with a debit voucher. See RCM 3.10.17 for information on debit vouchers.
3. If there is a name but not a claim number, forward the payment to the MU on a G-115F. The MU staff member will look up the beneficiary using MBD WebSphere or CMS BERT and take any further actions needed.
4. If there is a claim number associated with the payment, find the beneficiary on MOLI. If the MU staff member checks MOLI for the claim number and does not find a record, he/she should check for a pseudo-number. Type "3" in the "CD" field on MOLI, enter the appropriate prefix and then the claim number provided. If you cannot find the MOLI record move to step 5. If you find a MOLI record that does not have a direct bill record status of 22, 23 or 24, move to step 5. If you find a MOLI record that has a direct bill record status of 22, 23 or 24, move to RCM 3.10.11 for instructions on advancing the paid thru date.
5. The MU staff member should check to see if there is an open Medicare or RR debt on PAR for the beneficiary:
 - a. If the check comes with a G-145, find the claim number and billing document identification number. (If there is not a G-145 with the check, locate the claim number as instructed above in step 3.)
 - b. Search for the debt on PAR by entering the claim number on the ARCL screen. Verify the beneficiary name matches on PAR and on the payment submitted. Check to make sure the debt is a Medicare debt (the BILLING DOC ID will begin with B5).

(For example: enter 123456789A 1 in the "Account #" field and hit Enter..)

If the open debt is a Medicare debt, move to RCM 3.10.12 for instructions on posting cash to an open Medicare PAR debt. Most payments for an open Medicare debt will have a G-145 with the payment. If the open debt is not a Medicare debt, move to step 6.

If the Medicare debt is closed out (balance of zero dollars), or if there is no Medicare debt, search for an open RRA (B2) or RUIA (B8) debt. The clerk should send a G-115F to the MU examiner and indicate that no open Medicare, RRA, or RUIA debt was found. See RCM 3.10.13 for instructions. If an open RRA or RUIA debt was found, indicate this on the G-115F and forward to a MU examiner for handling. Note: to search for a B2 document, put an "A" and then the RR claim number in the ACCOUNT # field on the ARCL screen.

If the amount of the payment submitted is greater than the amount of the Medicare debt open on PAR, create a C5 document as instructed in RCM 3.10.12. Complete the G-115F and indicate that the open PAR balance has been closed out and that there is an excess amount yet to be credited. The clerk will attach the check to the G-115F and forward to the MU examiner for handling. See RCM 3.10.13 for instructions on handling such cases.

6. If there is no open debt, send a G-115F to the MU examiner. See RCM 3.10.13 for instructions on handling such cases.

3.10.11 Crediting Payments – Advancing Paid Thru Date

The MU is responsible for taking the following actions to advance the paid thru date on checks submitted for current Medicare premiums:

1. After reviewing MOLI's direct bill (DB) screen, take note of the beneficiary's monthly premium rate, the current paid thru date of the beneficiary, and if there is an excess premium on the record. If there is an excess premium, add that amount to the amount of the payment submitted.
2. Determine the new paid thru date after combining any excess premium and the amount of the check. Examples of determining a paid thru date follow:
 - A beneficiary's current record shows a paid thru date of August 2010. He has no excess premium and sends in a payment of \$289.20. Since his monthly premium rate is \$96.40, the payment of \$289.20 is for 3 months of premiums. The new paid thru date is November 2010.
 - A beneficiary's current record shows a paid thru date of July 2010. His monthly premium rate is \$96.40 and he has an excess premium of \$50.00. He submits a payment of \$350.00. Add together his excess premium and his payment to get a total credit of \$400.00. This will pay four months of premiums with an excess premium. The beneficiary's new paid thru date is November 2010 with an excess premium of \$14.40.
3. Complete a MEDCOR 20 to advance the paid thru date and update the excess premium amount on the beneficiary's record. See RCM 3.13.21 for instructions on completing a MEDCOR 20 activity.

While completing the MEDCOR 20, print the MEDCOR screen with the current paid thru date and the MEDCOR screen with the updated paid thru date. (It is important to document these screens before and after taking action to update the paid thru date. These screens will be imaged and will be helpful in the future if there is a problem with the record.)

4. Attach the check to the bottom of the updated MEDCOR 20 print and then staple the MEDCOR print-outs together with the updated action on top. In the upper right hand corner of the first page, write "PREMIUM PAYMENT" and release to be imaged.

Each payment credited must be documented by the MU staff member. For instructions on documenting premium payments credited, see RCM 3.10.14.

3.10.12 Crediting Payments – Posting Cash to Open PAR Debt

Payments submitted for open Medicare debts (arrearages and option cases) on PAR come into the lockbox as unprocessed payments. These checks can come attached to the PAR letter (G-145) or alone.

- The beneficiary may send back the G-145 letter without a payment attached, but instead request a waiver, partial withholding or full withholding. If the MU clerk receives a G-145 without a payment attached, the letter should be forwarded on a G-115F to a MU examiner for handling.
- The beneficiary might also make a selection on the G-145 and submit a payment at the same time. In this situation, the MU clerk should process the payment as instructed below, and forward a copy of the re-payment selection on a G-115F to MU examiner for handling. See RCM 3.10.13 for instructions on using the G-115F.
- If a payment comes in without the G-145, RCM 3.10.10 instructs the clerk to advance the paid through date or check for an open PAR debt if there is a claim number to work from. If the clerk does not have the G-145, but finds an open debt on PAR using the claim number, they would apply the payment and forward a copy of the payment with a G-115F to the MU examiner where they determine if an option was involved. The MU examiner would then change the Part B date and make PAR modification if necessary.

The open debt on PAR should be reduced upon receipt of a remittance by the amount of the current payment. The MPSS is responsible for taking the following actions to post the cash to the open PAR debt:

Take notice of the billing document identification number associated with the payment.

To apply the cash to an open PAR debt:

- From the ARCL screen, enter “N” in the ACTION line and “SUSF” in the SCREEN line and hit Enter.
 - Enter “NEW” in the FUNCTION field and tab to TRAN and enter “C5.”
 - Enter “2500” in the ORGN field.
 - Hit Enter.
1. On the next screen (Header Screen), enter the CD number from the previous “SUSF” screen in the DEP NUMBER field. In the DOCUMENT TOTAL field, enter the total amount of the payment. Hit Enter. *Note: if the payment amount is greater than the remaining balance of the debt on PAR, close out the debt. See RCM 3.10.13 for instructions on handling the remaining balance of the payment.
 2. On the Line screen, make the following entries:
 - Enter “001” in LINE NO,

*NOTE: If the open debt has two lines (001 and 002) on the ARCL screen, then the 002 line is the IRMAA portion of the debt. The open balance of the debt is the amount on the 001 line and the 002 line combined. Payments submitted for the debt should first be used to credit the 001 line. If a payment comes in and there is a remaining credit after the 001 line has been zeroed out, the rest of the payment should be applied to the 002 line. Enter “002” in the LINE NO field and follow the instructions mentioned above when crediting the payment to an IRMAA debt.

 - Enter “B5” in REF BD,
 - Enter the billing document number from ARCL in REF BD NUM,
 - Enter “001” in REF LINE,
 - Enter “SA” in TRANS TYPE,
 - Enter the account number from ARCL in PAYOR,
 - Enter the amount of the credit in AMOUNT,
 - Enter “X24” in ACTION OUT,
 - Enter the check number in CHECK NUMBER.
 - Enter “Q” in the COMMND field at the top of the screen.

- Hit Enter to go back to the Header Screen. If the payment is successfully applied to a PAR record, the message will read, "READY FOR APPROVAL." If an error message appears after hitting Enter, check to make sure all entries are correct. If there is still a problem, notify the SACM.
3. At the Header Screen, enter "A" in the COMMND field and hit Enter. If the payment is successfully applied to a PAR record, the message will read, "APPROVAL APPLIED." If an ERROR message appears instead of an APPROVAL message, go back and check that all entries are correct.
 4. Write the CD payment number for each credit on the copy of the check.
 5. Write "PREMIUM PAYMENT" in the upper right hand corner of the G-145 letter and tape the copy of the check to the bottom of the letter. If the payment did not come with a G-145 letter, tape the copy of the check to a blank piece of paper. Write "PREMIUM PAYMENT" and the claim number in the upper right hand corner of the document. Release to be imaged.

Each payment credited must be documented by the MPSS staff member. For instructions on documenting premium payments credited, see RCM 3.10.14.

3.10.13 Forwarding Unposted Payments with G-115F

If the lockbox receives a payment and the money could not be posted on PAR or used to advance the paid thru date on MOLI, a MU staff member should forward the payment to a MU examiner using a G-115F. The claim number associated with the payment should be written in the subject line. The blanks on the form indicating the amount of the payment and the date the payment was received should also be completed before forwarding the payment to an examiner.

The clerk should also select a reason from the choices on the G-115F indicating why the payment was not credited:

- The record status is terminated (RS = 90, 98, 99);
- The record status shows deductions in force (RS = 31);
- The record status shows no current Part B (RS = 11, 12, or 13 and option code is 2, 3, 4, 6 or 8);
- Unable to locate Medicare entitlements, no open PAR balance for RRA or RUIA debt;
- Premium paid thru current year (New premium amount not established);
- PAR open balance of \$_____ closed out. \$_____ in excess;

- And there is a blank space provided for any extraordinary circumstances to be written in.

Once the worksheet is filled out, the MU staff member should attach necessary documents and forward to the MU examiner for processing. In some cases, the MU examiner may determine that the payment can be credited to the beneficiary's account. In this situation, the MU examiner should process the payment and complete the bottom portion of the G-115F. The MU examiner will indicate how the case was processed:

- Posted to PAR on claim number _____;
- Used to advance paid thru date on claim number _____;
- Used to offset (RRA)(RUIA) overpayment on claim number _____;
- Refunded back to the beneficiary on claim number _____;
- Money was DI trust fund. Form G-240 attached (paid thru date advanced/refund made).

If a G-240 is needed, it should be notated on the G-115F and sent to TCIS for processing. Once all the necessary actions are completed, the form G-115F should be imaged. The Operations Analyst will review the G-115Fs to be certain that the cases have been completed.

3.10.14 Documenting Payments Deposited

All payments that were deposited into the lockbox, but were not credited mechanically through MIRTEL, must be documented on the Premium Payments Credited Worksheet located on the O drive (**O:\Operations\PSD\PPCW**). This includes payments credited to PAR for Medicare debts, payments used to advance the paid thru date on MOLI for current Medicare premiums, payments sent to the MU on a G-115F because non-MU staff could not credit the payment. The Premium Payments Credited Worksheet is very user-friendly. Only MU staff will enter information on the Data Input worksheet.

Follow the steps in the table below to document Medicare payments.

Step	Action
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1	<p>Enter the symbol/prefix (indicates type of beneficiary):</p> <ul style="list-style-type: none">• If the payment is not a RRB annuitant, enter “NA”.• If deposit only and no modifications, enter “DEP”.
2	<p>Enter the claim number:</p> <ul style="list-style-type: none">• Do no enter dashes.• Enter “999999999” for days where there are deposits only.• If there is no claim or valid number, enter “888888888”.
3	<p>Bank Date of Deposit:</p> <ul style="list-style-type: none">• Enter date of deposit that can be found in upper right hand corner of check.
4	<p>Amount:</p> <ul style="list-style-type: none">• Enter the amount electronically processed (if discrepancy see

5	<p>Type of payment processing; place only one “X” in the appropriate field (advance paid-thru-date, credit PAR, or G-115F):</p> <ul style="list-style-type: none"> • Advance Paid Thru Date: Enter an “X” in this column if you are advancing the paid thru date ONLY. • Aged or disabled indicator: Enter an “X” in either the ‘Age’ field for aged beneficiaries or in the ‘Disability’ field for disabled beneficiaries. (Note: If the beneficiary is under the age of 65 years old, he/she is disabled.) • Credit PAR: Enter an “X” in this column if you are: <ul style="list-style-type: none"> ▪ Crediting PAR ▪ Crediting PAR & Advancing the Paid Thru Date • G-115F: Enter an “X” in this box if you: <ul style="list-style-type: none"> ▪ Completed a G-115. ▪ Entered an “X” in the G-115F Transferred to Unit if payment was sent outside of section. (still enter “X” in the G-115F box even if you sent the payment to another unit) ▪ Completed G-115 & Advanced Paid Thru Date &/or PAR.
6	Credited by: Enter your initials.
7	Verify that the Manual Deposit Amt field matches the Payment Listing.

3.10.15 Miscellaneous Processing – Correspondence, NSF Checks, Post-Dated Checks, Foreign Remittances, etc.

Occasionally, miscellaneous items are sent along with the lockbox. US Bank separates any miscellaneous items from the payments received. Miscellaneous items include anything listed below. The MU staff should take the following actions in handling these work items:

- Correspondence: This includes notes or letters written on G-800’s or sent separately. All correspondence should be attached to a G-26 and forwarded to a MU examiner for handling.

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- **Post-Dated Checks:** Post-dated checks are payments that are sent in and dated in the future. US Bank will not be able to process such payments. If the check is dated within a week of the MPSS receiving it, the staff member should set it aside and process the payment by sending it to the lockbox once the check is current. See RCM 3.10.18. All other post-dated checks should be sent back to the beneficiary with an RL-371 indicating that the payment was not able to be credited because the check was dated in the future. Before releasing the RL-371 and the check to the beneficiary, the staff member should make a copy of those items to be imaged.
- **Erroneous Checks:** If a beneficiary submits a payment dated in the wrong year or made out to anything other than the RRB, US Bank will not be able to credit the payment. The MU staff member should send the beneficiary an RL-371 and manually notate why the payment was not credited and include the original payment. Before releasing the RL-371 and the check, the clerk should make a copy of those items to be imaged. NOTE: Sometimes the bank will deposit erroneous payments in the Medicare lockbox. See RCM 3.10.27 for information on refunding non-SMI premium payments.
- **Checks made out to US Bank:** The US Bank will no longer process any payments that are made payable to “US Bank.” If the US Bank receives a payment made payable to “US Bank,” the bank will forward the payment to the MPSS for handling. The bank will not deposit the payment because “US Bank” is not an acceptable payee in the formal work agreement between the RRB and the US Bank. The MPSS staff member should follow procedure listed above when handling such cases.
- **Debit Vouchers and Credit Vouchers:** See RCM 3.10.17 for instructions on handling such items.
- **Foreign Remittances:** If a payment is submitted in a foreign currency, the MPSS staff member should return the payment to the beneficiary with an RL-371 and advise that the payment needs to be in United States currency. Before releasing the RL-371, the clerk should make a copy and send to be imaged.
- **NSF (Non-Sufficient Funds) Checks:** If a beneficiary submits a check and does not have enough money in their account, US Bank will not credit the payment. US Bank will notify the RRB through ECP concerning any insufficient payments. A Policy & Systems staff member will check ECP daily for any insufficient notices and notify MU to take the appropriate actions needed.

3.10.16 Premium Payment Listing

When the Premium Payment listing is received from the 2nd floor, the MU staff member should check that the totals on the Premium Payment listing match the totals on the

Advice of Deposit lockbox listing. First, verify that one or two numbers on the lockbox listing are on the Premium Payment listing. Then, follow these steps to verify the totals match:

- Find the Grand Totals line at the bottom of the Premium Payment listing. This should indicate the number of items and also a grand total dollar amount.
- Find the Advice of Deposit lockbox listing with the same date as the Premium Payment listing.
- Add up the total dollar amount of batches with sequential batch numbers. This number should match the Grand Totals line at the bottom of the Premium Payment listing.

If a discrepancy is noted, or the Premium Payment listing is delayed more than three MIRTEL runs from the receipt of the lockbox listing, notify the SACM. (Note: MIRTEL processing may be delayed because of the dark period.)

3.10.17 Debit Vouchers and Credit Vouchers

If there is an adjustment concerning RRB Medicare accounts and a debit voucher or a credit voucher is issued, the US Bank will email the designated P&S Analyst to notify the RRB. The P&S Analyst will forward the email to the Chief of MPSS and the notification is filed and saved on the 'O' Drive.

3.10.18 Medicare Cash Payments Received in RRB Mailroom

If a check or cash is delivered to the RRB Mailroom and is identified by the Mail Clerk as a Medicare payment, it is forwarded to the MPSS. The mailroom identifies each payment received on a "Medicare Remittance Daily Log" worksheet and records each payment by claim number, name, and amount of payment. The worksheet is dated in the upper right hand corner and sent to the MPSS.

When the worksheet and payments are received by the MPSS, the MPSS/MU staff member records each payment on USTAR and puts the worksheet in the binder labeled "Medicare Remittance Daily Log." The payments are then forwarded to the lockbox, U.S. Railroad Retirement Board, Medicare Premium Payments, P.O. Box 979024, St. Louis, MO 63197-9000.

3.10.19 Verifying Non-lockbox Cash is Credited

The MU staff is responsible for verifying the payments described in RCM 3.10.18 have been credited. After the payments have been sent to the lockbox, the lockbox should be credited within one month. The MU staff is responsible for comparing the "Medicare Remittance Daily Log" mentioned above and the Premium Payments Credited Worksheet located on the O Drive to verify the payments were credited properly. The

MU staff should compare the worksheets on a monthly basis. If there is a discrepancy, the MU staff should notify the SACM.

3.10.25 Unapplied Cash – Medicare Money Deposited in RR or RUIA Lockbox

Medicare premium payments are occasionally erroneously deposited into either the RR or RUIA lockbox. The RBD/SBD Customer Service Section will identify Medicare payments that are erroneously deposited in the RR or RUIA lockbox, and send an unapplied cash packet to MU. The contents of the packet include:

- Form G-115F detailing the amount of unapplied cash and the claim number;
- A copy of the UNAP Table on PAR (MU will change the UNAP to put the payment in the PAR MEDICASH account.); and
- A copy of the unapplied check.

The MU examiner will take the following actions:

1. Review the packet. If the copy of the check is missing, check ECP to get a copy of the check. The copy is needed before action can be taken to apply the payment.
2. Check MOLI to see if the beneficiary is on direct bill. If the beneficiary is on direct bill, complete a MEDCOR 20 to advance the paid thru date. Move to step 3 if the beneficiary is not in direct bill status.
3. Check the ARCL table in PAR for an open Medicare debt. If the debt is open, complete a cash receipt document (C5 document) to apply the payment to the debt. If the Medicare debt is closed, move to step 4.
4. Verify that the payments posted on ARCL that closed the debt are valid and not write-off documents (WR or W5). If any of the postings are WR or W5, cancel the C5 document and credit the unapplied cash to the debt. If the debt is correctly closed or if there is excess cash after applying it to the debt, refund it to the beneficiary. See RCM 3.7.72.
5. After completing all actions, send the packet for imaging. Label the packet as "Premium Payment".

The MU examiner does not need to complete a Form G-240. The DRD will prepare Form SF-1081 to transfer the money to the Part B trust fund based on the PAR UNAP transactions that put the unapplied cash in the PAR MEDICASH account.

3.10.26 Unapplied Cash -- RRA or RUIA Money Deposited in Medicare Lockbox

RRA or RUIA payments are occasionally erroneously deposited into the Medicare lockbox, and occasionally Medicare payments are erroneously deposited into the RRA or RUIA lockbox. Instructions for transferring cash payments into the correct account are listed below. NOTE: Part D IRMAA premiums that are deposited erroneously are handled by Policy & Systems (P&S). Notify the P&S Medicare analyst if this occurs.

Process for Transferring RRA or RUIA Lockbox Credit to Medicare

1. The cash refund is posted to unapplied cash.
2. The DRD sends copy of check and correspondence to the Customer Service Representative section of the RBD or SBD.
3. The Customer Service Representative section of the RBD or SBD determines that unapplied cash should be transferred to Medicare and makes appropriate entries on PAR-UNAP.
4. The Customer Service Representative section of the RBD or SBD sends copy of unapplied cash packet to the MU.
5. The MU examiner will process credit as appropriate and send entire packet to imaging.

Process for Transferring Medicare Lockbox Credit to the RRA or RUIA accounts

1. The Customer Service Representative section of the RBD or SBD forwards a packet of unapplied Medicare lockbox cash to the MU for processing.
2. The MU determines that cash should be transferred to the RRA or RUIA.
3. The MU prepares appropriate forms G-240, and the Direct Deposit Specialist prepares appropriate forms SF-1081. The Direct Deposit Specialist submits SF-1081 forms to Bureau of Fiscal Operations (BFO) for transfer. A copy of Form SF-1081 is provided to the DRD via email. The remarks section will include the PAR Cash Receipt number and account number to post to open RRA or RUIA receivables.
4. The DRD will delete the C3 MED number associated with the payment and then establish a corresponding C2 or C8 using an action out code of 13A. The CR number and deposit date should remain the same.

The Process for Transferring Part B Refunds from the Medicare Account to RRA for an RRA Debt

1. When a Medicare Part B refund is available to offset an RRA debt, the MU examiner will send an email to the DRD-Group Mailbox to determine if the DRD wants to use the refund. The DRD will respond by email.
2. If the DRD will use the refund, the MU will prepare appropriate forms G-240, and the Direct Deposit Specialist will prepare appropriate forms SF-1081. The Direct Deposit Specialist then submits the SF-1081 forms to Bureau of Fiscal Operations (BFO) for transfer. A copy of the Form SF-1081 is provided to the DRD via email. The remarks section will include the account number or other appropriate information to identify the RRA or RUIA receivable.
3. The DRD will apply the credit to the open receivable.

3.10.27 Refund of Non-SMI Premium Payments

Occasionally a remittance is received and deposited by the Medicare lockbox that is not a SMI premium payment and cannot be used to reduce a debt on PAR. A medical provider, for example, may erroneously send a refund of Part B benefits to the Medicare lockbox, rather than to Palmetto GBA. Such payments are to be refunded to the provider or other party that submitted the payment. Here are the steps required to make the refund.

Step	Action
1	The MU Examiner will complete a Special Payment Request memorandum to request the MU to issue a special payment.
2	Complete a Form G-240 to transfer the amount of the payment from the SMI Premium Account – Age 65 (20 X 8004.5) to the SSEB Account (60 X 8010). See RCM 11 for additional instructions on completing Form G-240.
3	<p>Prepare and release a letter to the provider or other party to explain that a refund is being made. Here is some sample language:</p> <p style="padding-left: 40px;">“The payment in the amount of \$ 999.99 that you recently sent to the Railroad Retirement Board was apparently sent to us in error. We are refunding the amount of the payment to you. If you have not already received it, you will soon receive a check issued by the U.S. Treasury for the amount of the refund.</p> <p style="padding-left: 40px;">If your payment was a refund of an amount you received for services covered under Part B of Medicare, you should send your payment to Palmetto GBA, Railroad Medicare Part B Office, PO Box 10066, Augusta, GA 30999-0001. Palmetto</p>

	<p>GBA processes medical insurance (Part B) claims for railroad retirement beneficiaries.”</p> <p>Provide as much identifying information as possible, e.g. amount of payment, date of payment, patient’s name, etc., to help the provider or other party identify the erroneous payment.</p>
4	Hand deliver the request for a special payment and Form G-240 to the Director of Unemployment and Programs Support Division for authorization.

The MU will issue the special payment using the Secure Payment System (SPS) based on the information on the Special Payment Request memorandum.

3.10.28 Beneficiary Claims Payment Not Credited

The MU examiner should take the following actions if a beneficiary claims to have submitted a payment that has not been credited to his or her Part B premium paid thru date or Part B arrearage.

1. Did the beneficiary furnish the date and the amount of the payment? If yes, move to step 2. If no, request that the field office contact the beneficiary to obtain the date of the check or money order.
2. Look up the date in the “DT LAST PYMNT” field and “AMT PD” field on MOLI’s Direct Bill screen. If the date on the DB screen is close to the date of the check or money order and the amounts match, then the payment was credited. If the dates are not close, move to step 3.
3. Is there a Premium Payment Reject or Premium Payment Alert on MEDREF? If no, move to step 4.

If there is a Premium Payment Reject that has a date in the PYMT DT/ BCH NO field that is close to the date of the payment and has an amount in the PAID field that matches, then the payment in question was deposited in the lockbox. However, if there is a Premium Payment Reject, the payment has yet to be credited. Refer to RCM 3.10.29 for instructions on processing Premium Payment Rejects. If the dates are not close, process the referral and move to step 4.

If there is a Premium Payment Alert that has a date in the PYMT DT/ BCH NO field that is close to the date of the check and has an amount in the PAID field that matches, then the check in question was deposited in the lockbox and has been credited. Refer to RCM 3.10.29 for information on processing Premium Payment Alerts. If the dates are not close, process the referral and move to step 4.

4. Check the ARCL screen on PAR. Is there a C5 document with the Action Out Code of 24? If yes, and the TRANS DATE for the C5 document is close to the date of the check and the amounts match, then the payment was credited. If no, move to step 5.
5. Use The U.S. Treasury Electronic Check Processing System (ECP) to search for the copy of the check. Currently, only checks that the lockbox processes with a Form G-800 appear on ECP. (We are, however, working with the bank that operates the lockbox to ensure all checks processed through the lockbox appear on ECP in the future.) If you find the check on ECP, there should be a Form G-800 with it. If you locate the Form G-800, go back to Steps 2 and 3 to double check that the payment hasn't already been credited on MOLI. If you are sure it hasn't, complete a MEDCOR 20 to advance the paid thru date and notify the SACM who will contact P&S. P&S will investigate why a check with a Form G-800 didn't update mechanically. When the lockbox starts imaging all checks, it will not be necessary to inform P&S if you find a check without a Form G-800 that has yet to be credited. Move to Step 6 if no check was found.
6. Access the Premium Payment Credited logs on the "O" drive for the dates after the date of the check. The MPSS updates the log when they manually credit payments that are deposited through the lockbox without a Form G-800. If the MPSS can't process the credit, they forward the payment information on Form G-115F to the MU and notate the log. It is possible a Form G-115F with the check is in route to the MU, or the MPSS action to credit the payment did not work. If so, take action to credit the payment. Move to Step 7 if you do not find the payment on the logs.
7. If the check is not found have the field office contact the beneficiary to secure a copy of both sides of the cancelled check or a copy of the beneficiary's banking statement that indicates a withdrawal to the RRB was made. When the copy is received from the field office, take action to credit the payment.

3.10.29 Referrals

A. General

Rejects of regular premium payments are rare because the premium notices usually match the MIRTEL master from which they were generated. Before making any changes in the record, be sure that the referral and the master record being compared, as viewed through MOLI, refer to the same individual. Premium payments will reject when an activity has been processed to alter the MIRTEL master between the time the premium notice is generated and the time the premium payment is reentered into the system. Always be sure that the MIRTEL master, as viewed through MOLI, reflects the beneficiary's true situation. Do not change the input document to agree with

MIRTEL/MOLI when there is a chance that a recent activity erroneously changed the MIRTEL master.

B. Rejects and Alerts

A "reject" code is produced when a premium payment cannot be applied to the specific account. Although usually included in the discussion of rejects, some referral codes are "alert" codes. When an alert code is produced, the premium payment has been credited to the beneficiary's account. The alert is issued so that the MIRTEL record can be checked for some specific reason. Additional action may be required to bring the MIRTEL record up to date.

C. Handling MEDREF Referrals

The MU staff members handle all referral actions. The following general rules pertain to the handling of all referrals:

1. Obtain a MOLI printout for comparison of identifying data.
2. If a discrepancy is not apparent, consult MMAC records for the period between the date the premium due notice was released and the current date. The MEDDAR and MEDMAR reports can also be checked to determine when an activity may have been processed to alter the MIRTEL record.
3. If a discrepancy is still not apparent, prepare a MEDCOR Activity 99 for an Inquiry printout of the beneficiary's entire MIRTEL file.
4. It may be necessary to check the U.S. Treasury's Electronic Check Processing system (ECP) to verify a premium payment. This may also help to determine who made the payment.
5. Once the referral is handled, delete it from MEDREF. The referral should be printed and added to the PREMIUM PYMT PROOFS imaging package per RCM 3.7.73 if an imaging package is to be setup for scanning. The following is a list of possible premium payment and billing referral codes:

1400 - Premium Payment Reject - No Master

If the input was not correct, prepare a MEDCOR Activity 20 to advance the paid thru date and delinquency date. If the input was correct, determine why no master exists, or reestablish the MIRTEL master and update the paid thru date. Sometimes this reject is generated if the bank incorrectly keyed data that was on the premium due notice. Other times, the MIRTEL record was dropped and reestablished with a pseudo number. If the correct claim number cannot be determined, refer the case to Policy & Systems – PAS. PAS will check the file that generated the premium due notice.

1401 - Premium Payment Reject - MIRTEL Jurisdiction Pending

Clearance must be completed before premium payments can be applied to a beneficiary's record. If necessary, prepare a MEDCOR Activity 32 to force clearance. After clearance is completed, prepare a MEDCOR Activity 20 to advance the paid thru date and delinquency date.

1402 - Premium Payment Reject - Annuity In Force Without Premium Deduction

This referral is produced when the MIRTEL master contains record status code 11 (Annuity in force; no deductions required) and a Part B option code other than 1 or 5. Unless the current premium payment can be applied to a prior period of coverage, refund the amount of the payment using the Medicare Payment System (MPS).

1403 - Premium Payment Reject - Check Option

This referral is produced when the MIRTEL master contains record status code 12 (No annuity; no billing required) and a Part B option code other than 4 or 6. Determine the correct Part B option. If the MIRTEL/MOLI record is incorrect, prepare a MEDCOR Activity 22 to correct it. Refund any excess premiums using the Medicare Payment System (MPS) .

1404 - Premium Payment Reject - Annuity In Suspense

This referral is produced when the MIRTEL master contains record status code 13 (Annuity in suspense; no deductions required) and a Part B option code other than 4 or 6. Determine the correct Part B option and prepare a MEDCOR Activity 22 to correct the MIRTEL/MOLI record if necessary. Refund any excess premiums using the Medicare Payment System (MPS).

1405 - Premium Payment Reject - Premiums Being Deducted

This referral is produced when a premium payment is received after annuity deductions have begun. The initiation of annuity deductions will have corrected the record status code in the MIRTEL/MOLI record to 31 (Annuity in force; deductions made), so no further bills will be released. Refund any excess premiums using the Medicare Payment System (MPS).

1406 - Premium Payment Reject - No Longer QRRB Under This Number

Determine if all premiums due through the month of termination have been paid. If an arrearage exists, enter it into the accounts receivable record. If a refund is due, pay the refund using the Medicare Payment System (MPS).

1409 - Premium Payment Reject - Annuity In Force

This referral is produced when a record has been selected for mechanical adjustment to begin annuity deductions. The MIRTEL master as viewed through MOLI shows record status 21 (Annuity in force; adjustment required), and a stop bill code 2 or 3 has been entered. Refund any excess premiums using the Medicare Payment System (MPS).

1410 - Premium Payment Reject - Invalid Record Status

Send to Policy & Systems - PAS for referral to BIS analyst.

1411 - Premium Payment Reject - Duplicate Premium Payment

This referral usually means that the annuitant submitted two checks to the bank, and one was applied and the other rejected. Or, the referral could mean that the bankfile was processed twice. If numerous reason 1411 referrals are produced on the same day, notify Policy & Systems - PAS. PAS will check for a systems problem.

1413 - Premium Payment Reject - Invalid SMI Rate In MIRTEL

This referral is usually generated when the record status is 99 and the paid thru date is equal to the date of death. Determine what part of the payment should be applied and refund any amount that should not be applied using the Medicare Payment System (MPS). If the referral is generated for another reason, notify Policy & Systems – PAS. PAS will determine why the referral was generated.

1414 - Premium Payment Reject - Unable To Compute - SMI Effective Date Prior To 9/73

Send to Policy & Systems – PAS. PAS will determine why the referral was generated, or refer the case to BIS for investigation.

1415 - Premium Payment Reject - Excess Premium Exceeds SMI Premium Rate - Adjust Or Refund

This referral is produced when a premium payment is received and the excess premium amount on the MIRTEL master exceeds one month's premium. The MU must determine if the premium payment prior to this one was handled correctly. Generally, ALERT 2675 will have been produced before this reject. Prepare a MEDCOR Activity 20 to remove the excess premium amount on the MIRTEL/MOLI record and refund any amount due using the Medicare Payment System (MPS). Or, apply the current premium payment by preparing a MEDCOR Activity 20.

1420 – Premium Payment Reject – Unable to Compute – PTD Prior to History

This reject is produced when the system is unable to adjust the paid thru date. There is either no paid thru date or an old paid thru date on the MIRTEL/MOLI record. Verify that the paid thru date on MIRTEL/MOLI is correct and prepare a MEDCOR Activity 20 to advance the paid thru date.

1450 - Premium Billing Reject - SMI Rate Not Found In Table

This reject is generally produced when the SMI premium rate is a variable rate. Determine if the variable rate is correct, and if so, manually prepare and release a Form

RL-800/G-800. Form RL-800/G-800 is on RRAILS. If the premium related data is not correct, refer the case to P&S – PAS.

1451 - Premium Billing Reject - Invalid Delinquency Date

This reject is produced when an incorrect delinquency date prevents the premium bill from being generated. The MU must review the record and either terminate the Part B coverage or correct the delinquency date. A premium due notice is not generated.

1452 - Premium Billing Reject - Billed Amount Exceeds \$999.99

Verify that the bill is correct. If not correct, prepare a MEDCOR Activity 20 to adjust the paid thru date.

1453 - Premium Billing Reject - Unable To Compute

This reject is produced when MIRTEL contains premium payment data and the correct premium due amount cannot be calculated. The MU must determine the correct information and prepare a MEDCOR Activity 20 to correct the MIRTEL/MOLI record. If premium billing is required, advance the delinquency date. A premium due notice is not generated.

2412 - (Alert) - Premium Payment - Possible Refund

Check for any premium payments due the beneficiary. Refund any excess amount using the Medicare Payment System (MPS).

2415 - (Alert) - Premium Payment Received - Check Accounts Receivable

This referral is produced when premiums are received after Part B coverage has been terminated with an arrearage due.

1. Letter released to beneficiary and full payment is received before the PAR record is set up. - Reverse the Part B termination.
2. Letter released to beneficiary and full payment is received after the PAR record is set up. - Contact the beneficiary to see if he or she wants Part B coverage.

Update the Medicare record accordingly. - Properly close out the PAR record.

2416 - (Alert) - Premium Payment - Change In Third Party Code

This referral should no longer be generated. If it is, notify Policy & Systems – PAS to investigate.

2417 - (Alert) - Premium Payment Applied To Month(s) Prior To Previous Catastrophic Effective Date On MIRTEL

This referral is produced when the premium payment covers month(s) prior to the previous catastrophic effective date. MIRTEL applied the payment but is unable to determine the rate(s) for the prior period. Verify the rates and that the payment was correctly applied.

2418 - (Alert) - Premium Billed For Months Prior To Previous Catastrophic Effective Date On MIRTEL

This referral is produced when premiums are due for a period prior to the previous catastrophic effective date on MIRTEL, and MIRTEL cannot verify the amount of premiums due. The MU must determine the correct amount of premiums due. Manually prepare a Form RL-800/G-800.

2419- (Alert) – Premium Payment Due is Zero – No Bill Was Generated

Verify that the premium payment data on MIRTEL/MOLI is correct. If correct, no action is necessary.

2420 – (Alert) – Terminated for Non-Payment

When Part B coverage is terminated for non-payment of premiums, an accounts receivable record is established on the Program Accounts Receivable (PAR) System . Notice of premiums due after termination is released by PAR when the appropriate Text Type is entered. Refer to RCM 3.12.1 for instructions on establishing records on PAR.

The PAR record should be reduced upon receipt of a remittance by the amount of the current payment. If the receivable will be refunded on a recurring basis, an installment billing record must be established on PAR. Monthly billing notices are released until the entire balance is paid.

2675 - (Alert) - Premium Payment Yields Paid Thru Date Past December-Check Excess Premium

This referral is produced when the amount of the payment would extend the paid through date past December. Since MIRTEL cannot do this, the part of the payment that would extend the paid thru date past December was put into the excess premium and was deposited into the Part B Aged account. The MU should determine why this amount was paid. The payment might have been intended to also pay a spouse's or other family member's premium. Advance the paid through date for the proper enrollee. Transfer the premium to the correct fund and remove the excess premium amount. The excess amount must be removed from the MIRTEL/MOLI record in order for a premium due notice to be generated.

2676 - (Alert) - Premium Payments - Excess Premium Exceeds \$99.99

MIRTEL cannot record any excess premium amount of more than \$99.99. Determine both the correct amount of the excess premium and why the amount was paid. See ALERT - 2675.

D. Handling G-800 Edit Reject Referrals

The vendor for the Medicare Premium Lockbox transmits a daily file electronically to the RRB. This file contains Medicare Part B premium payments that were processed with an accompanying G-800 coupon.

The vendor manually inputs the scan line data from the G-800 and the actual payment amount received. The G-800 premium payment edit reject referral (approximately 8 ½ inches x 5 ½ inches in size) is generated when the G-800 scan line information is not keyed correctly for any particular premium payment. This means the payment rejected from file edits and cannot be sent to MIRTEL for processing.

The G-800 paper edit reject referrals are delivered to the Medicare and Payment Services Section (MPSS) by Computer Operations. The Senior Assistant to the Chief of MPSS (SACM) will refer the G-800 edit reject referrals to the MU examiner for adjudication.

The MU examiner will adjudicate the G-800 reject referral as follows:

1. Review the G-800 edit reject referral to identify the error. Each G-800 edit reject referral identifies the error that prevented the payment from processing mechanically through MIRTEL.
2. Use MOLI to verify the correct beneficiary who should receive credit for the payment shown on the G-800 edit reject referral. Generally, the RRB claim number reflected on the referral is correct. Complete a MEDCOR Activity 20 to update the paid through date, delinquency date, and any excess premium amount, if applicable for the beneficiary. Use the “amount paid” on the edit reject referral to determine the beneficiary’s new paid through date and any excess premium amount applicable. Sometimes, MMAC records and MEDDAR/MEDMAR reports may need to be checked to look for previous activities that may be pertinent to the investigation of the rejected premium payment.

Below is a list of the possible G-800 edit reject referral messages and how to handle each type of referral:

BENEFICIARY IDENT DISCREPANCY - Check MOLI to determine the correct beneficiary symbol for the payment. Update the MIRTEL/MOLI record that has the correct beneficiary symbol according to the “amount paid” shown on the G-800 edit reject referral.

PREFIX ERROR - Check MOLI to determine the correct prefix for the payment. Update the MIRTEL/MOLI record that has the correct prefix according to the “amount paid” shown on the G-800 edit reject referral.

RRB CLAIM NUMBER DISCREPANCY – Contact P&S for assistance in securing the correct claim number if the claim number cannot be found on MOLI. Send an e-mail to the P&S Inquiry Group Mailbox.

TYPE OF BENE ERROR – Find the correct beneficiary on MOLI. If the type of beneficiary code on the G-800 reject referral does not match the “TYPE OF BEN” code as shown on the MOLI General Data (GD) screen for the beneficiary, this is the reason for the reject. Update the MIRTEL/MOLI record according to the “amount paid” shown on the G-800 edit reject referral.

SEX CODE ERROR - Find the correct beneficiary on MOLI. If the sex code on the G-800 edit reject referral does not match the “SEX” code on the MOLI GD screen for the beneficiary, this is the reason for the reject. Update the MIRTEL/MOLI record according to the “amount paid” shown on the G-800 edit reject referral.

DATE OF BIRTH ERROR - Find the correct beneficiary on MOLI. If the date of birth on the G-800 edit reject referral does not match the “HI DOB” on the MOLI GD screen, this is the reason for the reject. Update the MIRTEL/MOLI record according to the “amount paid” shown on the G-800 edit reject referral.

RECORD TYPE ERROR – Find the correct beneficiary on MOLI. If the record type on the G-800 edit reject referral does not equal ‘0’, ‘1’, ‘2’, or ‘3’, this is the reason for the reject. Update the MIRTEL/MOLI record according to the “amount paid” shown on the G-800 edit reject referral.

AMOUNT DUE DISCREPANCY – Find the correct beneficiary on MOLI. If the amount billed as shown on the G-800 edit reject referral is not in correct numerical format, this is the reason for the reject. Update the MIRTEL/MOLI record according to the “amount paid” shown on the G-800 edit reject referral.

3RD PARTY ERROR - Find the correct beneficiary on MOLI. This code is not currently used. If the code is keyed into the BANKFILE record as anything other than ‘00’, the premium payment will reject. Update the MIRTEL/MOLI record according to the “amount paid” shown on the G-800 edit reject referral.

ACCR DEL CODE ERROR - Find the correct beneficiary on MOLI. This code is not currently used. If the code is keyed into the BANKFILE record as anything other than ‘0’, the premium payment will reject. Update the MIRTEL/MOLI record according to the “amount paid” shown on the G-800 edit reject referral.

PSEUDO ERROR – A pseudo number error may be caused by the vendor keying in the data in an incorrect numerical format or simply, incorrect numbers not associated with the beneficiary may be keyed in as the pseudo number. Find the correct beneficiary on MOLI using the railroad claim number reflected on the G-800 reject referral. If a match on MOLI cannot be found through the railroad claim number, then access DATA-Q and/or PREH by the railroad claim number to find the beneficiary's SSN or correct pseudo number for access to the correct beneficiary on MOLI. Update the MIRTEL/MOLI record according to the "amount paid" shown on the G-800 edit reject referral.

BILL PROCESS DATE ERROR - Find the correct beneficiary on MOLI. If the date that the bill was created is not keyed in as a proper date, the premium payment will reject. Update the MIRTEL/MOLI record according to the "amount paid" shown on the G-800 edit reject referral.

AMOUNT PAID ERROR – Find the correct beneficiary on MOLI. If the amount paid as shown on the G-800 edit reject referral is not in correct numerical format, this is the reason for the reject. Update the MIRTEL/MOLI record according to the "amount paid" shown on the G-800 edit reject referral.

PROCESS DATE ERROR - Find the correct beneficiary on MOLI. If the date that the premium payment was processed by the vendor is not keyed in as a proper date, the premium payment will reject. Update the MIRTEL/MOLI record according to the "amount paid" shown on the G-800 edit reject referral.

Once the referral is adjudicated, the screen print of the referral, the MOLI Direct Bill (DB) screen, any ECP screen prints, and the MEDCOR activity screen print showing the adjudicated action should be packaged and notated with the form type, PREMIUM PAYMENT for imaging per RCM 3.10.11.

3.10.30 Retention of Accounting Documents

Payment lists and credit listings, for both daily and third party payments, should be retained for at least one full fiscal year (October through September) after the fiscal year of processing. For instance, a payment listing produced in October 2002 should not be scheduled for storage until the fiscal year 2005 (October 1, 2004 through September 30, 2005). Photocopies of checks, third party bills, etc., may be destroyed when the payment and credit listings are sent to storage.

The payment and credit listings will be stored in accordance with item 5, RRB Records Schedule 10.

3.10.40 Part B Premium Funds Transfers

A. The chart below identifies funds transfers involving Part B premiums.

Type of Action/Reason for Transfer	FORM USED	WHO DOES THE TRANSFER	RCM REFERENCE
Premiums deducted from monthly "Check Issue" transferred to CMS	SF-1081	Direct Deposit Specialist	18.6.4.2
Premiums deducted from daily vouchers transferred to CMS	SF-1081	Direct Deposit Specialist	18.6.4.1
Reimbursement to RRB of MPS generated premium refunds	SF-1081	Direct Deposit Specialist	18.7.11
Reimbursement to RRB of MAMMA generated premium refunds	SF-1081	Direct Deposit Specialist	18.7.10
Reimbursement to RRB of premiums deducted from LAF E benefits	Premiums are included in the SSA Trust Fund Transfer Request memorandum	Direct Deposit Specialist	18.7.3
Reimbursement to RRB and SSA from Death Transfer listings	SF-1081	Direct Deposit Specialist	3.10.41
Reimbursement to CMS of returned premium refund payments	SF-1081	Direct Deposit Specialist	12.4.86
Transfer of direct bill premium payments to CMS DI account	G-286	Direct Deposit Specialist	3.10.42
Transfer of arrearage premiums to CMS DI account	G-286	Direct Deposit Specialist	3.10.42

Miscellaneous Form G-240 transfers	SF-1081 or G-286	Direct Deposit Specialist	11, Form G-240
Transfer of unapplied cash to RRB or CMS	SF-1081	MU and DRD	3.10.43

B. Transfers are generally made between the following trust funds or accounts:

Social Security Administration

Agency Location Code 28-04-0001

Social Security - OASI Trust Fund	28-28x8006
Social Security - DI Trust Fund	28-28x8007

Centers for Medicare and Medicaid Services

Agency Location Code 75-05-0080

Federal Hospital Insurance Trust Fund	75x8005
Federal Medical Insurance Trust Fund	75x8004
Medical Insurance Premiums-Aged	75x8004.5
Medical Insurance Premiums-Disabled	75x8004.7

Railroad Retirement Board

Agency Location Code 60-00-9301

Social Security Equivalent Benefit Account	60x8010
Railroad Retirement Account	60x8011
Social Security - Aged Trust Fund	60x8011(6)
Social Security - Disabled Trust Fund	60x8011(7)
RUIA Trust Fund	60x8051.01

Part B fund transfers involving premiums deducted from railroad retirement annuities are made between the Social Security Equivalent Benefit (SSEB) account (60x8010) and the applicable Part B account (75x8004.5) or (75x8004.7).

3.10.41 Processing the Death Transfer Listing

The Death Transfer listing is produced monthly. The listing identifies cases involving deduction of Part B premiums from payments which were not due the beneficiary because of death.

Example: A beneficiary dies on 10-31-2009. The RRB is notified of the death on 11-02-2009, and enters an October 2009 Term date with a death code of "01" on CHICO (DATA-Q). The termination is entered too late to stop the release of the payment dated 11-01-2009. The 11-01-2009 check had a premium deduction of \$96.40 that was transferred to CMS. The RRB needs to take action to transfer the \$96.40 back to the RRB trust fund.

The Direct Deposit Specialist must complete a Form SF-1081 each month to transfer premiums in cases shown on the Death Transfer listing from the proper Part B trust fund to the proper RR or SSA trust fund. The amounts and the trust funds involved in the transfers are broken down on 5 separate listings: (Note: The listings only show cases where the benefit went immediately from being in current pay status to being terminated with a death code (01 for EEs, 41 for survivors, 51 for spouses). If a suspension or a termination code other than death immediately precedes the death code in the TERM-SUSP-CAUSE-CODE field of PREH's 3277 screen, then MIRTEL will produce a 2224 referral (ALERT - PAID THRU DATE AFTER DOD - CHECK FOR POSSIBLE REFUND). The MU examiners process the 2224 referral.)

PART B TRUST FUND	RR OR SSA TRUST FUND
SMI AGED (75X8004.5)	RR SSEB ACCOUNT (60X8010)
SMI DIS (75X8004.7)	RR SSEB ACCOUNT (60X8010)
SMI AGED (75X8004.5)	SSA OASI ACCOUNT (28-28X8006)
SMI DIS (75X8004.7)	SSA DIS ACCOUNT (28-28X8007)

Each listing contains the following fields:

FIELD	EXPLANATION
RR Claim No	Self-explanatory

P/C	Payee Code
Term Dt	The month of death on CHICO
ACCTG DT	The month the date of death was entered on CHICO
Untitled field	Amount CMS needs to reimburse RR or SS trust fund for individual case
Cat	No longer used
Drug	No longer used
CD	Letters could appear in this field indicating the amount to be reimbursed needs to be verified.

The total of the amounts to be transferred for each listing are located on the last page of the listing in the “AMT TO BE TRANSFERRED” field. The Direct Deposit Specialist takes action to adjust this amount based on the investigation of the cases with an entry in the CD field.

The Direct Deposit Specialist will follow the steps below to investigate those cases.

1. Find the cases with a letter in the CD field.
2. Find the DOD on MOLI. Remember to search MOLI under the beneficiary’s own SSA number (GD-3) to find pseudo numbers.
 - If the DOD on MOLI matches the date in the TERM DT field, no action is necessary.
 - If the DOD on MOLI is earlier than the TERM DT, move to step 3.
 - If the DOD on MOLI is later than the TERM DT, move to step 4.
 - If there is no DOD on MOLI, move to step 5.
3. Line out the TERM DT and write in the DOD that appears on MOLI. Determine how much more needs to be transferred by adding the premium amounts deducted from the month after the DOD on MOLI through the TERM DT. To verify the premium rate for the months in question, check the rate deducted for those months in the SMI-PREM-AMT field on PREH. Write the additional amount next to the amount on the listing.

Example: The listing has a TERM DT of 06/2009 and an ACCTG DT of 07/2009. The listing indicates \$96.40 needs to be reimbursed. Because the CD field has an "A", a MU staff member needs to verify if \$96.40 is the correct amount. MOLI has a DOD of 01/2009. PREH's 3277 screen indicates \$96.40 was deducted for 02/2009 (the month after the DOD on MOLI) through 06/2009 (TERM DT) totaling \$482.00. Write \$482.00 next to the \$96.40 on the listing.

4. Line out the TERM DT and write in the DOD that appears on MOLI. If the later DOD on MOLI equals the ACCTG DT, then no money should be transferred. Write a minus sign in front of the amount on the listing.

If the DOD on MOLI is later than the TERM DT, but before the accounting date, add the premiums deducted from the TERM DT month to the month before the DOD on MOLI. To verify the premium rate for the months in question, check the rate deducted for those months in the SMI-PREM-AMT field on PREH. Write the sum with a minus sign next to the amount on the listing.

Example: The listing has a TERM DT of 01/2009 and an ACCT DT of 06/2009. The listing indicates \$480 needs to be reimbursed. Because the CD field has an "A", a MU staff member needs to verify if \$480 is the correct amount. MOLI has a DOD of 03/2009. PREH's 3277 screen indicates \$96.40 was deducted from 01/2009 (TERM DT) through 02/2009 (the month before the DOD on MOLI) totaling \$192.80. Write "- 192.80" in front of the amount on the listing.

5. If there is no DOD on MOLI, check PREH's 3277 screen. If there is no death code in the TERM-SUSP-EFF-DT field, then the beneficiary is alive. Write a minus sign in front of the amount on the listing. If there is a death code, make no change to the amount on the listing.
6. Add up the changes that were noted on the listing. Add that total to the amount in the "AMT TO BE TRANSFERRED" field on the last page of the listing.

NOTE: If the listing has duplicate claim numbers subtract the amount for one of the claim numbers and adjust the amount on the other claim number if necessary.

In the past, five SF-1081 forms would be completed to transfer funds from the CMS to the SSA or the RRB trust funds. Since the RRB cannot IPAC monies that do not involve a RR fund, the two Forms SF-1081 transferring funds from the CMS to the SSA were mailed to the SSA for processing. To make the process more efficient and enable the RRB to IPAC all amounts on the Forms SF-1081, the RRB now completes one Form SF-1081 to transfer all the adjusted amounts (including the amounts due SSA) in the "AMT TO BE TRANSFERRED" fields to the RRB trust funds (60X8010, 60X8011.6, 60X8011.7). The Direct Deposit Specialist will then complete one Form SF-1081 to transfer the amounts due the SS accounts from the RRB trust funds.

Follow the instructions in the table below to complete the Form SF-1081 to transfer all premiums to the RRB accounts:

ITEM	ENTRY
Transaction Date	Enter the date you are preparing the form.
Document No.	Leave blank.
CUSTOMER AGENCY	
Agency Location Code	75-05-0080
Customer Agency voucher No.	Leave blank.
Department	Centers for Medicare & Medicaid Services
Bureau	Division of Accounting
Address	P.O Box 7520 Baltimore, Maryland 21207-0520
Appropriation, Fund, Or Receipt Symbol	<div>75X8004.5 SMI</div> <div>AGED ACCT</div> <div>75X8004.7 SMI DIS</div> <div>ACCT</div>
Amount	<p>Enter the amount to be transferred from each fund.</p> <p>75X8004.5 – Enter the sum of the adjusted amounts in the “AMT TO BE TRANSFERRED” field on the listings labeled “TO SSEB ACCOUNT FROM PART B – AGE” and TO SS ACCT-OASI.</p> <p>75X8004.7 – Enter the sum of the adjusted amounts in the “AMT TO BE TRANSFERRED” field on the listings labeled “TO SSEB ACCOUNT FROM PART B – DIS”, “TO SS ACCT-DI FROM PART B – AGE” and “TO SS ACCT-DI FROM PART B –DIS”.</p>
Total	Add the two amounts from above and enter the total
BILLING AGENCY	

Agency Location Code (ALC)	60-00-9301
Billing Agency Voucher No.	The number consists of a P, the last two digits of the fiscal year, a dash and then the next available number from the voucher book. EX: P10-150
Department Bureau Address	Railroad Retirement Board Unemployment & Programs Support Division 844 N Rush St Chicago, IL 60611
Appropriation, Fund, Or Receipt Symbol	60X8010 60X8011.6 60X8011.7
Amount	<p>60X8010 - Enter the sum of the adjusted amounts in the “AMT TO BE TRANSFERRED” field on the listings labeled “TO SSEB ACCOUNT FROM PART B – AGE” and the adjusted amounts in the “AMT TO BE TRANSFERRED” field on the listings labeled “TO SSEB ACCOUNT FROM PART B – DIS”</p> <p>60X8011.6 Enter the adjusted amount in the “AMT TO BE TRANSFERRED” field on the listing labeled “TO SS ACCT-OASI”.</p> <p>60x8011.7 – Enter the sum of the adjusted amounts in the “AMT TO BE TRANSFERRED” field on the listings labeled “TO SS ACCT – DI FROM PART B AGE and “TO SS ACCT –DI FROM PART B –DIS”.</p>
Total	Add the three amounts above and enter the sum. This amount should equal the amount in the Customer Agency’s TOTAL field.
Details of Charges or Reference to Attached Supporting Documents	Enter “To Transfer From The SMIB Account To the SSEB Account Premiums That Were Deducted after The Death Of Beneficiaries Covered By Forms G-96 Processed in Month/Year”. (Use the month and year of the ACCTG DT)

Billing Agency Contact	Enter your initials after "Prepared By"
Certification of Customer Office	Must be signed and dated by a UPSD Certifying Officer

Follow these instructions to complete the Form SF-1081 to transfer premiums from the SSEB account to the SSA trust funds.

ITEM	ENTRY
Transaction Date	Enter the date you are preparing the form.
Document No.	Leave blank.
CUSTOMER AGENCY	
Agency Location Code	60-00-9301
Customer Agency voucher No.	Leave blank.
Department	Railroad Retirement Board
Bureau	Unemployment & Programs Support Division
Address	844 N Rush St Chicago, IL 60611
Appropriation, Fund, Or Receipt Symbol	60X8011.6 60X8011.7
Amount	60X8011.6 - Enter the adjusted amount in the "AMT TO BE TRANSFERRED" field on the listing labeled "TO SS ACCT-OASI". 60x8011.7 – Enter the sum of adjusted amounts in the "AMT TO BE TRANSFERRED" field on the listings labeled "TO SS ACCT – DI FROM PART B AGE and "TO SS ACCT –DI FROM PART B –DIS".
Total	Add the two above amounts and enter the sum.

BILLING AGENCY	
Agency Location Code (ALC)	28-04-0001
Billing Agency Voucher No.	Leave blank
Department Bureau Address	Social Security Administration PO BOX 47 Baltimore Maryland 21235
Appropriation, Fund, Or Receipt Symbol	28-28X8006 SSA OASI ACCT 28-28X8007 SSA DIS ACCT
Amount	Enter the amounts to be transferred to each SS fund. 28-28X8006 – Enter the amount in the “AMT TO BE TRANSFERRED” field of the listing labeled TO SS ACCT – OASI. 28-28X8007 – Enter the sum of the amounts in the “AMT TO BE TRANSFERRED” field of the listings labeled “TO SS ACCT – DI FROM PART B” and “TO SS ACCT – DI FROM DIS”.
Total	Add the two amounts from above and enter the sum. This amount should equal the amount in the Customer Agency’s TOTAL field.
Details of Charges or Reference to Attached Supporting Documents	Enter “To Transfer From The SSEB Account To The Social Security Accounts (OASI, DI) Premiums That Were Deducted after The Death Of Beneficiaries Covered By Forms G-96 Processed in Month/Year”. (Use the month and year of the ACCTG DT)
Billing Agency Contact	Enter your initials after “Prepared By”
Certification of Customer Office	Must be signed and dated by a UPSD Certifying Officer

When the forms are returned by a Certifying Officer, print 3 copies and distribute as follows:

- Deliver the original signed copy and 2 photocopies to the BFO-Accounting Section incoming tray.

Keep the other copy and file it in the Death Transfer folder.

3.10. 42 Processing PAR Report 46393, Page 13 of MIRTEL Statistics and Premium Payments Credited Worksheet

The lockbox deposits all premiums collected, whether for arrearages or for current direct bill payments, into the Part B aged account. The RRB must identify how much of the premiums deposited in the Part B aged account should be in the Part B disability account and then fax the information to CMS on form G-286.

- PAR Report 46393 (UNPAID PREMIUMS-DIS) identifies the amount of premiums to be transferred from the Part B aged account to the Part B disability account for premiums collected and credited to PAR for arrearages.
- Page 13 of the Monthly MIRTEL Statistics, Item 13-25 identifies the amount of premiums to be transferred from the Part B aged account to the Part B disability account for premiums collected and credited mechanically (G-800) to advance the MIRTEL paid thru date. NOTE: This information is not available yet.
- Premium Payments Credited Worksheet on "O" drive identifies the amount of premiums to be transferred from the Part B aged account to the Part B disability account for premiums collected and credited manually by the MU (MEDCOR Activity 20) to advance the MIRTEL paid thru date.

Follow the instructions below to complete Form G-286.

1. Get PAR Report 46393 and page 13 from the Monthly MIRTEL Statistics for the month the premiums are being transferred. If the MU does not have the reports call P&S for the PAR report and the SACM for the MIRTEL statistics.
2. Go to the "O" drive to get the total amount of premiums credited to disability cases for the month.
3. Follow the steps in the chart below to complete the G-286

ITEM	ENTRY
No.	Enter the next available "M" number.

Date	Enter the date you are completing the G-286
Reference	Enter the same "M" number entered in No. above.
Explanation	Enter, "To transfer the SMI premiums for disabled beneficiaries for monies deposited via lockbox (Direct billing and arrearages) from (First of the month) through (Last day of the month)
From	75x8004.5
To	75x8004.7
FROM*	Enter the sum of the amounts in "UNPAID PREMIUMS-DIS" from the PAR report, item 13-25 of the MIRTEL statistics and the disability total from the Form on the "O" drive.
TO*	Enter the same amount you entered in FROM.
Prepared By	Direct Deposit Specialist
Approved By	SACM

3.12.1 Introduction

The Federal Financial System (FFS) is an integrated financial management system designed specifically for federal agencies. FFS enables agencies such as the Railroad Retirement Board to comply with federal laws and regulations in tracking and accounting of revenue. FFS is maintained by the Bureau of Fiscal Operations.

The Program Accounts Receivable (PAR) system is a subsystem of FFS. Through the establishment and maintenance of tables and documents in PAR, an accounts receivable record for each overpaid beneficiary under the Railroad Retirement Act, the Railroad Unemployment Insurance Act and the Medicare program is created. Input of specific information into PAR allows the system to address a variety of operational and administrative functions. PAR provides for:

- Automated tracking and maintenance of accounts receivables that originate from uncollected Medicare premiums, Medicare Part A and Part B benefit overpayments and equitable relief enrollments.
- Automated billing and follow-up functions, including installment bills.
- Automated processing of cash receipts and maintenance of accounts receivable offset information.
- Semi-automated referral of uncollectible receivables to other agencies for collection.
- Reports concerning activities within the accounts receivable area.

3.12.2 Operation Of PAR

Medicare arrearages and benefit overpayments are recorded and tracked in PAR. Data entry, approval and scheduling are done on-line.

PAR includes a variety of on-line processes for maintaining receivable records after they have been entered into the system. Current balances are available along with a history of recovery actions. Tables exist which track the printing and release of follow-up letters and recovery by partial or full withholding. Information contained in PAR can be viewed by both headquarters and field office personnel.

PAR maintains three types of screens:

- Table and Document Input screens which contain billing information and are updated by DRD and MS staff;
- Reference Tables which define valid codes used for editing billing data and for reporting; and,

- System Maintained Application Tables which contain data that has been processed by application programs.

Billing and cash receipt data is constantly entered into the Table and Document Input Screens. Valid entries update the appropriate System Maintained Tables. The Reference Tables are more static in nature but are still maintained on-line.

- Table and Document Input Screens
- Billing Document Input Screen (BD)
- Case Receipt Document Input Screen (CR)
- Installment Billing and Payment Table (INBT)
- Waiver of Recovery Table (WAIV)
- Recurring Cash Receipt Table (RECR)
- Cash Collection Input Table (CCIT)
- Write-Off Table (WROT)
- Reference Tables
- Type of Overpayment Table (TYOP)
- Cause of Overpayment Table (CAUS)
- Source Table (SRCE)
- Action Out Table (ACTO)
- PAYOR/Debtor Information Table (PDIT)
- PAYOR Table (PAYR)
- Uncollectible (UNCL)
- System Maintained, Application Tables
- Accounts Receivable Case History Header Table (ARCH)
- Accounts Receivable Case History Line Table (ARCL)

- Accounts Receivable Header Table (ARHT)
- Accounts Receivable Line Table (ARLT)
- Cash Receipt Line Table (CRLT)
- Cash Receipt Header Table (CRHT)
- Action Out Cross Reference Table (AOXR)

Detailed instructions for data entry to each of these tables are contained in appropriate sections of this procedure. Before this information is presented, however, a general review of table screen layouts is presented.

General Screen Description

Each screen used to update a table can be divided up into four distinct components.

- An Action Line
- Table Name and Key Fields
- Table Data
- Error Message Area

The Action Line at the top of each screen is used to scan or maintain data in each table and consists of a Screen Action, Table I.D. and USER I.D./Password. The Screen Action on this line defines the kind of processing action desired on each table. Three types of actions are available:

- Data Retrieval Actions
 - S - To Scan the table based on key fields
 - G - To Get a specific record based on key fields
- Data Maintenance Actions
 - A - To Add data to the table
 - C - To Change non-key fields in a table
 - D - To Delete data from the table

- Session Control Actions
- N - To go to the Next table identified in the Table I.D. field
- E - To End the session
- L - To Leaf to the same record on another table with the same key fields
- P - To interrupt or Pause a table session. This command allows you to return to the specific record previously in use without scanning.

The Table I.D. field defines the unique four character identifier for the table. It is always shown when a screen is displayed. This field is only changed when the user wants to move from the current table to another table. In this case, the user enters a Screen Action of 'N' followed by the table I.D. of the table to which user wants to go to. The USER I.D. and password are always required before any action can be taken on a table. The four character USER I.D. is displayed while the Password remains hidden.

The second component of all table screens is the table name and key fields. The key fields define what fields need to be specified in order to take a certain action on the table. For the Scan (S) action, a partial key can be specified. This will cause scanning of the records on a table to occur at the first instance that the key is matched. For maintenance (A, C, D) actions, the entire key must be specified.

The third part of each screen is the actual table data. For some tables each screen may consist of multiple records. The last component of each screen is the Error Message Area where error messages are shown when invalid actions are taken on a table.

The first step in creating a PAR accounts receivable record is to establish two identification and information tables. These are the PAYOR (PAYR) and the PAYOR debtor information table (PDIT). Completing these two tables creates a unique identifier for the individual PAYOR/debtor involved and each overpayment attributed to that individual.

To enter overpayment and recovery information requires the creation of a document. Each document consists of three different entry screens called the startup screen, input screen and line screen. Overpayment and recovery information is entered on-line and then edited for errors. After the edits are completed, the document is placed in a hold status on a suspense file. The document will remain on the suspense file until all detected errors are corrected and it is approved and scheduled for processing.

3.12.3 PAR System Sign On Procedure

The PAR system is a separate database that contains information on debts and overpayments owed under the Railroad Retirement Act, Railroad Unemployment Insurance Act and the Medicare program.

From your TPX menu screen, select PAR – PAR Production System under the Sessid field. The Program Accounts Receivable System Initial Screen will appear. The cursor will be positioned in the command line. Complete the following steps to access PAR tables.

Step	Action
1	Enter the number “1” in the command line and press enter. The PAR FFS1 TABLEID screen will appear.
2	The ACTION field is prefilled with the letter “H”. Type the letter “N” over the “H”. Your cursor will move to the “TABLEID” field. Enter the PAR table ID you want to view or update. Press enter. Your cursor will appear in the ACTION field of the PAR TABLEID you selected.

3.12.4 Establishing An Accounts Receivable Record

When an arrearage, Medicare Part A and B benefit, or option enrollment overpayment has been identified, an open accounts receivable record is established in PAR by creating a billing document. The steps for creating a billing document are shown below. These screens must be completed in the order in which they are listed.

- PAYOR TABLE (PAYR) screen.
- PAYOR/DEBTOR INFORMATION TABLE (PDIT) screen.
- Suspense File (SUSF) screen.
- BILLING DOCUMENT INPUT screen.
- BILLING DOCUMENT LINE screen.

Note: The PAYOR TABLE (PAYR) is a permanent record of the individual from whom RRB is requesting repayment of an open receivable. Once a PAYOR TABLE has been established for an individual, it does not have to be reestablished for each additional receivable identified. If a PAYOR TABLE already exists, begin with the PAYOR/DEBTOR INFORMATION TABLE.

Be sure that all other applicable Medicare actions have been completed and required file documentation made before establishing a PAR system record.

3.12.5 Completing The Payor Table (PAYR) Screen

- A. Accessing the PAYR Screen - Once you have successfully signed on to the PAR system, access to the PAYR screen is accomplished as follows:
- Type "N" in the action field; your cursor will move to the "TableID" field.
 - Type "Table ID PAYR".
 - Press ENTER.
 - A blank PAYOR TABLE screen will appear.
- B. Completing the PAYR Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in order as data entry fields are completely filled. Use the tab key to advance past all fields not specifically referred to here.

Field ID	Action
ACTION:	When the PAYR screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.
	<ul style="list-style-type: none"> • The ACTION field will be prefilled with an S, which signifies Scan Record.
	<ul style="list-style-type: none"> • Type A for Add Record over the S.
	<ul style="list-style-type: none"> • The cursor will advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code NAME. Use the TAB key to advance to the next USER ID field.
USERID:	Enter your four character PAR user identification code and your four character PAR password. (Your password will not be displayed on the screen.) The cursor will advance to the ACCOUNT NUMBER field.
ACCOUNT NUMBER:	Enter the RRB claim NUMBER. Precede serial claim numbers with zeros. Do not begin with the prefix. The 10th position of the ACCOUNT NUMBER is used to identify the prefix. Following the claim number, enter the

	prefix for this RRB claim number. The last position is a counter. Enter the appropriate sequential number that reflects the total number of records on this ACCOUNT NUMBER. The cursor will advance to the DEBTOR NAME field.
DEBTOR NAME:	Enter the name of the individual to whom the letter is being sent. A maximum of 30 characters can be entered in this field. If all positions are used, the cursor will advance to the next field. If fewer than 30 characters are entered, use the TAB key to advance to the add line 1 field.
	NOTE: This field may contain an employee's, spouse's, widow's or representative payee's name. This field may contain a title such as Adm: Valley Nursing Home. It may contain the name of an individual who notified RRB of the death of an annuitant, or contain "Family or Friends" in cases where contact is unknown.
	SPECIAL SITUATIONS:
	<ul style="list-style-type: none"> • Development. In cases where development or investigative action is being taken to determine who is responsible for repayment, enter DEVELOPMENT in this field.
ADDR LINE 1:	Enter the first line of the address where the letter is being sent. <u>DO NOT</u> enter a group mark. In representative payee situations, <u>DO NOT</u> enter FOR and the annuitant's name on this line. In Family and Friends situations, <u>DO NOT</u> enter OF and the deceased annuitant's name on this line. A line is provided on the PDIT screen for this entry. A maximum of 30 characters can be entered in this field. Use the TAB key to advance to the PAYOR type field.
EXCEPTION:	If DEVELOPMENT was entered in the DEBTOR NAME field, enter an asterisk (*) in the first position of this field. Use the TAB key to advance to the PAYOR type field.
PAYOR TYPE:	Always enter an A in this field. The cursor will advance to the ADDR line 2 field.
ADDR LINE 2:	Enter the remaining portion of the address where the letter is being sent. A maximum of 30 characters can be entered in this field. If this line is not needed to continue

		the address from ADDR LINE 1, make no entry in this field. Use the TAB key to advance to the ADDR line 3 field. <u>DO NOT</u> enter the city, state, and ZIP code on this line.
ADDR LINE 3:		Enter the city, state and ZIP code where the letter is being sent.
	City	Enter the city name in the first 19 positions of ADDR LINE 3. If all positions are used, the cursor will advance to the state field, otherwise use the TAB key to advance the cursor.
	State	Enter the official state abbreviation. A complete list of abbreviations is shown in RCM 10.2, Appendix B. The cursor will advance to the ZIP code field of ADDR line 3.
	ZIP Code	This field is designed for the ZIP+4 configuration. <u>Only</u> complete the first five positions. Use the TAB key to advance to the group bills field.
EXCEPTION 1:		If DEVELOPMENT was entered in the DEBTOR NAME field, an asterisk (*) <u>must</u> be entered in the first position of the city, state and ZIP code fields. Use the TAB key to advance to the first position of each field.
EXCEPTION 2:		For foreign address cases <u>ONLY</u> , enter the street address, city and province on ADDR LINE 1 and 2. Enter the country name in the first 19 positions of ADDR LINE 3. The first position of <u>BOTH</u> the state field and ZIP code field <u>must</u> contain an asterisk (*). Use the TAB key to advance to the first position of these fields after the country name has been entered.
GROUP BILLS:		If this PAYOR will have multiple receivables on the same bill enter 'y', otherwise leave blank. Use the TAB key to advance to group dunn field.
GROUP DUNN:		If this DEBTOR will have multiple receivables on the same bill enter 'y', otherwise leave blank. Use the TAB key to advance to the Provider Ind field.
PROVIDER IND:		Always enter a B in this field, the cursor will return to the action field of the action line.

- C. Exiting from the PAYR Screen - After completing the PROVIDER IND field, review the information you have entered on the PAYR screen to verify these

entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.

1. Establishing the PAYOR TABLE - When all required entries have been completed and all information is correct, press ENTER. The message *LO30 ALL LINES ADDED will be displayed in the message area of the screen indicating the PAYOR TABLE has been established. In addition, the captions GROUP BILLS: and GROUP DUNN: will contain N's. These fields have been prefilled by the system, if they were left blank.
2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry or correct any entry as indicated. Continue to press ENTER and make any required corrections until the message *LO30 ALL LINES ADDED is displayed in the message area of the screen. It is important that all errors are corrected and all required entries are completed on the PAYR screen because subsequent screens are dependent on a PAYOR TABLE being established.

Once DEVELOPMENT action has been completed and the name and address of the individual responsible for repaying the debt has been determined, this information must be entered in the DEBTOR NAME, ADDR LINE 1:, ADDR LINE 2: and ADDR LINE 3: fields.

3.12.6 Completing The Payor/Debtor Information Table (PDIT) Screen

- A. Accessing the PDIT Screen - After completing and entering the PAYR screen as described in RCM 3.12.5, the cursor will be positioned in the ACTION field on the action line of the screen. To access the PDIT screen:
 - Type N for Next Screen in the ACTION field. The cursor will advance to the TABLEID field.
 - Type PDIT in the TABLEID field.
 - Press ENTER.
 - A blank PAYOR/DEBTOR INFORMATION TABLE screen will appear.
- B. Completing the PDIT Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of

each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the PDIT screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.
	<ul style="list-style-type: none"> The ACTION field will be prefilled with an S, which signifies Scan Record.
	<ul style="list-style-type: none"> Type A for Add Record over the S.
	<ul style="list-style-type: none"> The cursor will advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code NAME. Use the TAB key to advance to the user ID field.
USERID:	If you used the Next control command to access this screen from the payr screen, the USERID field will contain your PAR identification code and PAR password. (Your password will not be displayed on the screen.) Use the TAB key to advance to the ACCOUNT NUMBER field. Otherwise, you will need to enter your PAR identification code and PAR password. The cursor will advance to the ACCOUNT NUMBER Field.
ACCOUNT NUMBER:	Enter the ACCOUNT NUMBER for this overpayment exactly as it was entered on the PAYR screen. The cursor will advance to the BILLING DOC ID field.
BILLING DOC ID:	The Billing Document Identification code on the PDIT screen is made up of a combination of 13 letters and numbers. The first two positions are referred to as the TRANS CODE on subsequent screens and in error and referral messages. The remaining 11 positions of this field are referred to as the DOCUMENT NUMBER on subsequent screens. Enter the code as follows:
	<ul style="list-style-type: none"> Positions 1-2. Always enter B5 in the first two positions of this field. The cursor will advance to position 3.

	<ul style="list-style-type: none"> Positions 3-11. Always enter the HI or pseudo number. Precede serial claim number with zeros. 																																
	<ul style="list-style-type: none"> Position 12. Always enter the appropriate alpha code for the prefix and beneficiary symbol of the HI or pseudo number as shown below. 																																
	<table> <tr> <th>Prefix/Symbol</th><th>PAR Code</th></tr> <tr><td>A</td><td>A</td></tr> <tr><td>JA</td><td>B</td></tr> <tr><td>WCA</td><td>C</td></tr> <tr><td>MA</td><td>D</td></tr> <tr><td>PA</td><td>E</td></tr> <tr><td>WA</td><td>F</td></tr> <tr><td>CA</td><td>G</td></tr> <tr><td>WCD</td><td>H</td></tr> <tr><td>PD</td><td>I</td></tr> <tr><td>WD</td><td>J</td></tr> <tr><td>H</td><td>K</td></tr> <tr><td>WCH</td><td>L</td></tr> <tr><td>MH</td><td>M</td></tr> <tr><td>PH</td><td>N</td></tr> <tr><td>WH</td><td>O</td></tr> </table>	Prefix/Symbol	PAR Code	A	A	JA	B	WCA	C	MA	D	PA	E	WA	F	CA	G	WCD	H	PD	I	WD	J	H	K	WCH	L	MH	M	PH	N	WH	O
Prefix/Symbol	PAR Code																																
A	A																																
JA	B																																
WCA	C																																
MA	D																																
PA	E																																
WA	F																																
CA	G																																
WCD	H																																
PD	I																																
WD	J																																
H	K																																
WCH	L																																
MH	M																																
PH	N																																
WH	O																																
	<ul style="list-style-type: none"> Positions 13. Always enter the counter for the number of receivables on PAR claim number. 																																
	<ul style="list-style-type: none"> Upon completion of the Billing Document Identification code field, use the cursor to advance to the EE NAME field. 																																
EE NAME:	Enter the name of the railroad employee on whose account the overpayment occurred. This entry <u>must</u> be formatted last name followed by a comma and space, first name and middle initial. A maximum of 30 characters can be entered in this field. Use the TAB key to advance to the RRBCN field.																																
	EXAMPLE: JONES, JOHN A																																
RRBCN:	Enter the prefix and claim number of the railroad employee. After the prefix has been entered, the cursor will advance to the claim number field. Precede serial claim numbers with zeros. The cursor will advance to the ee NAME field.																																

	Enter the annuitant's claim number. Precede serial claim numbers with zeros. The cursor will advance to the next field.
RRBCN:	DEBTOR is not receiving an annuity. Make no entry in this field. Use the tab key to advance to the next field.
RRBCN:	Enter the prefix and claim number of the railroad employee. After the prefix has been entered, the cursor will advance to the claim number field. Precede serial claim numbers with zeros. The cursor will advance to the SSA field.
SSN:	Enter the railroad retirement employee's social security number. The cursor will advance to the next field. If this entry is not completed, use the TAB key to advance to the DEBTOR RRBCN field.
DEBTOR RRBCN:	Complete this field as follows:
	<ul style="list-style-type: none"> DEBTOR is the employee. Make no entry in this field. Use the TAB key to advance to the EOA field.
	<ul style="list-style-type: none"> DEBTOR is an annuitant but is not the employee.
	<ul style="list-style-type: none"> Enter the symbol and prefix of the annuitant whose name appears in the DEBTOR NAME field. If the symbol and prefix contain fewer than three positions, use the space bar to move to the proper position. The cursor will advance to the claim number portion of this field.
	<ul style="list-style-type: none"> Enter the annuitant's claim number. Precede serial claim numbers with zeros. The cursor will advance to the next field.
	<ul style="list-style-type: none"> DEBTOR is not receiving an annuity. Make no entry in this field. Use the TAB key to advance to the EOA field.
EOA:	Enter an "X" in this field if the individual responsible for repaying the debt is entitled to an annuity on another account number. If this item is completed, the cursor will advance to the next field. If the DEBTOR is not

	entitled on another account number, use the TAB key to advance to the DEBTOR NAME field.
DEBTOR NAME:	Complete this item for the following two situations only. If neither of these apply, use the TAB key to advance to the SSN field.
	<ul style="list-style-type: none"> Representative payee. If a representative payee's name or title was entered in the DEBTOR NAME field on the PAYOR TABLE screen, enter FOR and the overpaid annuitant's name in this field. Use the TAB key to advance to the SSN NAME field.
	<ul style="list-style-type: none"> Family or Friends. If Family or Friends was entered in the DEBTOR NAME field on the PAYOR TABLE screen, enter OF and the deceased annuitant's name in this field. Use the TAB key to advance to the SSN NAME field.
SSN:	Enter the DEBTOR 's own social security number. If the DEBTOR is the employee or if the social security number is not known, leave this item blank. If this item is completed, the cursor will advance to the DEBTOR NAME field. If this item is not completed, use the TAB key to advance to the DEBTOR NAME field.
DEBTOR NAME:	Complete this field as follows:
	<ul style="list-style-type: none"> Debtor and PAYOR <u>are</u> the same. If the overpaid annuitant (Debtor) and the person to whom the overpayment letter is being sent (PAYOR) are the same, make no entry in this field. Use the TAB key to advance to the next field.
	<ul style="list-style-type: none"> Debtor and PAYOR <u>are not</u> the same. If the Debtor and the person to whom the overpayment letter is being sent (PAYOR) are not the same, enter the name of the debtor (first, middle initial, last name separated by spaces.) Because a maximum of 20 characters can be entered in this field, it may be necessary to use an initial for the first name also. If all positions are used, the cursor will advance to the next field, otherwise use the TAB key to advance the cursor.
RRBCN:	If the debtor <u>is</u> the employee or the PAYOR, make no entry in this field. Use the TAB key to advance the

	cursor to the next field.
	If the debtor is <u>not</u> the employee or the PAYOR, complete this field as follows:
	<ul style="list-style-type: none"> Enter the symbol and prefix of the claim number of the individual whose name appears in the DEBTOR NAME field. If the claim number does not have a symbol, or the symbol contains fewer than two positions, use the space bar to move to the proper position. The cursor will advance to the claim number.
	<ul style="list-style-type: none"> Enter the claim number of the individual whose name appears in the DEBTOR NAME field. Precede serial claim numbers with zeros. The cursor will advance to the EOA field.
EOA:	Enter an 'X' if the debtor in this case is entitled under another RRB claim number. The cursor will advance to the SSN field. Use the tab key to advance to the desired field if no entry is made here.
SSN:	Enter the debtor's own social security number only if the DEBTOR NAME field contains an entry. If this item is completed, the cursor will advance to the next field. If an entry is not required, use the TAB key to advance to the next field.
OTHER DEBTOR NAME #1, #2:	If it becomes necessary to seek recovery from one or more annuitants in addition to the primary PAYOR/DEBTOR when the full amount of an overpayment cannot be recovered within 36 months or before loss of entitlement. If recovery from one or more annuitants is not in force, no further entries are needed. Press enter. If recovery from one or more annuitants is in force, complete these fields as follows:
	<ul style="list-style-type: none"> OTHER DEBTOR NAME #1: Enter the first name, middle initial and last name of an annuitant other than the PAYOR/DEBTOR from whom recovery is being made. A maximum of 25 characters can be entered in this field. If all positions are used, the cursor will advance to the other DEBTOR NAME #2 field, otherwise use the TAB key to advance the cursor.

	<ul style="list-style-type: none"> OTHER DEBTOR NAME #2: Enter the first name, middle initial and last name of a second annuitant other than the PAYOR/DEBTOR from whom recovery is being made. A maximum of 25 characters can be entered in this field. If all positions are used, the cursor will advance to the other PAYOR RRBCN #1 field, otherwise use the TAB key to advance the cursor.
OTHER PAYOR RRBCN #1:	Enter the symbol, prefix and RRB claim number of the individual whose name was entered in OTHER DEBTOR NAME #1. If the claim number does not have a symbol or the symbol contains fewer than two positions, use the space bar to move to the proper position. After completion of the symbol and prefix field, the cursor will advance to the claim number field. Precede serial claim numbers with zeros. The cursor will advance to the EOA field.
EOA:	Enter an X in this field if the individual whose name and claim number entered in OTHER DEBTOR NAME #1 and OTHER PAYOR RRBCN #1 is entitled to an annuity on another railroad retirement account. If this item is completed, the cursor will advance to the other PAYOR RRBCN #2 field, otherwise use the TAB key to advance the cursor.
OTHER PAYOR RRBCN #2:	Enter the symbol, prefix and RRB claim number of the individual whose name was entered in OTHER DEBTOR NAME #2. If the claim number does not have a symbol or the symbol contains fewer than two positions, use the space bar to move to the proper position. After completion of the symbol and prefix field, the cursor will advance to the claim number field. Precede serial claim numbers with zeros. The cursor will advance to the EOA field.
EOA:	Enter an X in this field if the individual whose name and claim number entered in OTHER DEBTOR NAME #2 and OTHER PAYOR RRBCN #2 is entitled to an annuity on another railroad retirement account.

- C. Exiting from the PDIT Screen - After completing the last required entry on the PDIT screen, review the information you have entered to verify these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or positions(s) and enter the correct information.

1. Establishing the PAYOR/DEBTOR INFORMATION TABLE - When all required entries have been completed and all information is correct, press ENTER. The message *L030 ALL LINES ADDED will be displayed in the message area of the screen indicating the PAYOR/DEBTOR INFORMATION TABLE has been established. The message *L030 ALL LINES CHANGED will be displayed if you were changing data as described in C3. In addition, the DEBTOR NAME: and PAYOR ADDR: fields completed on the PAYOR TABLE will now be displayed on this screen as well.
2. Errors Detected - If any errors are detected, or any required entries are not completed, an error or warning message(s) will be displayed in the message area of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry as indicated. Continue to press ENTER and make any required entry as indicated. Continue to press ENTER and make any required corrections until the message *L030 ALL LINES ADDED is displayed in the message area of the screen. It is important that all errors are corrected and required entries are completed on the PDIT screen because subsequent screens are dependent on a PAYOR/DEBTOR INFORMATION TABLE being established.
3. Changes Required - If no errors are detected which prevent processing but changes are required in data contained on the PDIT screen, Follow the steps below to change the data entries:
 1. After accessing the PDIT screen, for the specific record, type C for change in the action field of the ACTION LINE.
 2. Use the TAB key to advance to the desired field(s).
 3. Type the desired data in the appropriate field(s).
 4. Follow instructions in C1.
 - Using the TAB key, position the cursor in the ACTION field on the action line of the PDIT screen.
 - Type E for EXIT in the ACTION field.
 - Press ENTER, the message "V2 ENTER NEXT TASK CODE" will appear.

3.12.7 Completing The Suspense File (SUSF) Screen

Following the completion of the PDIT screen as described in RCM 3.12.6, the next step in establishing an accounts receivable record is the completion of the Suspense File (SUSF) screen.

- A. Accessing the SUSF Screen - To access the SUSF from any PAR screen, take the following actions:

Step	Action
1	Position the cursor in the action field from any PAR table.
2	Type the letter "N"; the cursor will move to the "TABLEID" field.
3	Enter "SUSF"; the cursor will tab to the USER ID field.
4	Press enter. The SUSF Screen will appear.

- B. Completing the SUSF Screen – Your cursor will appear in the "Action" field of the SUSF screen. Tab to the "Function" field and take the following steps to complete the SUSF table:

Step	Action
1	Enter "New"
2	Tab to the "TRAN" field under the document ID.
3	<ul style="list-style-type: none"> Enter B5. The cursor will advance to the DIVISION field.
4	<ul style="list-style-type: none"> Enter 2500. The cursor will advance to the ID NUMBER field.
5	<ul style="list-style-type: none"> Complete this field exactly as positions 3 through 13 of the BILLING DOC ID field on the PDIT screen. (This is the HI or pseudo number and beneficiary symbol and prefix code and counter.)
6	Press enter. The Billing Document Input screen will appear.

3.12.8 Completing The Billing Document Input Screen

- A. Access the BILLING DOCUMENT INPUT Screen - Following completion and entering of the SUSF screen, the BILLING DOCUMENT INPUT SCREEN will appear as described in RCM 3.12.7.
- B. Completing the BILLING DOCUMENT INPUT Screen - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields beginning with the DOC DATE in the BILLING DOCUMENT INPUT section and will move through the screen in the following order. Use the tab key to advance past all fields not specifically referred to below. The first required entry will be in the TRANS TYPE field.

Step	Action								
1	Enter the letter “E” in the action field. The cursor will tab to the “Trans Type Field.”								
2	Enter one of the following two position codes depending on the type of accounts receivable record you are establishing. The cursor will advance to the ACTION field.								
		If	Then						
		New Account	Enter “SA”.						
		Reactivating a Debt	Enter “SU”.						
		The cursor will move to the comments field.							
3	<table><tr><th>If</th><th>Then...</th></tr><tr><td>Debtor is in current pay status</td><td>Enter ASTRO; cursor will tab to the “Document Total Field”</td></tr><tr><td>Debtor not in current pay status</td><td>Leave blank and tab to the “Document Total Field”</td></tr></table>			If	Then...	Debtor is in current pay status	Enter ASTRO; cursor will tab to the “Document Total Field”	Debtor not in current pay status	Leave blank and tab to the “Document Total Field”
If	Then...								
Debtor is in current pay status	Enter ASTRO; cursor will tab to the “Document Total Field”								
Debtor not in current pay status	Leave blank and tab to the “Document Total Field”								

4	<p>Enter the total amount of the debt for the accounts receivable record you are establishing. You must use a decimal point and complete this entry to two decimal places. DO NOT use a dollar sign. Use the TAB key to advance to the bill print flag field.</p> <p>Note: The Centers for Medicare & Medicaid Services requires a breakdown of Part B premium amounts between IRMAA and non-IRMAA. When establishing PAR records for arrearages involving both IRMAA and non-IRMAA premium amounts, additional entries are required on the Billing Document (BD) Line screen (see RCM 3.12.9). The BD Line screen allows for entry of a breakdown of the arrearage amount (Document Total).</p>								
5	<p>Enter one of the following codes:</p> <table data-bbox="657 863 1088 1255"> <tr> <th>If</th><th>Then:</th></tr> <tr> <td>Initial Notice</td><td>Y</td></tr> <tr> <td>No Notice</td><td>N</td></tr> <tr> <td>No Notice; all aging and referral aging processes applicable</td><td>S</td></tr> </table> <p>The cursor will tab to the “Text Type Field”.</p>	If	Then:	Initial Notice	Y	No Notice	N	No Notice; all aging and referral aging processes applicable	S
If	Then:								
Initial Notice	Y								
No Notice	N								
No Notice; all aging and referral aging processes applicable	S								
6	<p>If Bill print flag is 'Y', enter one of the following two position codes to indicate the type of notice to be generated. (Be sure to make the corresponding entry on the Accounts Receivable Text Table (ARTX) after completing the billing document.) If special text is needed, see your supervisor. The cursor will tab to the “Dunning Flag” field.</p>								

Text Type	Description	Recovery Options
A1	PREMIUMS DUE	INSTL/WAIVER
A2	ARREARAGE	FWH/PWH/WAIVER

A3	ARREARAGE	INSTL
A4	ARREARAGE	DEDS/FWH/PWH
A5	ARREARAGE	DEDS/INSTL/WAIVER
A6	ARREARAGE	BILLING/INSTL
A7	DEC'D ENROLLEE PAYOR IN CURRENT PAY	FULL WITHHOLDING
A8	DEC'D ENROLLEE NOT CURRENT PAY	FULL REMITTANCE
E1	ERR TERM	BILLING/INSTL
E2	ERR TERM	BILLING/INSTL/FWH
E3	ERR TERM	DEDS/INSTL/FWH
E4	ERR TERM	DEDS/PWH/FWH
H1	EARLY OPTION	DEDS/FWH/INSTL
H2	EARLY OPTION	DEDS/PWH
H3	EARLY OPTION	BILLINGS/FWH/INSTL
H4	EARLY OPTION	BILLING/INSTL
H5	LATE OPTION	DEDS/FWH/PWH
H6	LATE OPTION	DEDS/INSTL
H7	LATE OPTION	DEDS/FWH/INSTL
H8	Enrollee Deceased	Full Remittance
AA	BIPA REDUCTION	INSTL/WAIV
AB	BIPA REDUCTION	FWH/PWH/WAIV
AC	BIPA REDUCTION	INSTL
AD	BIPA REDUCTION	FWH/PWH
AE	RETRO IRMAA	INSTL

AF	RETRO IRMAA	INSTL/WAIV
AG	RETRO IRMAA	FWH/PWH
AH	RETRO IRMAA	FWH/PWH/WAIV
AI	IRMAA	INSTL
AJ	IRMAA	INSTL/ WAIV
AK	IRMAA	FWH/PWH
AL	IRMAA	FWH/PWH/WAIV
S1	TERM NON-PAY	FULL REMITTANCE
	CURRENT PAY	FULL REMITTANCE
S2	TERM NON-PAY	
	NOT CURRENT PAY	FULL REMITTANCE
S3	SMALL CHECK ARRG	BILL/FWH/INSTL/WAVR
S4	SMALL CHECK ARRG	DEDS/INSTL
S5	SMALL CHECK ARRG	DEDS/FWH/INSTL/WAVR
S7	DEC'D OPT CURRENT PAY	FWH
S8	DEC'D OPT NOT C/P	FULL REMITTANCE
IA	MS INSTALLMENT BILLS	
IB	MS INSTALL WITH WH	

Examples

Example 1: An enrollee's current Part B premium of \$93.50 is reduced to zero because of a \$93.50 BIPA reduction applied to his Part B premium beginning January 1, 2007. RRB receives notice in July 2007 that the beneficiary disenrolled from the Medicare Advantage plan and is not entitled to a Part B premium reduction effective January 2007. RRB will take action to recover \$654.50, i.e. the \$93.50 reduction for January through July 2007. In this example, use text type:

AA - If the enrollee is not receiving monthly benefit payments.

AB - If the enrollee is receiving a monthly payment that can be withheld to recover the arrearage.

These text types will give the enrollee the option to request a waiver of the past due premiums. The option to request waiver is offered because the premium arrearage of \$654.50 is greater than 5 times \$93.50 (or \$467.50).

Note: When making retroactive adjustments to the Part B premium amount caused by a change in a BIPA reduction period or a change to the reduction amount, equitable relief must be considered. For equitable relief to apply, the total past due premium amount (premium arrearage) must be greater than 5 months' premiums at the current base rate.

Example 2: An enrollee's current Part B premium of \$93.50 is reduced to \$43.50 because of a \$50.00 BIPA reduction beginning January 1, 2007. We collect premiums of \$43.50 for January through April 2007. RRB receives notice in April 2007 that the beneficiary switched to a Medicare Advantage plan that does not offer a BIPA reduction effective January 2007. RRB will take action to recover \$200.00, i.e. the \$50.00 reduction for January through April 2007. In this example, use text type:

AC - If the enrollee is not receiving a monthly payment.

AD - If the enrollee is receiving a monthly payment that can be withheld to recover the arrearage.

These Text Types will not give the enrollee the option to request a waiver of the past due premiums. The option to request waiver is not offered because the premium arrearage of \$200.00 is not greater than 5 times \$93.50 (or \$467.50).

Example 3: An enrollee's Medicare Part B effective date is March 1, 2007. The RRB collected premiums of \$124.40 (\$93.50 for the basic rate and an IRMAA of \$30.90) beginning March 1, 2007. The RRB receives information May 2007, that the enrollee's IRMAA should be \$67.90. In this example, the RRB will take action to recover \$111.00, the difference between the initially collected IRMAA amount and the newly established IRMAA for the period of March 2007 through May 2007. In this example use text type:

AE – If the enrollee is not receiving a monthly payment.

AG – If the enrollee is receiving a monthly payment.

These text types will not give the enrollee the option to request waiver of the past due premiums. The option to request waiver is not offered because the premium arrearage of \$111.00 is not greater than 5 times \$161.40 (or \$807.00).

Note: When making retroactive adjustments to the Part B premium amount caused by the addition of an IRMAA or by a change in the IRMAA amount,

equitable relief must be considered. Equitable relief is to be automatically extended if the past due IRMAA (premium arrearage) exceeds 5 times the current standard Part B premium plus the IRMAA.

Example 4: The RRB began collecting premiums of \$138.10 (\$113.50 for the basic rate and an IRMAA of \$24.60) effective January 2009. (Please note that the basic premium and IRMAA amounts used in this example are not actual amounts.) The RRB receives information in November 2009 that the enrollee's IRMAA for 2009 should be \$203.70. In this example, RRB will take action to recover \$1970.10, the difference between the initially deducted IRMAA amount of \$24.60 and the newly established IRMAA of \$203.70 for the period January 2009 through November 2009. In this example use text type:

AF - If the enrollee is not receiving a monthly payment.

AH - If the enrollee is receiving a monthly payment.

These text types will give the enrollee the option to request waiver of the past due premiums. The option to request waiver is offered because the premium arrearage of \$1970.10 is greater than 5 times \$317.20 (or \$1586.00).

Step	Action						
7	<table border="1"> <tr> <th>If</th><th>Then</th></tr> <tr> <td>If system will generate follow-up notices</td><td>Y</td></tr> <tr> <td>If no follow-up notices</td><td>N</td></tr> </table> <p>The cursor will move to the account number field.</p>	If	Then	If system will generate follow-up notices	Y	If no follow-up notices	N
If	Then						
If system will generate follow-up notices	Y						
If no follow-up notices	N						
8	Enter the ACCOUNT NUMBER exactly as it was established and entered on the PAYOR TABLE screen. The cursor will move to the Cause of Overpayment field.						
9	Enter the three position code from the list below which describes the event which resulted in the receivable, and press enter.						
	Cause of Overpayment						
	C01 Option Case						
	C02 State Buy-In Deletion						

	C03 Loss of QRRD Status
	C04 Cessation of Disability
	C05 Untimely Jurisdiction Transfer
	C06 No Reply to Direct Billing
	C07 Delay In Enrollment
	C08 Fraud
	C09 Calculation Error
	C10 Duplicate Payment
	C11 Unreasonable/Unnecessary Service
	C12 Excessive Charge
	C13 Provider Not Qualified
	C14 Improper Deductible/Co-Ins
	C15 Non-Entitlement of Beneficiary
	C16 Provider Not at Fault
	C17 Premiums Not Deducted
	C18 RBD or SBD Referral
	C19 DSUBD Referral
	C20 Delayed Application
	C21 Changes in Part B Premium Reduction Plan Enrollment (MCR or BIPA606 Plan)
	C22 Retroactive IRMAA B
	C23 IRMAA B
	C24 Reserved

NOTE: The PAR CAUS TABLE contains a complete list of cause of overpayment codes, including those used by the Bureau of Budget and Fiscal Operations – Division of Debt Recovery (DRD) and Operations – Medicare Section (MS).

Examples:

Example 1: A beneficiary originally enrolled in a Medicare Advantage plan effective February 2006, that offered an \$87.70 reduction in his Part B premium. Reduced Part B premiums of \$.80 were withheld from the beneficiary's monthly benefits effective with his February 1, 2006 payment. In May 2006, the RRB receives notice that the beneficiary switched his enrollment to a new Medicare Advantage plan that did **not** offer a Part B premium reduction. His enrollment in the new plan was effective April 1, 2006. We begin withholding unreduced Part B premiums of \$88.50 effective with the beneficiary's June 1 payment. A Part B premium arrearage of \$175.40 (2 months at \$87.70) is due from the beneficiary. Use Cause Code C21 when completing the Billing Document Input screen.

Example 2: We began collecting premiums of \$105.80 (\$93.50 for the basic rate and an IRMAA amount of \$12.30) in January 2007. The RRB receives information from SSA in April 2007, that the enrollee's IRMAA should be \$30.90, rather than \$12.30, beginning January 2007. In this example, we must recover

the monthly difference of \$18.60 between the initially deducted IRMAA amount and the newly established IRMAA amount for the period of January through April 2007. Use Cause Code C22 when completing the Billing Document Input screen.

Example 3: We began collecting premiums in January 2007, at the basic rate of \$93.50. In May 2007, we receive information from SSA that the enrollee must pay an IRMAA of \$49.40 for all months in 2007. In this example, we must recover the IRMAA amount for the months January through May 2007. Use Cause Code C23 when completing the Billing Document Input screen.

- C. Exiting from the BILLING DOCUMENT INPUT Screen - After completing the CAUSE OF OVERPAYMENT field, review the information you have entered on the BILLING DOCUMENT INPUT screen to verify these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information. When all information is correct, press ENTER. The BILLING DOCUMENT LINE SCREEN will appear.

3.12.9 Completing The Billing Document Line Screen

Note: When establishing PAR records for arrearages involving both IRMAA and non-IRMAA premium amounts, additional entries are required on the Billing Document (BD) Line screen in order to provide a breakdown of the Document Total entered on Billing Document Input screen. The BD Line screen allows for entry of a detailed breakdown of the arrearage amount (Document Total).

- A. Accessing the BILLING DOCUMENT LINE Screen - Following completion and entering of the BILLING DOCUMENT INPUT SCREEN described in RCM 3.12.8, the BILLING DOCUMENT LINE SCREEN displayed below will appear.
- B. The MODE, DOCID and USERID fields on the action line of this screen will be prefilled from these entries you completed on the STARTUP screen. Completing the BILLING DOCUMENT LINE Screen - previously entered on another screen or table. Each BILLING DOCUMENT LINE screen will accommodate entries for two overpayment types. Therefore, for an enrollee, several types of overpayments can be entered using the same BILLING DOCUMENT number. Repeat steps 1 – 7 if debtor has multiple debts. Make the following entries next to the captions displayed on the screen:

Step	Action
1	Your cursor will be positioned in the Line No: field. Enter "001." Or "002" if you are creating multiple debt entries. The cursor will

	move to the amount field.												
2	<p>Enter the amount of debt using the decimal point for cents.</p> <table border="1"> <thead> <tr> <th>If</th><th>Then</th></tr> </thead> <tbody> <tr> <td>If the debt is only for Part B.</td><td>Enter the amount entered on the Billing Document Input Screen.</td></tr> <tr> <td>If debt for Part B with IRMAA.</td><td>Enter the amount of Part B premiums owed without IRMAA.</td></tr> </tbody> </table> <p>Then tab to the "I/D" field.</p>	If	Then	If the debt is only for Part B.	Enter the amount entered on the Billing Document Input Screen.	If debt for Part B with IRMAA.	Enter the amount of Part B premiums owed without IRMAA.						
If	Then												
If the debt is only for Part B.	Enter the amount entered on the Billing Document Input Screen.												
If debt for Part B with IRMAA.	Enter the amount of Part B premiums owed without IRMAA.												
3	"I/D" field. Use this field for reactivated or modified debts to increase or decrease the amount of the debt. Tab to the "Trans Type" field.												
4	<p>Tab to the "Type of Overpayment" field. Enter one of the following codes:</p> <table border="1"> <thead> <tr> <th>Code</th><th>Type</th></tr> </thead> <tbody> <tr> <td>520</td><td>SMIB Overpayment</td></tr> <tr> <td>530</td><td>Unpaid Premiums - Age 65</td></tr> <tr> <td>535</td><td>Unpaid Premiums – Disabled</td></tr> <tr> <td>540</td><td>HIB Overpayment (U.S.)</td></tr> <tr> <td>550</td><td>HIB Overpayment (Canada)</td></tr> </tbody> </table>	Code	Type	520	SMIB Overpayment	530	Unpaid Premiums - Age 65	535	Unpaid Premiums – Disabled	540	HIB Overpayment (U.S.)	550	HIB Overpayment (Canada)
Code	Type												
520	SMIB Overpayment												
530	Unpaid Premiums - Age 65												
535	Unpaid Premiums – Disabled												
540	HIB Overpayment (U.S.)												
550	HIB Overpayment (Canada)												
5	The cursor will move to the "Source Fields." Enter one of the												

following source codes:

Code	
SC01	Maintenance Referral
SC02	Records Reconciliation
SC03	Screening Reject
SC04	Inquiry
SC05	Special Project A
SC06	Special Project B
SC07	Special Project C
SC08	Inspector General
SC09	Carrier or Intermediary
SC10	Beneficiary
SC11	CMS
SC12	SSA Referral
SC13	Palmetto GBA
SC14	Part A Intermediary
SC15	Part B Carrier Not Palmetto GBA
SC16	Provider Not at Fault
SC17	Premiums Not Collected
SC18	DBD Referral
SC19	OPNS Referral
SC20	Delayed Application
SC21	CMS/RRB Mass

			Reconciliation	
		SC22	Reserved	
		SC23	Reserved	
		SC24	Reserved	
		SC25	Reserved	
		SC26	Reserved	
6	Press the home key. You will be taken to the Command Line. Enter the letter “Q” and hit enter. See 3.12.10			
7	Press the home key. You will be taken to the Command Line. Enter the letter “H” to place the BD on hold pending authorization.			

Each BILLING DOCUMENT LINE screen will accommodate entries for two overpayment types. Therefore, for an enrollee, several types of overpayments can be entered using the same BILLING DOCUMENT number.

If both sections of this screen must be completed, use the TAB key to advance the cursor from the ACTION OUT field in the top portion of the screen. The cursor will advance to the LINE NO field in the bottom portion of the screen. If multiple type overpayment exist, complete each entry on the lower portion of the screen as described for each caption above for more than two lines, press 'enter' after completing line two, otherwise follow instruction below.

- C. Exiting from the BILLING DOCUMENT LINE Screen - After completing the TYPE OF OVERPAYMENT field, either in the top portion of the screen or at the bottom of the screen if both LINE NOS are completed, review the information you have entered on the BILLING DOCUMENT LINE screen to verify these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.

3.12.10 Quick Edit Function

The Quick Edit function is used to edit entries you have completed on the BILLING DOCUMENT INPUT and BILLING DOCUMENT LINE screens. This function also signals the PAR System that all table and document screens required to establish an accounts receivable record have been completed.

- A. Beginning the Quick Edit Process - Following your review of the BILLING DOCUMENT LINE screen and your determination that all required entries are complete and correct, Quick Edit is accomplished as follows:

- Position the cursor in the ACTION field on the action line of the screen.
- Type Q for Quick Edit in the ACTION field.
- Press ENTER.

B. Results of the Quick Edit Process - The PAR system always returns to the initial screen in a document screen series for display of edit, error or acceptance messages.

- The BILLING DOCUMENT INPUT screen will be displayed.
 - The MODE field on the action line of the screen will contain a C indicating the system is in the correction mode.
1. No Errors Are Detected During Quick Edit - If all required entries on the BILLING DOCUMENT INPUT and BILLING DOCUMENT LINE screens have been completed and the system does not detect any errors, the DEBTOR NAME, ADDRESS, CITY, STATE and ZIP fields will be filled with entries you completed on previous screens. In addition, the following three messages will be displayed in the message area at the bottom of the BILLING DOCUMENT INPUT screen:
 - A -*CQ93 - DOCUMENT REJECTED
 - H -*FO53 - DOCUMENT NOT APPROVED
 - H -*S401 - READY FOR APPROVAL

A printout of this screen should be filed on the left side of the folder.

Route file to authorization.

2. Errors Are Detected - If any errors are detected during the Quick Edit process or any required entries are not complete, an error or warning message(s) will be displayed in the message area of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and make the required corrections.

The ACTION field on the action line of the screen may contain the letters EM. Because a maximum of six edit or error messages can be displayed on a screen, EM indicates there are additional edit or error messages for the screen you are viewing. To view the additional messages, press ENTER. The same screen with the additional edit or error messages will be displayed.

- a. Moving from the BILLING DOCUMENT INPUT Screen to the BILLING DOCUMENT LINE Screen While Performing Quick Edit – Error messages always appear at the bottom of the BILLING DOCUMENT INPUT screen first. To check for any edit or error messages which may be displayed on the BILLING DOCUMENT LINE screen, or to make any corrections to the BILLING DOCUMENT LINE screen which are displayed on the BILLING DOCUMENT INPUT screen, press Enter.
- b. Moving from the BILLING DOCUMENT LINE Screen to the BILLING DOCUMENT INPUT Screen While Performing Quick Edit - If it is necessary to return to the BILLING DOCUMENT INPUT screen from the BILLING DOCUMENT LINE screen while in the correction mode of Quick Edit:

- Position the cursor in the ACTION field on the action line of the screen.
- Press and hold down an alternate shift key (Alt),
- Press the cursor home key (),
- Release the alternate shift key (Alt).
- Type NLO (zero) for Move to Top of Document in the ACTION field.

NOTE: The third position of this ACTION command is numeric.

- Press ENTER. The Billing Document Input screen will again be displayed.

C. Exiting from Quick Edit - When all corrections have been made on both the BILLING DOCUMENT INPUT and BILLING DOCUMENT LINE screens, perform the Quick Edit function as described in section A. Continue to make all corrections and perform Quick Edit until the DEBTOR NAME, ADDRESS, CITY, STATE and ZIP, as well as the three messages described in section B1 are displayed on the BILLING DOCUMENT INPUT screen.

D. HOLDING THE BILLING DOCUMENT FOR APPROVAL

After the Quick Edit function has successfully been performed, the accounts receivable record you have completed must be held for approval. This is accomplished as follows:

- Position the cursor in the ACTION field on the action line of the screen
- Press and hold down an alternate shift key (Alt),
- Press the cursor home or rule key,

- Release the alternate shift key (Alt).
- Type H for Hold Document in the ACTION field.
- Press ENTER.

The STARTUP screen with the message A -*CQ8H - DOCUMENT HELD shown in the message area of the screen will be displayed.

This completes the data entry position for the establishment of an initial accounts receivable record.

3.12.11 Approval Of The Billing Document

Before an accounts receivable record is actually processed and a billing document is established by the PAR System, the data entered on the BILLING DOCUMENT INPUT and BILLING DOCUMENT LINE screens must be approved by an authorizer. If any errors were detected in the calculation of the amount or the letter which requires correction, DO NOT approve or schedule the billing document. Return the folder to the claims examiner for correction of the PAR document screens, award and/or overpayment letter. Billing documents awaiting approval are housed in the SUSPENSE FILE TABLE (SUSF). Documents requiring approval are designated by the letters HELD in the STAT field and five zeros in the APPRV field on this table.

- A. Accessing the SUSF Screen - To access the SUSPENSE FILE TABLE (SUSF) screen, take the following actions:

Step	Action
1	Access PAR using instructions in 3.12.3.
2	Access the SUSF table using instructions in 3.12.7.
3	Under the Document ID "TRAN" field, enter "B5". The cursor will move to the "ORGN" field.
4	Enter 2500. The cursor will move to the "Number" field.
5	Enter the numeric and alpha characters of the billing doc number you want to approve, and press enter. The SUSF screen will reflect the billing document ID you entered.
6	Press the "Home" key. Your cursor will move to the "Action" field.

7	Change the "R" to an "S".
8	Press the Tab key until the cursor appears on the line of the billing document you wish to approve. Then press enter. The billing document input screen will appear.

- B. Approval Process - Once the billing document requiring approval and scheduling is accessed and visible on the screen, take the following actions.

<u>Step</u>	<u>Action</u>						
1	<p><u>Review the billing document input screen for errors.</u></p> <table> <tr> <th>If</th><th>Then</th></tr> <tr> <td>BD Input Screen has errors.</td><td>Correct the errors and perform the Quick Edit function.</td></tr> <tr> <td>BD Input Screen does not have errors.</td><td>Go to step 2.</td></tr> </table>	If	Then	BD Input Screen has errors.	Correct the errors and perform the Quick Edit function.	BD Input Screen does not have errors.	Go to step 2.
If	Then						
BD Input Screen has errors.	Correct the errors and perform the Quick Edit function.						
BD Input Screen does not have errors.	Go to step 2.						
2	Press enter; the billing doc line screen will appear.						
3	<p><u>Review the billing document line screen for errors.</u></p> <table> <tr> <th>If</th><th>Then</th></tr> <tr> <td>BD Line Screen has errors.</td><td>Correct the errors and perform the Quick Edit function.</td></tr> <tr> <td>BD Line Screen does not have errors</td><td>Go to step 4.</td></tr> </table>	If	Then	BD Line Screen has errors.	Correct the errors and perform the Quick Edit function.	BD Line Screen does not have errors	Go to step 4.
If	Then						
BD Line Screen has errors.	Correct the errors and perform the Quick Edit function.						
BD Line Screen does not have errors	Go to step 4.						
4	Press the "Home" key. The cursor will move to the "COMMND" line.						
5	Enter an "A" and press enter. Your cursor will remain on the						

	"COMMND" field.
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C. Exiting an approved document.

Once the billing document has been approved, take the following actions:

1	Press the "Home" key. Your cursor will move to the "COMMND" field.
2	Enter the letter "E" in this field and press enter. You exit the billing document you approved.

3.12.12 Billing Document Corrections And Cancellations

It may be necessary to change or cancel an existing record because of incorrect information or the record was established under an incorrect document number. Use the following chart to determine if a Billing Document should be cancelled, Modified or Reduced by Cash Document:

Situation	Corrective Action Required	Action Out Code Required
Address/Name Incorrect	Modify Billing Document	None
Amount of Debt	Modify (Increase/Decrease)	Yes
Billing Document ID	Cancel (See Supervisor)	Never Cancel a Billing Document
No Debt Exist	Modify Billing Document	Yes

Follow the steps below to modify or cancel a billing document as appropriate:

Modifying a Billing Document - Follow the steps below to modify a billing document when existing information must be changed.

Step	Action
1	Access the SUSF screen using the instructions in 3.12.7.
2	Access the Billing Document Input screen using instructions in 3.12.7.

3	Press the “Tab” key. Your cursor will move to the “Trans Type” field.						
4	<table border="1"> <thead> <tr> <th>If</th><th>Then</th></tr> </thead> <tbody> <tr> <td>Reactivating a debt.</td><td>Enter “SU”.</td></tr> <tr> <td>Modifying an existing debt.</td><td>Do not make an entry. Leave this blank.</td></tr> </tbody> </table>	If	Then	Reactivating a debt.	Enter “SU”.	Modifying an existing debt.	Do not make an entry. Leave this blank.
If	Then						
Reactivating a debt.	Enter “SU”.						
Modifying an existing debt.	Do not make an entry. Leave this blank.						
5	Press the “Tab” key. Your cursor will move to “Document Total” field.						
6	Enter the amount of the debt you are reactivating.						
7	Press the “Tab” key until you reach the “Dunning Flag” field.						
8	Enter “N”. Your cursor will move to the “Account Number” field.						
9	Enter the “Account Number” as it appeared on the history table. Press enter. Your cursor will appear on the line screen “Line NO:” field.						
10	Enter “001”. Your cursor will move to the amount field.						
11	Enter the same dollar amount entered on the BD input screen. Your cursor will move to “I/D” field.						
12	Enter the letter “I” if you are increasing the debt. Enter the “D” if you are decreasing the debt.						
13	Press the “Home” key.						
14	Perform the Quick Edit function.						
15	Press the “Home” key						
16	Enter the letter “H” to place the document on hold.						
17	Enter the letter “E” to exit the document						

3.12.13 Using PAR to Generate Letters

The PAR system provides for automatic generation of notices called Bills and Dunning notices both one time and recurring. By selecting certain options on user maintained tables you can determine the type of notices to be generated. This chapter discusses the following types of system generated notices.

1. Initial notice
2. Installment Bill

A. Initial Arrearage Notices

To use the initial notice function on PAR, the 'Bill Print Flag' on the billing document input screen (3.12.8) must be set to 'Y'.

You must then select the type of text you want printed on the notice by making the appropriate entry in the 'Text Type' field of the same screen. A Corresponding entry is also required on the Accounts Receivable Text Table (ARTX). An entry on this screen (ARTX) allows you to specify custom text to appear at the beginning of the initial notice. Instructions for using the ARTX are found in this chapter. Initial notices with corresponding ARTX are available for most cases entered in PAR.

B. Installment Bills

Installment bills request payment of a predefined amount of the outstanding balance each month. A DEBTOR can request that payment be made in installments. If this is approved, the installment plan and terms are established in the installment Billing and Payment Table (INBT). Once an entry is made in this table, the installment amount plus any past due amount will be billed each month.

The Premium Collections Clerk may change the installment amount if the need arises or deactivate the installment plan by setting the Active Indicator to 'N'. When the installment is deactivated, the text type must be changed by processing a modified billing document.

If a past due installment plan is re-negotiated, users should update the Effective Date field on the Installment Billing and Payment Table (INBT). If this field is not updated, Cash Receipts will continue to be applied to the past due amount, not to the renegotiated amount.

All other fields in the Installment Billing and Payment Table (INBT) are system maintained and updated when the bill is produced or cash is received against the bill.

C. Printing Text on Bills

PAR allows you to associate text clauses and custom text to the Billing Document. This text is printed on the bill.

Standard clauses have been preset and can be printed on the bill by entering the appropriate code from the Clause Text Type (TXTP). A Text Type code can be entered on the Billing Document Header and on each line of the Billing Document. If the Text Type is entered on the Billing Document, the pre-set clauses associated to that Text Type are printed on the bill. The program ensures that clauses are not duplicated on the bill. If no Text Type is entered on an Accounts Receivable Line Table (ARLT) record, the system will print a default text type.

D. Reprint Option

Bills can be re-printed by the system using the Bill Generation programs. If a bill/notice is generated with incorrect or missing data, it must be reprinted as described below:

Incorrect/Missing ARTX entries:

- Access the existing ARTX record, if any, and make appropriate changes using the C change control command. If corrections to this screen are not possible, i.e. BDID#, delete the incorrect record and re-enter.
- Change the Bill Print Flag on the outstanding billing documents table (OBDT) from 'P' to 'Y'.

NOTE: Bills re-printed from this process will retain original dates.

Incorrect/Missing Document entries:

- To correct errors in a processed document, process a modified billing document according to RCM 3.12.12.

NOTE: Bill reprinted from this process will reflect current system generated or user specified dates.

3.12.14 Accounts Receivable Text Table (ARTX)

Always use this table when the initial notice is to be prepared by PAR, the bill print flag is set to 'Y' or 'C'. This table allows the user to insert specified customer text at the beginning of the initial notice. The examiner must select from the choices of inserts and complete required information.

After the billing document has passed quick edits and been placed or 'held' status pending approval, access the Accounts Receivable Text Table by following the steps below:

A. Accessing the ARTX Screen The ARTX screen is accessed as follows:

- Type “N” in the Action field. Your cursor will move to the “TableID field”.
- Type the table ID ARTX
- Press enter.
- A blank Accounts Receivable Text table screen will appear.

B. Accessing the Paragraph Inserts on the ARTX Screens Make the following entries next to the captions displayed on the screen. Use the tab key to move through the screen in the following order.

Caption	Entry
Action:	When the ARTX is accessed, the cursor will be position in the Action Field on the action line screen. The Action field will be pre-filled with an 'R' - type an S over the R and TAB to the Table USER ID field.
USER ID:	Enter your four character PAR user identification number and your four character PAR password. (The password will not be displayed on the screen.) The cursor will advance to the next field.
Table ID:	The Table ID field will be pre-filled with ARTX. Use the TAB key to advance to the USER ID field.
TEXT INDICATOR:	Always type B. Cursor will advance to BD ID field.
BD ID:	Type the 2 character code that was entered as a text type on the billing document screens, i.e., A1, S2, H3.
	Press enter.
	The selected insert paragraph will appear. An 'R' will be displayed in the action field.

C. Completing the ARTX Screen Make the following entries next to or below the captions displayed on the screen. Use the arrows to advance to the desired position. When a space is required, the space bar should be used.

ACTION: Type 'A', for add over the 'R' in the action field.

TEXT INDICATOR: Always type 'B'.

BD ID: Type the complete billing document ID number over the insert title displayed in this field, i.e., type "B5 123456789J1" over "A1 Prem Due Instl/Wav".

REFERENCE ID: This area, located on the top right corner of the text portion of the screen will contain a reference ID number. The reference ID number is used to identify the text type and requestor on the printed letter. Type the last 2 digits of your examiner number over the last 2 zeros.

TEXT: All Medicare insert texts are 'fill in the blanks'. Type the requested text next to or below the captions as appropriate.

- Names - Enter First Name, Middle Initial, Surname
- Dates - MM-DD-YY or MM-DD-YY thru MM-DD-YY
- Dollar Values - Type dollar values using two decimal places and dollar signs

Press enter after all entries have been made. The message "All lines Added" will be displayed.

Use the C change control command to make any corrections other than the BD ID. Selected records must be deleted and re-entered to correct the BD ID.

D. Authorizing/Reviewing the ARTX Screen

For authorization or review Scan the desired 'Billing Document' record on the ARTX as described below.

- Type S in the Action field
- Type B in text indicator
- Type the complete Billing document ID number in BD ID field
- Press Enter.

E. Exiting from the ARTX Screen

- Using the TAB key, position the cursor in the Action field on the action line of the ARTX screen.
- Type E for Exit in the action field.

- Press enter, the message "V2 Enter Next Task Code" will appear.

3.12.15 Installment Billing And Payment Table (INBT)

Manually complete this table once an installment arrangement has been approved for a specific debt. A processed record on this table for an open billing document will result in the automatic release of monthly bill for the specified installment amount. An installment line will be added to this table each time an installment bill is generated or a cash payment is received. The system will update this table to reflect the received amount for each installment.

A. Accessing the INBT Screen

- Type "N" in the Action field; your cursor will move to the "TableID" field.
- Type the Table ID name INBT.
- Press enter.
- A blank Installment Billing table screen will appear.

B. Completing the INBT Screen

Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each data entry fields and will move through the screen in the following order. Make entries only in the specified fields. Other fields are either completed by the system or not used at all.

ACTION: When the INBT screen is accessed, the cursor will be position in the ACTION field on the action line of the screen.

The ACTION field will be prefilled with on S which means Scan Record.

Type A for Add Record over the S.

The cursor will advance to the "TableID" field.

TABLE ID: "TableID" field will contain the correct table code name. Use the tab key to advance to the next field.

USER ID: Enter your four character PAR user identification code and your four character PAR password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.

PAYOR CODE: Enter the full ACCOUNT NUMBER for the outstanding debt to be referenced just as it is shown on the PAYOR or PDIT screens.

BILLING DOC ID: Enter the Billing document ID code for debt to be referenced.

INST AMT: Enter the amount to be remitted each month. Use decimal points. Do not use dollar signs (\$).

ACT IND: Use this field only if installment billing must be interrupted. Otherwise, leave blank. To interrupt billing set Act Ind. to 'N'.

TEXT: Enter one of the following codes to indicate that the special installment paragraph that is to be associated with this notice each month.

IA - Installments only

IB - Installments and Withholding

If both annuity withholding and installment billing apply as described in RCM 3.12.18, use text IB. Text IB advises the beneficiary that the withheld amount will not be reflected in the balance until the end of the recovery period.

Press Enter when all entries complete.

3.12.16 Securing The Billing Document Identification Number

Generally, a copy of the notice or form containing the billing document identification number will be returned with the payment or method of recovery selection. If it is necessary to secure the billing document identification number assigned to the overpayment when the open accounts receivable record was established, scan the ACCOUNTS RECEIVABLE CASE HISTORY HEADER TABLE (ARCH), Header table (ARHT) or any other table containing the billing document ID and other information.

- A. Accessing the ARCH or ARHT Screen - The ARCH and ARHT screens are accessed as follows.
 - Sign on to the PAR System as described in RCM 3.12.3.
 - Enter the letter "N" in the action field. Your cursor will move to the "TableID" field.
 - Enter ARCH/ARHT table ID.
 - Press enter.
- B. Scanning the ARCH or ARHT Screen - Because this is an information table, entries can only be made on the action line and key line of the table. Make the following entries next to or below the captions displayed on the action and key lines of the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen. The ACTION field will be prefilled with an S, which means Scan Record. Use the TAB key to advance to the "TableID" field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the USER ID field.
USERID:	Enter your four character PAR user identification code and your four character PAR password. (Your password will not be displayed on the screen.) The cursor will advance to the ACCOUNT NUMBER field.
ACCOUNT NUMBER:	Enter the RRB claim, followed by the prefix. Precede serial claim numbers with zeros. Billing Document ID numbers begin with B5. The cursor will advance to the identifier position of the PAYOR CODE field. DO NOT make any entry in this field.
	After completing the PAYOR CODE field on the key line of the ARCH screen, press ENTER. An ACCOUNTS RECEIVABLE CASE HISTORY HEADER TABLE for the railroad claim number entered in the PAYOR CODE field will be displayed.
	The action field will change to R, press enter until you have located the desired document.
	The data area of the ARCH screen will be filled with information entered on the PAYOR TABLE, the PAYOR/DEBTOR INFORMATION TABLE and the billing document screens which were completed when the accounts receivable record was established.
	In many cases, only one open accounts receivable record will have been established for a claim number. Where more than one open receivable record exists, by entering only the railroad claim number in the PAYOR CODE field on the key line of the screen, the first open receivable will be displayed. When determining the billing document identification number, it is necessary to page through the record in all cases to verify the number of records that exist and to determine which open accounts receivable record is related to the payment you are processing. To page through the record to get to the applicable billing document, press ENTER. The next ARCH/ARHT record

	in sequence will be displayed. You can only page forward. If you pass the record you need, enter an S for Scan Record in the ACTION field on the action line of the screen and re-enter the claim number in the PAYOR CODE field on the key line of the screen. Press ENTER. The initial record for that claim number will again be displayed on the ARCH screen.
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C. Exiting from the ARCH or AHRT Screens - The command for leaving the ARCH table is determined by your next task.

1. Moving from the ARCH Table to Another PAR Table Screen - If you want to access another PAR table screen from the ARCH table screen, take the following actions.

- Position the cursor in the ACTION field on the action line of the screen.
- Type N for Next Screen in the ACTION field.
- The cursor will advance to the TABLEID field.
- Type the Table ID name you want to access over ARCH.
- Press ENTER.

A blank screen for the table you requested will be displayed.

2. Ending the Session - To exit from the ARCH/ARHT table, take the following actions.

- Position the cursor in the ACTION field on the action line of the screen.
- Type E for Exit in the ACTION field.
- Press ENTER.

3.12.17 Creating A Cash Receipt Document Using The Cash Collection Input Table (CCIT) Screen

- Cash receipt document is mechanically produced by PAR for the following recovery methods by completing the CASH COLLECTION INPUT TABLE (CCIT).
- Cash refund (cash, check or money order.
- Tolerance.

- Waiver.
- One time annuity withholding.
- Amount was withheld from an accrual due,
- Small overpayment recovery situation.
- Compromise.

Creating a cash receipt document through completion of a CCIT screen has several advantages. When recovering for multiple fund accounts on the same receivable, the cash receipt document generated in PAR by the CCIT will automatically allocate the recovery between multiple accounts. Another advantage in creating a cash receipt document from the CCIT screen is that less data entry fields require completion.

Both the PAYOR CODE and the BILLING DOCUMENT IDENTIFICATION NUMBER assigned to the overpayment when the accounts receivable record was established must be known to complete a CCIT screen. If a copy of the notice or form containing these identifiers does not accompany a payment or method of recovery selection and the folder does not contain the information, or the CCIT screen is being completed without a folder. RCM 3.10.16 provides instructions for securing these keys.

Creating a Cash Receipt Document Using Table Screens - PAR has three table screens which mechanically generate cash receipt documents. The table screen completed depends on the method which will be used to reduce or recover the receivable. The following PAR tables generate cash receipt documents and are completed for the recovery methods listed below each table name.

1. Cash Collection Input Table (CCIT).

- Cash refund (cash, check or money order)
- Tolerance
- Waiver
- One time annuity withholding
- Overpaid amount withheld from accrual due
- Small overpayment recovery situations
- Compromise

Cash receipt documents created in PAR from the completion of the CCIT require approval and scheduling for processing like the cash receipt document created by completing the document screens. Instructions for completing the Cash Collection Input Table are found in RCM 3.12.18. Procedures for approval and scheduling of this PAR generated cash receipt document are located in RCM 3.12.24.

2. Recurring Cash Receipt Table (RECR).

- Partial annuity withholding
- Full annuity withholding

Unlike the cash receipt document created from completion of the CCIT, the cash receipt document generated in PAR from completion of the RECR does not require approval and scheduling for processing. Instructions for completing the Recurring Cash Receipt Table are found in RCM 3.12.18.

3. Write-Off Table (WROT).

- Used to transfer amounts from PAR to uncollectible

The cash receipt document generated in PAR from the completion of the WROT does not require approval or scheduling for processing. Instructions for completion of the Write-Off Table are found in RCM 3.12.19.

A. Accessing the CCIT Screen - The CCIT screen is accessed as follows:

- Sign on to the PAR System, as described in RCM 3.12.3.
- Type MIT, leave one space, then type the table code name CCIT.
- Press ENTER.
- A blank CASH COLLECTION INPUT TABLE screen will appear.

B. Completing the CCIT Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the CCIT screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.

	<ul style="list-style-type: none"> The ACTION field will be prefilled with an S, which means Scan Record.
	<ul style="list-style-type: none"> Type A for Add Record over the S.
	<ul style="list-style-type: none"> The cursor will advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the USER ID field.
USERID:	Enter your four character PAR user identification code and your four character PAR password. (Your password will not be displayed on the screen.) The cursor will advance to the CR DOC ID field.
CR DOC ID:	The Cash Receipt Document Identification code on the CCIT screen is made up of a combination of 13 letters and numbers. The first two positions are referred to as the TRANS CODE on error and warning messages. The remaining 11 positions are referred to as the DOCUMENT NUMBER. Complete this field as follows:
	Pos. 1-2 - Always enter C5
	Pos. 3 - 13 Enter as described below for the specific credit type:
	Cash -
	<ul style="list-style-type: none"> 'CD'
	<ul style="list-style-type: none"> Certificate of Deposit Number
	<ul style="list-style-type: none"> PCU Assigned counter for this deposit item
	Annuity Withholding
	<ul style="list-style-type: none"> 'AW'
	<ul style="list-style-type: none"> Year and month of withholding; i.e., (9103 for March 1991)
	<ul style="list-style-type: none"> Last 2 digits of examiner number
	<ul style="list-style-type: none"> 3 digit counter, to indicate the number of withholdings for the specified date (9103) by this examiner today i.e., 001, 002, 010.

	Reclamation/Stop Credit via Treasury
	<ul style="list-style-type: none"> • 'TF'
	<ul style="list-style-type: none"> • Year and month credit received; i.e., (9103 for March 1991)
	<ul style="list-style-type: none"> • Last 2 digits of examiner number
	<ul style="list-style-type: none"> • 3 digit counter, to indicate the number of Treasury credits received on the specified date by this examiner today.
	SMIB Refunds
	<ul style="list-style-type: none"> • SR
	<ul style="list-style-type: none"> • Year and Month refund withheld (YYMM)
	<ul style="list-style-type: none"> • Last 2 digits of examiner number
	<ul style="list-style-type: none"> • 3 digit counter
	Administrative liquidations
	Use when a debt is liquidated by administrative decision such as, administrative cost exceeding recoverable amount, referred to CMS or compromise.
	<ul style="list-style-type: none"> • AD
	<ul style="list-style-type: none"> • Year and month of decision (YYMM)
	<ul style="list-style-type: none"> • Last 2 digits of examiner number
	<ul style="list-style-type: none"> • 3 digit counter
TOTAL PAYMENT:	Enter the total amount of the remittance or recovery. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> use a dollar sign. Use the TAB key to advance to the ACCOUNT NUMBER field.
ACCOUNT NUMBER:	Enter the ACCOUNT NUMBER which was established on the billing document when the accounts receivable record which is being offset by this cash receipt document was established. Use the TAB Key to advance to the DIVISION field.
DIVISION:	Always enter 2500 in this field. The cursor will advance to the

	next field.
DEPOSIT #:	Complete this entry as follows. This field will accommodate an entry of 12 positions. If all positions are used, the cursor will advance to the next field, otherwise use the TAB key to advance the cursor to the trans type field.
	<ul style="list-style-type: none"> If the method of recovery is by cash, check or money order, enter the certificate of deposit number (CD#).
	<ul style="list-style-type: none"> If the method of recovery is by annuity withholding, waiver, tolerance, reclamation credit, etc. (any method other than cash, check or money order,) enter MS.
TRANS TYPE:	Always enter 'SA'.
ACTION OUT:	Enter the three position code from the list below which best describes how the overpayment was recovered or the reason for modifying. The cursor will advance to the next field.
	X21 Waiver
	X22 Offset Part B Benefits
	X23 Credit Card
	X24 Cash Refund
	X25 Partial Withholding
	X26 Full Withholding
	X27 SSA Benefit Offset
	X28 State Buy-In Offset
	X29 Cash Refund To Carrier/Inter.
	X31 Referred to CMS
	X32 No Overpayment Exist
	X33 Provider is Overpaid
	X34 Incorrect Trust Fund
	X35 Previous Offset
	X36 Administrative Error
	X37 Non-Sufficient Funds Check
	X38 RRA Offset Invalid
	X39 Compromise
	X41 No Means of Recovery
	X42 Administrative Cost Exceed Debt
	X43 Overreimbursement
	X44 Statute of Limitations
	X45 Referred to SSA
	X46 Premium Refund Offset
	X47 Delayed Reduced Premiums

	X48 Retro Income Adjustment Amount
	X49 Income Adjustment Amount
	X50 Tolerance
	X51 Write-Off Future Entitlement Possible
	X52 Reserved Write-Off Future Entitlement Possible
	X53 Reserved Write-Off Future Entitlement Possible
	NOTE: The PAR ACTO TABLE contains a complete list of action out codes, including those used by the Bureau of Fiscal Operations - Debt Recovery Division (DRD) and Operations - Medicare Section (MS).
REFERENCE BILL DOC ID:	Enter the Billing Document Identification Number which was assigned when the accounts receivable record, which is being offset by this cash receipt document, was established. <u>Always</u> enter B5 in the first two positions of this field. The cursor will advance to the remaining 11 positions. Upon completion of the document number field, the cursor will advance to the next field.
	NOTE: <u>Always</u> enter the REFERENCE BILL DOC ID online 01. Lines 02 through 07 are reserved for BUSI use only.
AMOUNT RECEIVED:	Enter the same amount as was entered in the TOTAL PAYMENT field above. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> use a dollar sign. The cash receipt document generated by PAR will create the appropriate lines of activity from the information contained in the billing document.
	NOTE: <u>Always</u> enter the AMOUNT RECEIVED on line 01. Lines 02 through 07 are reserved for BUSI use only.

- C. Exiting from the CCIT Screen - After completing the AMOUNT RECEIVED field, review the information you have entered on the CCIT screen to verify that these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.
1. Establishing the CASH COLLECTION INPUT TABLE - When all required entries have been completed and all information is correct, press ENTER. Be sure the 'A' is in action: The message *L030 ALL LINES ADDED will be displayed in the message area of the screen indicating the CASH COLLECTION INPUT TABLE has been established.
 2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area at the bottom of the screen. Refer to Appendix A of this

chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry as indicated. Continue to press ENTER and make any required corrections until the message *L030 ALL LINES ADDED is displayed in the message area of the screen. It is important that all errors are corrected and all required entries are completed on the CCIT screen. PAR will not mechanically generate a cash receipt document as long as errors are present.

- D. Approving the Cash Receipt Document Generated from Completion of the CCIT Screen - Cash receipt documents generated in PAR from completion of CCIT screens require approval and scheduling for processing. Generally, a cash receipt document which is created through CCIT completion one day will appear on the DOCUMENT SUSPENSE FILE INQUIRY (SUSF) table the following day.

The approval and scheduling process for cash receipt documents generated from CCIT screen completion is the same as for the cash receipt document created through document screen series completion. Refer to RCM 3.12.24 for instructions on the approval and scheduling process.

3.12.18 Creating A Cash Receipt Document Using The Recurring Cash Receipt Table (RECR) Screen

Where partial or full annuity withholding is the method which will be used to offset an open accounts receivable record, a cash receipt document is generated through completion of the RECURRING CASH RECEIPT TABLE (RECR) screen. Unlike cash receipt documents created through completion of the document screen series or those mechanically generated from CCIT, cash receipt documents created from RECR do not require approval or scheduling for processing.

Both the PAYOR CODE and the BILLING DOCUMENT IDENTIFICATION NUMBER assigned to the record when the accounts receivable record was established must be known to complete a RECR screen. Instructions for securing these keys are located in RCM 3.12.16.

It is essential that the RECR screen be completed timely because the date entered in the OFFSET BEGIN DT field can only be the current or a future date. If the RECR screen is not completed until after withholding is in force, paragraph E of this section provides instructions for this situation.

- A. Accessing the RECR Screen - The RECR screen is accessed as follows.
- Sign on to the PAR System as described in RCM 3.12.3.
 - Type "N" in the Action field. Your cursor will move to the "TableID" field.

- Type the Table ID name RECR.
- Press ENTER.
- A blank RECURRING CASH RECEIPT TABLE screen will appear.

B. Completing the RECR Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the RECR screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.
	<ul style="list-style-type: none"> • The ACTION field will be prefilled with an S, which means Scan Record.
	<ul style="list-style-type: none"> • Type A for Add Record over the S.
	<ul style="list-style-type: none"> • The cursor will advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the USER ID field.
USERID:	Enter your four character PAR user identification code and your four character PAR password. (Your password will not be displayed on the screen.) The cursor will advance to the ACCOUNT NUMBER field.
PAYOR CODE:	Enter the ACCOUNT NUMBER which was established on the billing document when the accounts receivable record, which is being offset by partial or full annuity withholding, was established. The cursor will advance to the Billing DOC ID field.
BILLING DOC ID:	Enter the Billing Document Identification Number which was assigned when the accounts receivable record, which is being offset by partial or full annuity withholding was established. Always enter B5 in the first two positions of this field. The cursor will advance to the remaining 11 positions. Upon completion of the document number field, the cursor will advance to the ACTION OUT field.

ACTION OUT:	Enter one of the following codes which describes how recovery is being made.
	<ul style="list-style-type: none"> X25 Partial annuity withholding.
	<ul style="list-style-type: none"> X26 Full annuity withholding.
CURRENT OFFSET AMT:	Enter the recurring withholding amount. You must use a decimal point and complete this entry to two decimal places. DO NOT enter a dollar sign. Use the TAB key to advance to the OFFSET BEGIN DT field.
OFFSET BEGIN DT:	Enter the month, day and year of the check issue date partial or full annuity withholding is effective. Precede single digit month and day entries with a zero. EXAMPLE: 03 01 90. Use the Tab key to advance to the TRANS TYPE field.
	NOTE: The OFFSET BEGIN DT entered in his field cannot be prior to the calendar date on which the RECR screen is completed. It can be a future date. If annuity withholding is to be effective with the payment issued on July 1, the RECR screen can be completed on July 1 or anytime prior with an OFFSET BEGIN DT of 07 01. If annuity withholding was effective with the payment issued on July 1, but the RECR screen was not established by that date, 08 01 must be entered in the OFFSET BEGIN DT field. Paragraph E of this section provides instructions for special handling when the RECR screen is completed after withholding is in effect.
TRANS TYPE:	Always enter the letters SA in this field. The cursor will advance to the ORIG OFFSET field.
ORIG OFFSET MONTHS:	Enter the number of months partial or full annuity withholding will be in force. This is a three position field. Inasmuch as withholding will rarely be in force for more than 36 months, enter zeros in the first two positions as necessary. EXAMPLES: 036, 007.
APPLIED OFFSET MONTHS:	This item is completed from information contained within PAR. The cursor will skip over this field.
HOLD IND:	Make no entry in this field. Use the TAB key to advance to the next field. If withholding must be suspended for any reason, see paragraph E of this section for special instructions.

CASH ACCT:	Make no entry in this field. Use the TAB key to advance to the next field.
ARCHIVE FLAG:	Make no entry in this field when the RECR screen is being established. This field is only completed once partial or full annuity withholding has been completed and the CURRENT BALANCE field on this screen has been reduced to zero. Paragraph D of this section provides instructions for completing this entry once recovery through annuity withholding has been completed.

- C. Exiting from the RECR Screen - After completing the ORIG OFFSET MONTHS field, review the information you have entered on the RECR screen to verify that these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.
1. Establishing the RECURRING CASH RECEIPT TABLE - When all required entries have been completed and all information is correct, press ENTER. The message *LO30 ALL LINES ADDED will be displayed in the message area of the screen indicating the RECURRING CASH RECEIPT TABLE has been established. Approval and scheduling of the RECR screen are not necessary. Pressing ENTER and having the above message displayed on the screen will establish this table in PAR. Each month, a cash receipt document will be mechanically generated for the withholding amount entered in the CURRENT OFFSET AMT field until the open balance has been reduced to zero.
 2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area at the bottom of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry as indicated. Continue to press ENTER and make any required corrections until the message *LO30 ALL LINES ADDED is displayed in the message area of the screen. It is important that all errors are corrected and all required entries are completed on the RECR screen. PAR will not mechanically process and generate a recurring cash receipt document as long as errors are present.

The ORIG O/P FOR OFFSET, CURRENT BALANCE, HOLD IND, ARCHIVE FLAG, PEN %, ADMN COST and INT % fields in the data area of the screen will be filled with information derived from the PAR System.

D. Archiving the RECURRING CASH RECEIPT TABLE - The final cash receipt document generated from the RECR table will be for the remaining amount of the open balance. Once the CURRENT BALANCE field has been reduced to zero, and the claim is recertified to remove partial or full annuity withholding, the RECURRING CASH RECEIPT TABLE must be archived. This is accomplished as follows:

- Sign on to the PAR System as described in RCM 3.12.3.
- Type "N" in the Action field. Your cursor will move to the "TableID" field.
- Type the Table ID name RECR.
- Press ENTER. A blank RECURRING CASH RECEIPT TABLE screen will be displayed. The ACTION and TABLEID fields will contain the correct entries.
- Enter your PAR password and user identification code following the USERID caption on the action line of the screen.
- Complete the ACCOUNT NUMBER and BILLING DOC ID on the key line of the screen.
- Press ENTER. The RECURRING CASH RECEIPT TABLE for the PAYOR CODE and BILLING DOC ID you entered on the key line of the screen will be displayed.
- Type C for Change Record over the R in the ACTION field on the action line of the screen.
- Use the TAB key to move the cursor to the ARCHIVE FLAG field.
- Type Y for yes over the N appearing in the ARCHIVE FLAG field.
- Press ENTER. The following two messages will be displayed in the message area at the bottom of the screen.
- 01-PP01W DVAL TABLE ENTRY NOT FOUND
- 01-*LO31 ALL LINES CHANGED

An example of a RECURRING CASH RECEIPT TABLE in which the ARCHIVE FLAG has been set appears below.

When the RECURRING CASH RECEIPT portion of PAR is processed, this record will be archived and will no longer be displayed as a table screen.

E. Special Situations.

1. Annuity Suspended While Partial or Full Annuity Withholding is in Effect - Occasionally, it may be necessary to suspend an annuity from which deductions are being made to recover an overpayment. Because PAR does not interface with the payment systems, PAR must also be alerted if an annuity is suspended from which partial or full annuity withholding is in force. This is accomplished by changing the HOLD IND field on the RECURRING CASH RECEIPT TABLE (RECR). Take the following actions.
 - Sign on to the PAR System as described in RCM 3.12.3. Type "N" in the Action field. Your cursor will move to the "TableID" field.
 - Then type the Table ID name RECR.
 - Press ENTER. A blank RECURRING CASH RECEIPT TABLE screen will be displayed. The ACTION and TABLEID fields will contain the correct entries.
 - Enter your PAR password and user identification code following the USERID caption on the action line of the screen.
 - Complete the PAYOR CODE and BILLING DOC ID on the key line of the screen.
 - Press ENTER. The RECURRING CASH RECEIPT TABLE for the PAYOR CODE and BILLING DOC ID you entered on the key line of the screen will be displayed.
 - Type C for Change Record over the R in the ACTION field on the action line of the screen.
 - Use the TAB key to move the cursor to the HOLD IND field.
 - Type Y for yes over the N appearing in the HOLD IND field.
 - Press ENTER. The following two messages will be displayed in the message area at the bottom of the screen.
 - 01-PP01W DVAL TABLE ENTRY NOT FOUND
 - 01-*LO30 ALL LINES CHANGED

NOTE: If the HOLD IND field is not completed timely, any cash receipt document(s) posted in error must be cancelled. Check the ACCOUNTS RECEIVABLE CASH RECEIPT LINE (ARCL) screen to determine if any

erroneous cash receipts were posted and to obtain the Cash Receipt Document (C5) Number.

An example of a RECURRING CASH RECEIPT TABLE in which the HOLD IND has been set to Y appears below.

Once the annuity has been returned to pay status, the HOLD IND must be changed back to N. This is accomplished by the same procedure as outlined above for changing the HOLD IND to Y.

2. RECURRING CASH RECEIPT TABLE Created After Partial or Full Annuity Withholding Has Gone into Effect - As stated earlier, the date entered in the OFFSET BEGIN DT cannot be prior to the calendar date on which the RECR screen is being completed. In the event the RECR screen is not completed until after one or more months of annuity withholding have occurred, take the following actions.
 - a. Complete the CASH COLLECTION INPUT TABLE.
 - Calculate the amount which has been recovered from annuity payments prior to establishment of the RECR screen.
 - Complete a CCIT screen as described in RCM 3.12.18.
 - Enter the amount withheld from annuity payments in the TOTAL PAYMENT field.
 - Enter AW for annuity withholding in the TRANS TYPE field.
 - Enter one of the following codes in the ACTION OUT field.
 - X25 Partial Annuity Withholding.
 - X26 Full Annuity Withholding.
 - Have the completed CCIT generated cash receipt document approved and scheduled for processing.
 - b. Complete the RECURRING CASH RECEIPT TABLE.
 - Determine the total number of months annuity withholding has been in force prior to completion and processing of the RECR screen.
 - Complete a RECR screen as described in paragraph B of this section.

- Enter the first day of the next monthly annuity payment from which full or partial withholding will be applied in the OFFSET BEGIN DT field.
- Enter the total number of months partial or full withholding will be applied, reduced by the number of months recovery has already been made prior to establishment of the RECR screen, in the ORIG OFFSET MONTHS field.
- The CURRENT BALANCE field, which is filled by the system, will reflect the amount which was recovered and processed through completion of the CCIT screen prior to establishment of the RECR screen.

C. Annuity Withholding and Simultaneous Recovery through Installment Billing - Occasionally, because of the amount of an overpayment, full annuity withholding may be in force. At the same time, the annuitant may have agreed to remit a certain amount each month in order to reduce the overpayment. Because both an INSTALLMENT BILLING AND PAYMENT TABLE (INBT), used to produce monthly billing statements, and a RECURRING CASH RECEIPT TABLE (RECR) cannot exist at the same time, examiners must take the following actions.

1. Establish a record for the debt on the Installment Billing Table(INBT) as described in RCM 3.12.15 Special Instructions.
2. Calculate the expected date of recovery by dividing the debt by the total of the withholding amount and the monthly installment amount.
3. Set an MS call-up for that date.

3.12.19 Creating A Cash Receipt Document Using The Write-Off Table (WROT) Screen

The Write-Off Table (WROT) is used to mechanically create a cash receipt document which will transfer open accounts receivable records from PAR to the uncollectible account. Accounts receivable records which have not had any collection activity posted to them for 60 days from the delinquency date will automatically default to WROT. In order for records appearing on WROT to actually be transferred to uncollectible, examiners must change the write-off flag and reason code and complete the action out code. Receivables to be transferred to uncollectible which do not appear on WROT can also be added to this table.

When transferring amounts to uncollectible, it is essential that the PAYOR TABLE contains the name of the person responsible for the debt as opposed to RECLAMATION, ESTATE DEVELOPMENT, etc. Paragraph E of this section provides instructions for correcting the DEBTOR NAME if necessary.

A. Accessing the WROT Screen - The WROT screen is accessed as follows.

- Sign on to the PAR System as described in RCM 3.12.3.
- Type “N” in the Action field. Your cursor will move to the “TableID” field.
- Type the Table ID name WROT.
- Press ENTER.
- A blank WRITE-OFF TABLE screen will appear.

B. Transferring Existing WROT Records to Uncollectible - To transfer an existing accounts receivable record to uncollectible, make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields beginning with ACTION and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the WROT screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen. The ACTION field will be prefilled with an S, which means Scan Record. Use the TAB key to advance to the next field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four character PAR user identification code and your four character PAR password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.
ACCOUNT NUMBER	Enter the ACCOUNT NUMBER for this record. Precede serial claim numbers with zeros. The cursor will advance to the identifier position of the PAYOR ID field. DO NOT make any entry in this field.
	After completing the ACCOUNT NUMBER ID field on the WROT screen, press ENTER. The WRITE-OFF TABLE record for the railroad claim number entered in the ACCOUNT NUMBER field will be displayed on line 01 of the screen.
	The ACCOUNT NUMBER ID, BD ID, TOTAL BILL AMOUNT, LAST DUN DATE, WRITEOFF FLAG and RSN fields will be filled with data contained within PAR.

CAPTION	ENTRY
	To transfer the existing record to uncollectible, make the following entries next to or below the captions displayed on the screen.
	NOTE: Caution must be exercised when changing existing fields and completing required entries while in the CHANGE mode, as all records displayed on the screen are subject to change.
ACTION:	When the WROT screen for the ACCOUNT NUMBER ID you entered above is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.
	<ul style="list-style-type: none"> The ACTION field will be prefilled with an R which means Refill Record.
	<ul style="list-style-type: none"> Type C for Change Record over the R.
	<ul style="list-style-type: none"> Use TAB key to advance to the write-off flag field.
WRITEOFF FLAG:	This field will be prefilled with an N, which means No. Type Y for YES over the N. The cursor will advance to the WRITE-OFF RSN field.
WRITEOFF RSN:	This field will be prefilled with an A, which means Uncollectible - OPR. Select a Write-Off Reason Code from the list below which best describes the reason for transfer to uncollectible. Type this code over the A. The cursor will advance to the ACT OUT field.
	1. Waiver
	2. Compromise
	3. Statute of limitations
	4. Reserved
	5. Recovery efforts exhausted
	6. Adm. cost exceed debt
	7. Referred to CMS
	8. Reserved
	9. Reserved
ACT OUT:	Enter one of the following three position codes which best describes the reason for transfer of the accounts receivable to uncollectible.

CAPTION	ENTRY
	X21 Waiver
	X31 Referred to CMS
	X39 Compromise
	X41 Recovery Efforts Exhausted
	X42 Adm. cost exceed debt
	X44 Statute of limitations
	X50 Tolerance
	X51 Write-Off Future Entitlement Possible
	X52 Reserved Write-Off Future Entitlement Possible
	X53 Reserved Write-Off Future Entitlement Possible

- C. Adding a Record to the WROT Screen - To add a record to the Write-Off Table, make the following entries next to or below the captions displayed on a blank WROT screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

Caption	Entry
Action:	When the WROT screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.
	<ul style="list-style-type: none"> The action field will be prefilled with an S, which means Scan Record.
	<ul style="list-style-type: none"> Type A for Add Record over the S.
	<ul style="list-style-type: none"> Use the tab key to advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the tab key to advance to the USERID field.
USER ID:	Enter your four character PAR user identification code and your four character PAR password. (Your password will not be displayed on the screen.) The cursor will advance to the ACCOUNT NUMBER field.
ACCOUNT NUMBER :	Enter the prefix and railroad claim number which was assigned as the ACCOUNT NUMBER CODE when the accounts receivable record was established. Precede serial claim numbers with zeros. The cursor will advance to the identifier position. Enter the identifier position which was assigned when this record was established. The

	cursor will advance to the BD ID field.
BD ID:	Always enter B5 in the first two positions of this field. The cursor will advance to the remaining 11 positions. Enter the Billing Document Identification number assigned when the accounts receivable record was established. The cursor will advance to the TOTAL BILL AMOUNT FIELD.
TOTAL BILL AMOUNT:	Enter the amount of the overpayment for the accounts receivable record which is being transferred to uncollectible. You must use a decimal point and complete this entry to two decimal places. DO NOT use a dollar sign. Use the Tab key to advance to the WRITE OF FLAG field.
WRITEOFF	
FLAG:	Always enter a Y for YES in this field. The cursor will advance to the WRITEOFF RSN field.
WRITEOFF RSN:	Enter the one position code from the list below which best describes the reason for transfer of this record to uncollectible. Use the cursor to advance to the ACT OUT field.
	1. Waiver
	2. Compromise
	3. Statute of limitations
	4. Reserved
	5. Recovery efforts exhausted
	6. Adm. cost exceed debt
	7. Referred to CMS
	8. Reserved
	9. Reserved
ACT OUT:	Enter one of the following three position codes which best describes the reason for transfer of this record to uncollectible.
	X21 Waiver
	X31 Referred to CMS
	X39 Compromise
	X41 Recovery efforts exhausted
	X42 Adm. cost exceed debt
	X44 Statute of limitations
	A maximum of 13 records to be transferred to uncollectible

	can be added on one WROT screen.
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- D. Exiting from the WROT Screen - After completing the ACT OUT field, review the entries you have changed or added to the WROT screen to verify these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.
1. Establishing the WRITE-OFF TABLE - When all required entries have been completed or changed and all information is correct, press ENTER. Where the ACTION field was completed with an A, and a record was added to this table, the message *L030 ALL LINES ADDED will be displayed in the message area of the screen. Where the ACTION field was completed with a C, and an existing record was changed, the message *L031 ALL LINES CHANGED will be displayed in the message area of the screen. The display of one of these messages indicates the WRITE-OFF TABLE has been established. Approval and scheduling of the WROT screen are not necessary. Pressing ENTER and having one of the above messages displayed on the screen will establish this table in PAR. A cash receipt document will be mechanically generated to reduce the open accounts receivable balance by the amount displayed under the TOTAL BILL AMOUNT caption and transfer this amount to uncollectible.
 2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area at the bottom of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry as indicated. Continue to press ENTER and make corrections until one of the messages described in D1 is displayed in the message area of the screen. It is important that all errors are corrected and all required entries are completed on the WROT screen. PAR will not mechanically process a cash receipt document and transfer an amount to uncollectible as long as errors are present.

3.12.20 Creating A Cash Receipt Document Directly Through The Cash Document Screens

Open receivable records are offset in PAR by creating a cash receipt document. The cash receipt document screen series can be used to generate a cash receipt document for all methods of recovery except for partial or full annuity withholding. This is the only method which can be used to post receipts to a receivable where the balance has previously been reduced to zero because of over reimbursement or duplicate recovery. The cash receipt document screen series must also be completed in situations where no billing document exists. The document startup, input and line screens must be completed to create a complete cash receipt document.

- A. Accessing the STARTUP Screen - To access the STARTUP screen follow the instructions in RCM 3.12.3.
- B. Completing the SUSF Screen - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.
- TRAN - Always enter C5. The cursor will advance to the DIVISION field.
 - DIVISION - Always enter 2500. The cursor will advance to the ID NUMBER field.
 - ID NUMBER - This number is made up of a combination of 11 letters and numbers. Enter the code as follows.
 - Cash
 - 'CD'
 - Certificate of Deposit Number
 - PCU Assigned counter for this deposit item
 - Annuity Withholding
 - 'AW'
 - Year and month of withholding; i.e., (9103 for March 1991)
 - Last 2 digits of examiner number
 - 3 digit counter, to indicate the number of withholdings for the specified date (9103) by this examiner today.
 - Reclamation/Stop Credit via Treasury
 - 'TF'
 - Year and month credit received; i.e., (9103 for March 1991)
 - Last 2 digits of examiner number
 - 3 digit counter, to indicate the number of Treasury credits received on the specified date by this examiner today.

- SMIB Refunds
- 'SR'
- Year and month refund withheld (YYMM)
- Last 2 digits of examiner number
- 3 digit counter
- **Administrative liquidations** Use when a debt is liquidated by administrative decision such as, administrative cost exceeding recoverable amount, referred to CMS or compromise.
- 'AD'
- Year and month of decision (YYMM)
- Last 2 digits of examiner number
- 3 digit counter

After the ID NUMBER has been completed, use the TAB key to advance to the USER ID field.

USER ID: Enter your four character PAR user identification code and your four character PAR password. (Your PAR password will not be displayed on the screen.) The cursor will advance to the next field.

- C. Exiting from the STARTUP Screen - After you have entered your PAR user identification code and PAR password, review the information you have entered on the STARTUP screen to verify that these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information. When all information is correct, press ENTER. The CASH RECEIPT INPUT SCREEN will appear.

3.12.21 Completing The Cash Receipt Input Screen

- A. Accessing the CASH RECEIPT INPUT SCREEN - Following completion and entering of the STARTUP screen as described in RCM 3.12.20, the CASH RECEIPT INPUT SCREEN displayed below will appear.

The MODE, DOCID and USERID fields on the action line of this screen will be prefilled from these entries completed on the STARTUP screen.

- B. Completing the CASH RECEIPT INPUT SCREEN - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields beginning with DOC DATE and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	Enter E for entry. Use the tab key to advance to the DEP NUMBER field.
FUND:	Always enter HCFAAR
TRANS TYPE:	Enter 'SA' in recoveries for active accounts. Enter 'SU' in recoveries for reactivated uncollectible records.
DEP NUMBER:	Complete this entry as follows. This field will accommodate an entry of up to 12 positions. If all positions are used, the cursor will advance to the next field, otherwise use the TAB key to advance the Document Total.
	<u>If the method of recovery is by cash, check or money order, enter the certificate of deposit number (CD#).</u>
	<u>If the method of recovery is by annuity withholding, waiver, tolerance, etc. (any method other than cash, check or money order,) enter MPS.</u>
DOCUMENT TOTAL:	Enter the amount of the payment or recovery for the cash receipt document you are establishing. You must use a decimal point and complete this entry to two decimal places. DO NOT use a dollar sign. Use the TAB key to advance to the next field.

- C. Exiting from the CASH RECEIPT INPUT SCREEN - After completing the DOCUMENT TOTAL field, review the three entries you have completed on the CASH RECEIPT INPUT SCREEN to verify that these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information. When all information is correct, press ENTER. The CASH RECEIPT LINE SCREEN will appear.

3.12.22 Completing The Cash Receipt Line Screen

- A. Accessing the CASH RECEIPT LINE SCREEN - Following completion and entering of the CASH RECEIPT INPUT SCREEN as described in RCM 3.12.21, the CASH RECEIPT LINE SCREEN displayed below will appear.

The MODE, DOCID and USERID fields on the action line of this screen will be prefilled from these entries completed on the STARTUP screen.

- B. Completing the CASH RECEIPT LINE SCREEN - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields beginning with LINE NO and will move through the screen in the following order.

CAPTION	ENTRY
LINE NO:	Enter 001 for the first line you establish for a cash receipt document to offset a specific billing document. Increase this number by one for each succeeding line completed which pertains to the same billing document. This is a three position field. Since it is unlikely that more than a single digit number of lines will be established for any cash receipt document, enter zeros in the first two positions of this field. The cursor will advance to the REF TC field.
REF TC:	Enter B5 in the two positions of this field if a billing document has been established. The cursor will advance to the next field.
	EXCEPTION: If no billing document has been established, or if the amount outstanding has already been reduced to zero, make no entry in this field. Use the TAB key to advance to the next field.
<u>A payor screen must be established using the ACCOUNT NUMBER entered in the VND/PRV before this document will process.</u>	
REF NUMBER:	Enter the 11 position Billing Document Identification code to which this cash receipt document is being posted. The cursor will advance to the next field.
	EXCEPTION: If no billing document has been established, or if the amount outstanding has already been reduced to zero, make no entry in this field. Use the TAB key to advance to the next field.

CAPTION	ENTRY
<u>A payor screen must be established using the ACCOUNT NUMBER entered in the VND/PRV before this document will process.</u>	
REF LINE:	Enter the three position code which represents the line of the receivable this credit should be applied to on the original billing document, i.e., 001, 002. Use the TAB key to advance to the fund field.
	EXCEPTION: If no billing document has been established, or if the amount outstanding has already been reduced to zero, make no entry in this field. Use the TAB key to advance to the next field.
FUND:	Make no entry in this field. Use the TAB key to advance to the Fund field.
	EXCEPTION: If no billing document has been established, or if the amount outstanding has already been reduced to zero, enter 8011 in this field. Use the TAB key to advance to the Trans Type field.
TRAN TYPE:	Enter one of the following two position codes. The cursor will advance to the next field.
	<ul style="list-style-type: none"> SA Use in all recoveries for active accounts.
	<ul style="list-style-type: none"> SU Use in all recoveries for re-activated uncollectible accounts.
VND/PRV:	Enter the ACCOUNT NUMBER for the debt record to which this document is to be applied.
AMOUNT:	Enter the amount of the recovery to be credited to the type of overpayment code entered following the REF LINE caption above. You must use a decimal point and complete this entry to two decimal places. DO NOT enter a dollar sign. Use the TAB key to advance to the Action Out field.
	EXAMPLE: A full cash remittance received for a receivable comprised of both age and disability funds. The combined amount of the age and disability portions will be entered in the DOCUMENT TOTAL field on the CASH RECEIPT INPUT SCREEN. However, on this screen, the amount of each portion will be entered on separate lines.

CAPTION	ENTRY
ACTION OUT:	Enter the four position code from the list below which best describes how the overpayment was recovered. The cursor will advance to the next field.
	X21 Waiver
	X22 Offset Part B Benefits
	X23 Credit Card
	X24 Cash Refund
	X25 Partial Withholding
	X26 Full Withholding
	X27 SSA Benefit Offset
	X28 State Buy-In Offset
	X29 Cash Refund to Carrier/Inter.
	X31 Referred to CMS
	X32 No Overpayment Exist
	X33 Provider is Overpaid
	X34 Incorrect Trust Fund
	X35 Previous Offset
	X36 Administrative Error
	X37 Non-Sufficient Funds Check
	X38 RRA Offset Invalid
	X39 Compromise
	X42 No Means of Recovery
	X43 Overreimbursement
	X44 Statute of Limitations
	X45 Referred To SSA
	X46 Offset Premium Refund
	X47 Delayed Reduced Premiums
	X48 Retro Income Adjustment Amount
	X49 Income Adjustment Amount
	X50 Tolerance
	X51 Write-Off Future Entitlement Possible
	X52 Reserved Write-Off Future Entitlement Possible
	X53 Reserved Write-Off Future Entitlement Possible

CAPTION	ENTRY
	NOTE: The PAR ACTO TABLE contains a complete list of action out codes, including those used by DRD and MS.
	Each CASH RECEIPT LINE SCREEN will accommodate entries for two separate lines of activity. If both sections of this screen must be completed, use the TAB key to advance the cursor from the ACTION OUT field in the top portion of the screen. The cursor will advance to the LINE NO field in the bottom portion of the screen. Complete each entry on the lower portion of the screen as described for each caption above.

- C. Exiting from the CASH RECEIPT LINE SCREEN - After completing the ACTION OUT field on the last required line of activity, review the information you have entered on the CASH RECEIPT LINE SCREEN to verify that these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.

3.12.23 Quick Edit Function

The Quick Edit function is used to edit entries you have completed on the CASH RECEIPT INPUT SCREEN and CASH RECEIPT LINE SCREEN. This function also signals the PAR System that all document screens required to establish a cash receipt document have been completed.

- A. Beginning the Quick Edit Process - Following your review of the CASH RECEIPT LINE SCREEN and your determination that all entries are complete and correct, Quick Edit is accomplished as follows:
- Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key (),
 - Release the alternate shift key (Alt).
 - Type Q for Quick Edit in the ACTION field.
 - Press ENTER.

B. Results of the Quick Edit Process - The PAR System always returns to the initial screen in a document screen series for display of edit, error or acceptance messages.

- The CASH RECEIPT INPUT SCREEN will be displayed.
- The MODE field on the action line of the screen will contain a C indicating the system is in the correction mode.
- The letters RH indicating additional handling is required will be displayed under the STATUS caption.

1. No Errors Are Detected During Quick Edit - If all required entries on the CASH RECEIPT INPUT SCREEN have been completed and the system does not detect any errors, the following three messages will be displayed in the message area at the bottom of the CASH RECEIPT INPUT SCREEN:

- A -*CQ93 - DOCUMENT REJECTED
- H -*FO53 - DOCUMENT NOT APPROVED
- H -*S401 - READY FOR APPROVAL

NOTE The above messages will appear if no errors are detected on the CASH RECEIPT INPUT SCREEN but errors may still exist on the CASH RECEIPT LINE SCREEN. Therefore, it is essential to page to the CASH RECEIPT LINE SCREEN for display of any error messages. This is accomplished by typing NS for Next Screen in the ACTION field on the action line of the screen and pressing ENTER. Because the system will remain in correction mode, any errors detected in LINE screen entries will be displayed in the message area at the bottom of the screen. If no errors are detected, the message area will be blank.

2. Errors Are Detected During Quick Edit - If any errors are detected during the Quick Edit process or any required entries are not complete, an error or warning message(s) will be displayed in the message area of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and make the required entries.

The ACTION field on the action line of the screen may contain the letters EM. Because a maximum of six edit or error messages can be displayed on a screen, EM indicates there are additional edit or error messages for the screen you are viewing. To view the additional messages, press

ENTER. The same screen with the additional edit or error messages will be displayed.

- a. Moving from the CASH RECEIPT INPUT SCREEN to the CASH RECEIPT LINE SCREEN While Performing Quick Edit - Error messages always appear at the bottom of the CASH RECEIPT INPUT SCREEN first. To check for any edit or error messages which may be displayed on the CASH RECEIPT LINE SCREEN, or to make any corrections to the CASH RECEIPT LINE SCREEN which are displayed on the CASH RECEIPT INPUT SCREEN:

- Position the cursor in the ACTION field on the action line of the screen.
- Press and hold down an alternate shift key (Alt),
- Press the cursor home key (),
- Release the alternate shift key (Alt).
- Type NS for Next Screen in the ACTION field.
- Press ENTER.

The CASH RECEIPT LINE SCREEN containing any additional edit or error messages will be displayed.

- b. Moving from the CASH RECEIPT LINE SCREEN to the CASH RECEIPT INPUT SCREEN While Performing Quick Edit - If it is necessary to return to the CASH RECEIPT INPUT SCREEN while in the correction mode of Quick Edit:

- Position the cursor in the ACTION field on the action line of the screen.
- Press and hold down an alternate shift key (Alt),
- Press the cursor home key (),
- Release the alternate shift key (Alt).
- Type NLO for Move to Top of Document in the ACTION field.

NOTE: The third position of this ACTION command is numeric.

- Press ENTER.

The CASH RECEIPT INPUT SCREEN will again be displayed.

- c. Exiting from Quick Edit - When all corrections have been made to the CASH RECEIPT INPUT SCREEN and CASH RECEIPT LINE SCREEN, perform the Quick Edit function as described in section A. Continue to make all corrections and perform Quick Edit until the three messages described in section B1 are displayed in the message area of the CASH RECEIPT INPUT SCREEN.
- d. HOLDING THE CASH RECEIPT DOCUMENT FOR APPROVAL - After the Quick Edit function has successfully been performed, the cash receipt document you have completed must be held for approval. This is accomplished as follows:
 - Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key,
 - Release the alternate shift key (Alt).
 - Type H for Hold Document in the ACTION field.
 - Press ENTER.

The STARTUP screen with the message A -*CQ8H-DOCUMENT HELD shown in the message area of the screen will be displayed.

This completes the data entry portion for the establishment of a cash receipt document by means of completion of the cash receipt document screen series.

3.12.24 Approval Of The Cash Receipt Document

Before a cash receipt document is actually processed and established by the PAR System, the data entered on the CASH RECEIPT INPUT SCREEN and CASH RECEIPT LINE SCREEN must be approved by an authorizer. Cash receipt documents awaiting approval are housed in the SUSPENSE FILE TABLE (SUSF). Documents requiring approval are designated by the letters HELD in the STAT field and five zeros in the APPRV field on this table.

- A. Accessing the SUSF Screen - To access the SUSPENSE FILE TABLE (SUSF) screen, take the following actions:
 - Sign on to the PAR System as described in RCM 3.12.3.
 - Type "N" in the Action field. Your cursor will move to the "TableID" field.

- Then type the "TableID" name SUSF.
- Press ENTER.
- A blank SUSPENSE FILE TABLE screen will appear.

B. Completing the SUSF Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the SUSF screen is accessed, the cursor will be positioned in the ACTION field which is prefilled with an S, which means Scan Record. Use the TAB key to advance to the next field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four character PAR user identification code and your four character PAR password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.
BATCH ID:	TRAN - Make no entry in this field. Use the TAB key to advance to the next field.
	ORG 1 - Make no entry in this field. Use the TAB key to advance to the next field.
	NUMBER - Make no entry in this field. Use the TAB key to advance to the next field.
DOCUMENT ID:	TRAN - Always enter C5 in the first two positions of the Transaction Code. Use the TAB key to advance to the next field.
	ORG 1 - Always enter 2500 in this field. The cursor will advance to the next field.
	NUMBER - Enter the 11 position alpha and numeric code assigned to the cash receipt document which requires approval.

	After completing the TRAN, ORG 1, and NUMBER fields under the DOCUMENT ID caption, press ENTER.	
	•	The cursor will return to the ACTION field on the action line of the screen.
	•	The ACTION field will now contain an R for Refill.
	•	The cash receipt document you requested will appear on the first data line of the screen.
	•	In addition to the DOCUMENT ID field which you completed, the STAT, APPRV, ENTRY DATE, LAST DATE, LAST TERMINAL and LAST USER fields will now be prefilled by the PAR System.

C. Accessing the CASH RECEIPT INPUT SCREEN and CASH RECEIPT LINE SCREEN for Approval - To access the CASH RECEIPT INPUT SCREEN, take the following actions.

- Type S for Scan Record over the R in the ACTION field on the action line of the screen.
- The correct TABLEID and your USERID will be prefilled in these fields.
- Use the RETURN key to advance the cursor to the first position of the first data line on the SUSF table screen.
- Press ENTER.
- The CASH RECEIPT INPUT SCREEN will be displayed.
- The cursor will be positioned in the ACTION field on the action line of the screen,
- The ACTION field will be blank,
- The MODE field will be prefilled with a C for Correction Mode,
- The DOCID field will be prefilled with the cash receipt document number you requested,
- The letters RH indicating additional handling required will be displayed under the STATUS caption,

- Two messages will appear in the message area at the bottom of the CASH RECEIPT INPUT SCREEN;
- H -*S401-READY FOR APPROVAL 1,
- H -*F053-DOCUMENT NOT APPROVED.

D. Approval Process - Once the cash receipt document requiring approval and scheduling is accessed and visible on the screen, take the following actions.

- Review the information on the CASH RECEIPT INPUT SCREEN to verify all entries are correct. Complete or correct any data entry items as necessary.
- Type NS for Next Screen in the ACTION field on the action line of the screen.
- Press ENTER. This will access the CASH RECEIPT LINE SCREEN.
- The FUND:, BUDGET ORG/SUB:, BOC/SUB: and VND/PRV: on each line of activity will be filled from information entered into the PAR System when the billing document was established.
- Review the information on the CASH RECEIPT LINE SCREEN to verify all entries are correct. Complete or correct any data entry items as necessary.
- Perform the Quick Edit function as described in RCM 3.12.23.
- Correct any data entry errors if possible.
- If you are unable to correct data entry errors, return the cash receipt document to HOLD until corrective action can be determined.
- Type A for Approval in the ACTION field on the action line of the screen. Use the NEW LINE key () to move the cursor to the APPRVL field.
- Type Y in the APPRVL field.
- Press ENTER.
- The CASH RECEIPT INPUT SCREEN will be displayed showing the following two messages in the message area at the bottom of the screen.
- A -*S001-APPROVAL 1 APPLIED.
- A -*CY41-APPROVED DOCUMENT.

E. SCHEDULING THE CASH RECEIPT DOCUMENT FOR PAR PROCESSING.

After the cash receipt document has been approved, it must be returned to the SUSPENSE FILE TABLE and scheduled for processing by PAR. This is accomplished as follows.

- Return the cursor to the ACTION field on the action line of the screen.
- Type the letter O for Off-line processing.
- Press ENTER. The SUSPENSE FILE TABLE screen will be displayed.

The cash receipt document you have just approved will be displayed on the top line in the data area of the screen. The STAT field will still show HELD and the APPRV field will still display five zeros.

To verify the cash receipt document has been approved and scheduled:

- Type N for Next Screen in the ACTION field on the action line of the screen.
- Press ENTER. A blank SUSPENSE FILE TABLE screen will be displayed.
- The ACTION field will be prefilled with an S for Scan Record,
- The TABLEID field will contain the correct table code name,
- The USERID field will contain your PAR user identification code and password.
- Position the cursor on the first line of the data area of the screen.
- Type C2 in the TRANS field under the DOCUMENT ID caption. Use the TAB key to advance to the next field.
- Type 2000 in the ORG 1 field. The cursor will advance to the next field.
- Type the 11 character alpha and numeric cash receipt document number you have just approved in the NUMBER field.
- Press ENTER.

The approved cash receipt document will appear on the top line in the data area of the screen. The STAT field will now show SCHED indicating the cash receipt document has been scheduled for processing. The first position of the APPRV field will display a Y, indicating the cash receipt document has been approved.

3.12.25 Waiver of Recovery Table (WAIV)

The Waiver of Recovery Table is used to maintain data related to request for reviews and waivers of payment. Examiners may enter and update the waiver date, waiver denial date and current status of the waiver process. A record is mechanically added to this table when a receivable is established.

- A. Accessing the WAIV Screen - The WAIV screen is accessed as follows:
- Sign on to the PAR system as described in RCM 3.12.3
 - Type “N” in the Action field. Your cursor will move to the “TableID” field.
 - Type the Table ID name WAIV
 - Press ENTER
 - A blank WAIV table will appear.
- B. Scanning the WAIV Screen - To scan for a receivable record on the WAIV table, make the following entries next to or below the captions displayed on the screen. The cursor will be positioned in the ACTION field.

CAPTION	ENTRY
ACTION:	The action field will be prefilled with an 'S' if the WAIV table was accessed from another table or 'next task code' prompt, otherwise type 'S' in this field.
TABLE ID:	The TABLEID field will contain the correct table code name. Use the tab key to advance to the USER-ID field.
USERID:	Enter your four character PAR user identification code and your four character PAR password. The cursor will advance to the Billing Doc ID field.
BILLING DOC ID:	Enter the complete Billing Doc ID number, i.e. B5 123456789A1.
	Press Enter: - The selected record will be displayed on the top line.

- C. Completing the WAIV Screen - To update the status of the waiver/review status, make the following entries next to or below the captions displayed on the screen.

The cursor will place you in the first position of each of the data entry fields beginning with ACTION and will move through the screen in the following order.

CAPTION	ENTRY	
ACTION:	Type 'C' over the 'R' displayed in this field. Use the TAB key to advance to the field to be updated.	
WAIVER		
EXPIRATION DATE:	Enter the expiration date for waiver request rights for this receivable. Enter MMDDYY.	
WAIVER REQUEST:	Enter one of the following codes to indicate if a waiver or review has been requested.	
	•	Enter 'Y' to indicate that a waiver has been requested.
	•	Enter 'L' to indicate that the waiver was requested late.
		The system default is 'N' for No.
WAIVER DENIAL NOTICE:	Enter the date the payor was notified of the waiver denial. Enter MMDDYY. (A WAIVER expiration date must be entered)	
STATUS:	Enter one of the following code to indicate the status withholding the waiver/review process:	
	Code	Description
	1	Review of the Facts
	2	Review of the Facts and Personal Conference
	3	Waiver Consideration
	4	Review of the Facts and Waiver Consideration
	5	Waiver Consideration and Personal Conference
	6	Review of the Facts, Waiver Consideration, and Personal Conference
	7	Appeal to bureau of Hearings and Appeals
	8	Appeal to Three Member Board

	9	Appeal to Court
	A	File Released to Field Office - Review of the Facts and Personal Conference
	B	File Released to Field Office - Waiver Consideration and Personal Conference
	C	File released to Field Office - Review of the Facts, Waiver Consideration, and Personal Conference
	D	File Returned From Field Office - Review of the Facts and Personal Conference
	E	File Returned From Field Office - Waiver Consideration and Personal Conference
	F	File Returned From Field Office - Review of the Facts, Waiver Consideration, and Personal Conference
STATUS CHANGE DATE:	Enter the date that the status was last changed.	
	Enter MMDDYY	

3.13.1 MEDCOR

The on-line Medicare Correction system (MEDCOR) replaces the paper Medicare input Forms G-810 and G-811 with on-line data input screens. MEDCOR edits the Medicare activity information on-line. A MEDCOR activity file is created to update the Medicare Information Recorded, Transmitted, Edited, and Logged (MIRTEL) system.

3.13.2 MEDCOR/MEDREF (on-line Medicare Referral system) Database

MEDCOR activity information is kept in a combined MEDCOR/MEDREF database, separate from other systems and resides on the Railroad Automated Processing Integrated Database (RRAPID).

Completed activity information may not match the information on the MIRTEL On-line Inquiry (MOLI) database if a MIRTEL rerun or MOLI rollback is necessary. If a MIRTEL rerun is necessary, the activity file would be brought back into the MIRTEL run. When the rollback is complete, all activity updates would be correctly shown.

Information from pending and completed activities is kept on the MEDCOR/MEDREF database. Pending activities may be viewed, deleted or changed. Pending activities are held in the MEDCOR/MEDREF database until processed in the next daily MIRTEL run. Information about processed activities is also held for management reports. Limited information about the processed activities can be viewed.

3.13.3 MEDCOR Security

Access to MEDCOR is limited by levels of security established through ACF2. Each level allows the user to browse, create, update and delete activities associated with that level. Access is also limited to individual screens and fields within screens. In addition, various types of activity processing for miscellaneous input, formerly the Form G-811, are limited.

The USER field is the user's signon id and is displayed on all MEDCOR screens. The USER field cannot be changed by the user and is included on any activity which a user creates, changes or deletes. An audit trail is established based on the user signon. MEDCOR's levels of security are:

- MEDCORSEE - MEDCORSEE allows the user access to limited MEDCOR activities to create, view and delete.
- MEDCORBFS - In addition to MEDCORSEE, the field offices will have access to MEDCORBFS. MEDCORBFS allows the user access to specific MEDCOR activities for the Field Service to create, view and delete.

- MEDCORDPS - In addition to MEDCORSEE, DPS examiners will have access to MEDCORDPS. MEDCORDPS allows the user access to specific MEDCOR activities for the examiners in the Disability Section to create, view and delete.
- MEDCORORS - In addition to MEDCORSEE, OPRNS examiners will have access to MEDCORORS. MEDCORORS allows the user access to specific MEDCOR activities for the clerks and examiners in the Retirement Benefits Division and the Survivor Benefits Division to create, view and delete.
- MEDCORMPS - In addition to MEDCORSEE, MS examiners will have access to MEDCORMPS. MEDCORMPS allows the user access to all MEDCOR activities for the examiners in the Medicare Section to create, view and delete.
- MEDCORMNG - In addition to MEDCORSEE supervisory access will have access to MEDCORMNG. MEDCORMNG allows the user access to all MEDCOR activities for MS supervisors and other designated individuals to create, view and delete and an additional delete function.

3.13.4 MEDCOR Screens

Screen MCMM001, the MEDCOR MENU screen, is the first screen displayed when entering MEDCOR and allows the user access to the various MEDCOR screens.

Most of the MEDCOR screens are used for inputting activity information. The activity screens are used to establish, maintain or delete a Medicare record on MIRTEL, and when necessary to update the Entitlement Database (EDB) at the Centers for Medicare & Medicaid Services.

The following are MEDCOR's 11 main activity screens:

- Screen MCMU011 – MISCELLANEOUS INPUT;
- Screen MCMU012 – ACTIVITY 12 ESTABLISH/SCREEN SS;
- Screen MCMU013 – ACTIVITY 13 ESTABLISH ONLY;
- Screen MCMU020 – ACTIVITY 20 INTERNAL CHANGE;
- Screen MCMU021 – ACTIVITY 21 RESCREEN SS;
- Screen MCMU022 – ACTIVITY 22 INTERNAL CHANGE/URIC;
- Screen MCMU031 – ACTIVITY 31 ESTABLISH/CROSS REFER SS;
- Screen MCMU032 – ACTIVITY 32 CORRECT/CROSS REFER SS;
- Screen MCMU033 – ACTIVITY 33 ESTABLISH/CROSS REFER RR; and

- Screen MCMU034 – ACTIVITY 34 CORRECT/CROSS REFER RR.
- Screen MCMU162 – ACTIVITY 62 DUPLICATE MEDICARE CARD REQUEST

The following are MEDCOR's subordinate activity screens:

- Screen MCMU014 - VARIABLE PART B;
- Screen MCMU015 - PREVIOUS INFORMATION;
- Screen MCMU016 – ADDRESS; and
- Screen MCMU214 – PART B PREMIUM REDUCTION / IRMAA.

The main activity screens are accessed from Screen MCMM001. The subordinate screens are accessed from certain main activity screens in MEDCOR.

There are also 2 MEDCOR screens displaying limited information about MEDCOR activities: Screen MCMU017 (Pending Activities List screen) and Screen MCMI018 (Completed Activities List screen).

When a MEDCOR screen is displayed, the cursor is always placed on the first field which an entry can be made or changed. After an entry is made in this field, the cursor will then be placed on the next field which an entry can be made or changed in either the right or left column. If an error is detected, the cursor will be placed on the first incorrect field.

Some fields on the MEDCOR activity screens are for on-line editing, some fields are for display only (protected fields), and others will be used for additional processing at a later date.

3.13.5 Prefilling MEDCOR Screens

A. For New Activities

For newly created activities, the fields on MEDCOR Screens MCMU012, MCMU013, MCMU014, MCMU015, MCMU016, MCMU031 and MCMU033 will be blank. However, if there is a record on DATAQ, Screen MCMU016 will be prefilled from DATAQ.

For newly created activities, certain fields on MEDCOR Screens MCMU011, MCMU014, MCMU015, MCMU020, MCMU021, MCMU022, MCMU032, and MCMU034 will be prefilled with information from the MOLI database. Screen MCMU016 and MCMU162 will be prefilled from MOLI if there is an address on the MOLI record. If the address is not on MOLI but there is a record on DATAQ, Screen MCMU016 and MCMU162 will be prefilled from DATAQ.

B. For Pending Activities

For pending activities, the fields on the MEDCOR screens will contain data that was previously entered on the MEDCOR activity screens and added to MEDCOR. If a subordinate screen was not added to MEDCOR, the fields on the subordinate screens will be blank, even if previously prefilled.

3.13.6 Colors On MEDCOR Screens

Colors are consistent on all MEDCOR screens. The following colors are used:

- Blue is used for program names, map name, current date, page, time, directional messages and field labels.
- White is used for screen title, variable messages and user entered data and prefilled fields that can be changed.
- Red is used for error messages.
- Red reverse video is used for fields that do not pass the edits.
- Green is used for data fields which cannot be changed.
- Pink is used for system changed fields.

3.13.7 Layout Of MEDCOR Screens

The layout of the MEDCOR screens is consistent. The following applies:

- Row 1 has the screen id (map name), title and date and cannot be changed by the user.
- Row 2 has dialog name, title and time and cannot be changed by the user.
- Row 3 on the main activity screens has the RRB claim number. For the subordinate activity screens, Row 3 has the RRB claim number and the activity input number.
- Rows 4 through 19 contain the data headings and fields. Data headings cannot be changed by the user. The last line of data has the unit and user id.
- Rows 20 and 21 displays system generated information or error messages and cannot be changed by the user.
- Row 22 displays '----RESPONSES----.'
- Rows 23 and 24 display valid key functions.

3.13.8 Help Screen On MEDCOR

The Help Messages were created by using the On-line Help (OLH), a package which works with the database system. The Help Message allows for instructions or examples to be displayed by pressing the PF1 key. Help information is displayed for a screen. However, if the cursor is placed on a specific field where help information is defined, help information is displayed for that field.

3.13.9 Function Keys On MEDCOR

The following function keys are the same for all MEDCOR screens:

- CLEAR exits a screen and goes to the previous screen within MEDCOR. If the activity screen was not added via the PF2 key, the data will not be used to create an activity or change a pending activity. If deleting a pending activity, if the activity screen was not deleted via the PF4 key, the activity will remain on MEDCOR. If on Screen MCMM001, the MEDCOR Menu screen, clear will exit MEDCOR and returns to the RRAPID MAIN MENU screen.
- PF1 displays the HELP SCREEN associated with the screen or field which the cursor is on.
- PF24 displays a list of all key functions even if not applicable for the screen.

The following function keys are used on selected MEDCOR screens:

- ENTER processes the selection made on Screen MCMM001, the MEDCOR Menu screen and Screen MCMU017, the Pending Activities List screen.
- PA1 goes to Screen MCMM001, the MEDCOR Menu screen. If the activity screen was not added via the PF2 key, the data will not be used to create an activity or change a pending activity. If deleting a pending activity, if the activity screen was not deleted via the PF4 key, the activity will remain on MEDCOR.
- PA2 exits MEDCOR and returns to the RRAPID MAIN MENU screen. If the activity screen was not added via the PF2 key, the data will not be used to create an activity or change a pending activity. If deleting a pending activity, if the activity screen was not deleted via the PF4 key, the activity will remain on MEDCOR.
- PF2 adds the entries made on a main or subordinate activity screen to MEDCOR after passing edits.

All entries made on any subordinate activity screen will be held until the main activity screen is added. The user will return to the main activity screen after the PF2 key is pressed twice on the subordinate activity screen.

When the main activity screen is added, all entries from added subordinate activity screens and the entries from the main activity screen will be added to the MEDCOR/MEDREF database and be used to create the activity record to update the MIRTEL master record. From the main activity screen, the user will return to Screen MCMM001, the MEDCOR Menu screen, or Screen MCMU017, the Pending Activities List screen, after the PF2 key is pressed twice.

The user who created the activity can change the pending activity they created. Only managers can change any activity on MEDCOR.

- PF4 deletes screens with activity information which was previously added on MEDCOR. If a main activity screen is deleted, any subordinate activity screens previously added to MEDCOR will also be deleted. A subordinate activity screen may be deleted, leaving the main activity screen.

The user will return to Screen MCMU017 after the PF4 key is pressed twice from a pending main activity screen. The user will return to the main activity screen after the PF4 key is pressed twice from a pending subordinate activity screen.

The user who created the activity may delete an activity they created. The users can only delete the activity from the pending activity screen. Only a manager can delete any activity on MEDCOR and delete the activity from Screen MCMU017, the Pending Activities List screen.

- PF5 refreshes the screen to the original information that was on the screen, blank, prefilled information from MOLI/DATAQ or what was added or changed on MEDCOR.
- PF7 pages to a previous page of information on Screen MCMU017, the Pending Activities List screen and Screen MCMI018, the Completed Activities List screen. This is true only if the claim number entered was in the database.
- PF8 pages to the next page of information on Screen MCMU017, the Pending Activities List screen and Screen MCMI018, the Completed Activities List screen. This is true only if the claim number entered was in the database.
- PF9 displays Screen MCMM001, the MEDCOR Menu screen.
- PF14 brings up Screen MCMU014, the Variable Part B screen.
- PF15 brings up Screen MCMU015, the Previous Information screen.
- PF16 brings up Screen MCMU016, the Address screen.
- PF17 brings up Screen MCMU017, the Pending Activities List screen.
- PF18 brings up Screen MCMI018, the Completed Activities List screen.

- PF 19 pages to the first page of information on Screen MCMU017, the Pending Activities List screen and Screen MCMI018, the Completed Activities List screen.
- PF20 pages to the last page of information on Screen MCMU017, the Pending Activities List screen and MCMI018, the Completed Activities List screen.

3.13.10 Creating, Changing Or Deleting An Activity On MEDCOR

Depending on the type of main activity screen, some of the subordinate activity screens are mandatory while others are optional. To create an activity record to update MIRTEL, a main and any subordinate activity screens must be added to MEDCOR. In order to include the information from any subordinate activity screens to the activity record to update MIRTEL, a main activity screen must be added to MEDCOR.

If the claim number, unit, (if applicable, beneficiary's social security account number (SSAN), pseudo number) and activity input fields are correct, information on a pending activity, either a main or subordinate activity screen, may be changed. A subordinate activity screen may also be added to a pending activity if not previously added. A pending activity may also be deleted. In addition, information on a subordinate activity screen may be deleted leaving the main activity screen to be processed. However, if a main activity screen is deleted, any subordinate activity screen are also deleted.

Except for managers deleting an activity, any changes or deletions of a pending activity must be made from the main or subordinate activity screens. The pending activity screens will be in the corresponding main or subordinate activity edit screens.

After the PF2 key is pressed twice, (to add a newly created activity or to add changes made to a pending activity), on the activity screens, the information from the subordinate activity screens is included on the activity record with the information from the main activity screen to create the activity record to update MIRTEL. After the PF4 key is pressed twice (to delete an activity that was previously added to MEDCOR), on the activity screens or on Screen MCMU017, the information from the main activity screen and any subordinate activity screens will be deleted.

3.13.11 Accessing MEDCOR

Access to MEDCOR is through RRAPID. Access the RRAPID MAIN MENU as instructed in RCM 16.2.5. When the RRAPID MAIN MENU appears, type 27 in the NEXT SELECTION field on the RRAPID MAIN MENU screen and press ENTER. Screen MCMU001 - the MEDCOR Menu screen will appear.

MEDCOR uses the "Hot Key" function. The user can go to other systems on RRAPID without having to reenter the identifying data. Each system allows the user to change the identifying data.

3.13.12 Screen MCMM001 - MEDCOR Menu Screen

Screen MCMM001 is the first screen displayed when entering MEDCOR. Screen MCMM001 allows the user to access the MEDCOR main activity screens, Screen MCMU017 and Screen MCMI018.

If MEDCOR was entered via the "Hot Key" function, the claim number, beneficiary social security number and pseudo number may be carried over and inserted in the CLAIM NUMBER, BEN SSA NUMBER and PSEUDO NUMBER fields. These fields may be typed over or spaced out.

Below is an example of Screen MCMM001.

<u>MCMM001</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YYCC</u>	
<u>MCDM001</u>	<u>MEDCOR MENU</u>	<u>HH:MM</u>	
UNIT			
CLAIM NUMBER _ - -			
BEN SSA NUMBER - -			
PSEUDO NUMBER - -			
ACTIVITY INPUT			
VALID ACTIVITIES 12, 13, 20, 21, 22, 31, 32, 33, 34, 62,11 MISC INPUT			
		USER XXXXXXXX	
MESSAGE			
MESSAGE			
-----RESPONSES-----			
ENTER=PROCES S	CLEAR/PA2=RRAPID	PF1=HELP	PF5=REFRESH
PF9=MEDREF	PF17=PACTL	PF18=CACTL	PF24=KEYS

A. Accessing a Main Activity Screen on MEDCOR

To access a main activity screen to create an activity on MEDCOR, entries are mandatory in the UNIT, CLAIM NUMBER AND ACTIVITY INPUT fields on Screen MCMM001.

Entries should be made in the BEN SSA NUMBER and PSEUDO NUMBER fields on Screen MCMM001 as follows:

- For Employees: Make no entry in the BEN SSA NUMBER and PSEUDO NUMBER fields on Screen MCMM001.
- For Beneficiaries Other Than Employees:
 - If there is no MOLI record and the beneficiary does not have a pseudo number, make an entry only in the BEN SSA NUMBER field on Screen MCMM001.
 - If there is no MOLI record and the beneficiary does have a pseudo number, make an entry in the BEN SSA NUMBER and PSEUDO NUMBER (MS only) fields on Screen MCMM001.
 - If there is a MOLI record and the beneficiary does not have a pseudo number, make an entry only in the BEN SSA NUMBER field on Screen MCMM001.
 - If there is a MOLI record and the beneficiary does have a pseudo number, make an entry only in the PSEUDO NUMBER field on Screen MCMM001.

See Appendix A for entries for the edit fields on Screen MCMM001.

After entries are made in the UNIT, CLAIM NUMBER, BEN SSA NUMBER and/or PSEUDO NUMBER and ACTIVITY INPUT fields on Screen MCMM001, press the ENTER key. The MEDCOR main activity screen will then be displayed. For more information on the MEDCOR activity screens, see 3.13.13 through 3.13.18 and 3.13.21 through 3.13.27.

B. Accessing Screen MCMU017 or Screen MCMI018

To access Screens MCMU017 or MCMI018 an entry is mandatory in the UNIT field on Screen MCMM001. Entry in the CLAIM NUMBER field on Screen MCMM001 is optional. Entries should not be made in the BEN SSA NUMBER, PSEUDO NUMBER and ACTIVITY INPUT fields on Screen MCMM001. See Appendix A for entries for the edit fields on Screen MCMM001.

After entries are made in the UNIT field and if applicable, the CLAIM NUMBER field on Screen MCMM001, press PF17 to display Screen MCMU017 or press PF18 to display Screen MCMI018. For more information, see 3.13.19 for Screen MCMU017 and 3.13.20 for Screen MCMI018.

3.13.13 Screen MCMU011 - Miscellaneous Input Screen

Screen MCMU011 is a main activity screen. Screen MCMU011 allows the user to create various activities which include, deleting a MIRTEL record, making updates to a MIRTEL record and the EDB, secure jurisdictional clearance from SSA, clears jurisdiction, initiate the release of a Medicare identification card, etc. All users who have access to MEDCOR have access to Screen MCMU011. However, the activities that the user can create are limited.

Screen MCMU011 is accessed by entering 11 in the ACTIVITY INPUT field on Screen MCMM001 for a new miscellaneous input activity or selecting a pending miscellaneous input activity from Screen MCMU017.

If the day of birth is 00, the system will display 15. The MIRTEL master will also be updated with the 15 in the day position when the activity is processed. If the month and day are 00, use Screen MCMU022 to create the activity.

To create a miscellaneous input activity an entry is mandatory in the ACTIVITY field on Screen MCMU011 and entries in other fields on Screen MCMM011 should be made as follows:

- If the entry in the ACTIVITY field on Screen MCMU011 is a 05, 22, 26, 52, 60, 61, 62, 98 or 99, no other entry should be made on Screen MCMU011.
- If the entry in the ACTIVITY field on Screen MCMU011 is a 23, 24, 25, 27, 50 or 51, entries should also be made in the EVENT CODE and EVENT DATE fields on Screen MCMU011. No other entries should be made on Screen MCMU011.
- If a 06 is entered in the ACTIVITY field on Screen MCMU011, entries are optional in the EVENT CODE and EVENT DATE fields; either enter both or leave both blank. No other entries should be made on Screen MCMU011.
- If the entry in the ACTIVITY field on Screen MCMU011 is a 21, 30, 32 or 36, an entry should be made in the FORMER SS CL NO field on Screen MCMU011. No other entries should be made on Screen MCMU011.
- If the entry in the ACTIVITY field on Screen MCMU011 is a 34 or 35, an entry should be made in the FORMER RR CL NO field on Screen MCMU011. No other entries should be made on Screen MCMU011.

See Appendix B for valid entries for the edit fields on Screen MCMU011.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for that activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU011. PF2 will also add the changes made on Screen MCMU011 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU011.

<u>MCMU011</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>
<u>MCDU011</u>	<u>MISCELLANEOUS INPUT</u>	<u>HH:MM</u>
	XCA 000 - 00 – 0000	
ACTIVITY		
TYPE BENEFICIARY		
DATE OF BIRTH <u> - -</u>		
DATE OF DEATH <u> - -</u>		
SEX CODE		
PSEUDO NUMBER <u> - -</u>		
EVENT CODE		
EVENT DATE <u> -</u>		
FORMER SS CL NO <u> - -</u>		
FORMER RR CL NO <u> - -</u>		
UNIT XXX USER XXXXXXXXX		
MESSAGE		
MESSAGE		
-----RESPONSES-----		
CLEAR/PA1=MENU	PA2=RRAPID	PF1=HELP
PF4=DELETE	PF5=REFRESH	PF9=JUMP
		PF24=KEYS

3.13.14 Screen MCMU012 - MEDCOR Activity 12 Establish/Screen SS Screen

Screen MCMU012 is a main activity screen. Screen MCMU012 allows the user to create a MIRTEL record, secure jurisdictional clearance from SSA, establish the EDB record when jurisdiction clears, initiate the release of a Medicare identification card and

if necessary, start the premium deduction. Screen MCMU012 is restricted to MS and OPRNS users.

Screen MCMU012 is accessed by entering 12 in the ACTIVITY INPUT field on Screen MCMM001 for a new Activity 12 or selecting a pending Activity 12 from Screen MCMU017. When Screen MCMU012 is added to MEDCOR, Screen MCMU016 must also be added.

Entries in the following edit fields on Screen MCMU012 are mandatory: RECORD STATUS, TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH, HI DATE OF BIRTH, EE SSA NUMBER, PART A EFF DATE, PART B OPTION and ID ISSUE CODE.

Entries in the PSEUDO NUMBER and BEN SSA NUMBER fields on Screen MCMU012 are carried over from Screen MCMM001 and cannot be changed on Screen MCMU012. Entry in BEN SSA NUMBER is required on Screen MCMM001. If assigning a pseudo number, entries in both the BEN SSA NUMBER and PSEUDO NUMBER fields on Screen MCMM001 should be made.

Entries in the ANN BEGIN DATE and 1ST FULL MO DIS edit fields on Screen MCMU012 are optional for disabled children and mandatory for other disabled type beneficiaries, otherwise the entries in these fields are optional.

Based on the entries in other fields on Screen MCMU012, entries in the following edit fields on Screen MCMU012 are optional: FORMER SS CL NO, PART B FILING DATE, GEP CODE, PART B EFF DATE, PART B PREM RATE and PAYEE CODE. Entry in the GEP CODE field will not be used to update MIRTEL.

BENEFICIARY NAME field is protected on the activity screen and will be blank until Screen MCMU016 is added. After Screen MCMU016 is added, the name entered there will be displayed on Screen MCMU012. If the name is incorrect after Screen MCMU016 was added, go back to Screen 16, make correction and add the screen again.

Entry in the EQ RELIEF ENROLL edit field is optional but restricted to MS users and will not be used to update MIRTEL.

See Appendix C for valid entries for the edit fields on Screen MCMU012.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU012. PF2 will also add the changes made on Screen MCMU012 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU012.

<u>MCMU012</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>	
<u>MCDU012</u>	<u>ACTIVITY 12 ESTABLISH/SCREEN</u> <u>SS</u>	<u>HH:MM</u>	
	XCA 000-00-0000		
BENEFICIARY NAME			
RECORD STATUS		PART A EFF DATE -	
TYPE BENEFICIARY		PART B FILING DATE -	
SEX CODE		EQ RELIEF ENROLL	
PYMT DATE OF BIRTH - -		GEP CODE	
HI DATE OF BIRTH - -		PART B OPTION	
PSEUDO NUMBER - -		PART B EFF DATE -	
BEN SSA NUMBER - -		PART B PREM RATE	
EE SSA NUMBER - -		PAYEE CODE	
FORMER SS CL NO - -		ID ISSUE CODE	
ANN BEGIN DATE -		1ST FULL MO DIS -	
		UNIT XXX USER XXXXXXXXX	
MESSAGE			
MESSAGE			
-----RESPONSES-----			
CLEAR/PA1=MENU PA2=RRAPID	PF1=HELP	PF2=ADD	PF4=DELETE
PF5=REFRESH	PF9=JUMP	PF16=ADDR	PF24=KEYS

3.13.15 Screen MCMU013 - MEDCOR Activity 13 Establish Only Screen

Screen MCMU013 is a main activity screen. Screen MCMU013 allows the user to create a MIRTEL record without any information being sent to SSA or CMS, release a

Medicare identification card and if necessary, start, stop or change the premium deduction. Screen MCMU013 is restricted to MS users.

Screen MCMU013 is accessed by entering 13 in the ACTIVITY INPUT field on Screen MCMM001 for a new Activity 13 or selecting a pending Activity 13 from Screen MCMU017. When Screen MCMU013 is added to MEDCOR, Screen MCMU016 must also be added. Screen MCMU014 and Screen MCMU015 can be accessed, but cannot be added as part of the activity.

Entries in the following edit fields on Screen MCMU013 are mandatory: RECORD STATUS, TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH, HI DATE OF BIRTH, EE SSA NUMBER, PART A EFF DATE, PART B OPTION and ID ISSUE CODE.

Entries in the PSEUDO NUMBER and BEN SSA NUMBER fields on Screen MCMU013 are carried over from Screen MCMM001 and cannot be changed on Screen MCMU013. Entry in BEN SSA NUMBER is required on Screen MCMM001. If establishing a MIRTEL record with a pseudo number, entries in both the BEN SSA NUMBER and PSEUDO NUMBER fields on Screen MCMM001 should be made.

Based on the entries in other fields on Screen MCMU013, entries in the following edit fields on Screen MCMU013 are optional: FORMER SS CL NO, ANN BEGIN DATE, 1ST FULL MO DIS, PART B FILING DATE, EQ RELIEF ENROLL, PART B EFF DATE, PART B TERM DATE, PART B TERM CODE, PART B PREM RATE, PAID THRU DATE, EXCESS PREMIUM, SBI ACC DATE, SBI DEL DATE, 3RD PTY/PROT CODE, PAYEE CODE, DATE OF DEATH. Entries in the EQ RELIEF ENROLL and PART B TERM CODE fields will not be used to update MIRTEL.

BENEFICIARY NAME field is protected on the activity screen and will be blank until Screen MCMU016 is added. After Screen MCMU016 is added, the name entered there will be displayed on Screen MCMU013. If the name is incorrect after Screen MCMU016 was added, go back to Screen 16, make correction and add the screen again.

No entries can be made in the PART A TERM DATE, DELINQUENCY DATE and ARREARAGE DUE CODE fields on Screen MCMU013. The PART A TERM DATE and ARREARAGE DUE CODE fields are for future use and will not be used for editing purposes or updating the MIRTEL. The DELINQUENCY DATE field is calculated by MEDCOR.

See Appendix C for valid entries for the edit fields on Screen MCMU013.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU013. PF2 will also add the changes made on Screen MCMU013 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU013.

MCMU013 MEDCOR/MEDREF MM/DD/YY
MCDU013 ACTIVITY 13 ESTABLISH ONLY HH:MM

XCA 000-00-0000

BENEFICIARY NAME

RECORD STATUS EQ RELIEF ENROLL

TYPE BENEFICIARY PART B EFF DATE -

SEX CODE PART B TERM DATE -

PYMT DATE OF BIRTH - - PART B TERM CODE

HI DATE OF BIRTH - - PART B PREM RATE .

PSEUDO NUMBER - - PAID THRU DATE -

BEN SSA NUMBER - - EXCESS PREMIUM .

EE SSA NUMBER - - DELINQUENCY DATE -

FORMER SS CL NO - - ARREARAGE DUE CODE

ANN BEGIN DATE - SBI ACC DATE -

1ST FULL MO DIS - SBI DEL DATE -

PART A EFF DATE - 3RD PTY/PROT CODE

PART A TERM DATE - PAYEE CODE

PART B FILING DATE - ID ISSUE CODE

PART B OPTION DATE OF DEATH - -

UNIT XXX USER XXXXXXXXX

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP PF2=ADD PF4=DELETE
PF5=REFRESH

PF9=JUMP PF14=VAR B PF15=PREV INFO PF16=ADDR PF24=KEYS

3.13.16 Screen MCMU014 - MEDCOR Variable Part B Screen

Screen MCMU014 is a subordinate activity screen. Screen MCMU014 allows the user to create an activity with information about the Medicare Part B premium and is optional. This screen added with Screens MCMU022 and MCMU016 will create an activity formerly known as a "17."

Screen MCMU014 may only be accessed through the following main activity screens: Screen MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 or MCMU034 by pressing the PF14 key. The data on Screen MCMU014 will only be added to an activity record when Screen MCMU022 is added.

The PART B PREMIUM RATE field on Screen MCMU014 will always be carried over from the main activity. If an entry is made in the PART B PREMIUM RATE field on Screen MCMU014 that is different from what was entered on the main activity screen, the corresponding field on the main activity field will also be changed. When the main activity appears, the PART B PREMIUM RATE field on the main activity screen will be protected. If necessary to change the Part B premium rate, the change must be made on Screen MCMU014.

If Screen MCMU014 is added to MEDCOR, entries in the following edit fields on Screen MCMU014 are mandatory: PART B PREM RATE, CURR RESIDENCY CD, CURR VAR RATE CD, CURR PEN PERCENT and CURR CAT EFF DATE. If the entry in the CURR VAR RATE CD field on Screen MCMU014 is "V," an entry must also be made in CURR VAR BASE RATE. The entries in these fields will only be used to update MIRTEL when Screen MCMU022 is added.

No entries or changes can be made to the PREV PART B PREM RATE, PREV RESIDENCY CD, PREV VAR RATE CD, PREV PEN PERCENT, PREV CAT EFF DATE, PREV CAT ACCTG DATE, PREV VAR BASE RATE, 2ND PART B PREM RATE, 2ND RESIDENCY CD, 2ND VAR RATE CD, 2ND PEN PERCENT, 2ND CAT EFF DATE, 2ND CAT ACCTG DATE, 2ND VAR BASE RATE, 3RD PART B PREM RATE, 3RD RESIDENCY CD, 3RD VAR RATE CD, 3RD PEN PERCENT, 3RD CAT EFF DATE, 3RD CAT ACCTG DATE, 3RD VAR BASE RATE fields. These fields are for future use and will not be used for editing purposes or updating of the MIRTEL.

See Appendix D for valid entries for the edit fields on Screen MCMU014.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU014. PF2 will also add the changes made on Screen

MCMU014 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU014.

<u>MCMU014</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>
<u>MCDU014</u>	<u>VARIABLE PART B</u>	<u>HH:MM</u>
A 000-00-0000 ACTIVITY INPUT 00		
PART B PREM RATE _.	2ND PART B PREM RATE _.	
CURR RESIDENCY CD _	2ND RESIDENCY CD	
CURR VAR RATE CD _	2ND VAR RATE CD	
CURR PEN PERCENT _	2ND PEN PERCENT	
CURR CAT EFF DATE _.	2ND CAT EFF DATE _.	
CURR VAR BASE RATE _.	2ND CAT ACCTG DATE _.	
2ND VAR BASE RATE _.		
PREV PART B PREM RATE _.	3RD PART B PREM RATE _.	
PREV RESIDENCY CD _	3RD RESIDENCY CD	
PREV VAR RATE CD _	3RD VAR RATE CD	
PREV PEN PERCENT _	3RD PEN PERCENT	
PREV CAT EFF DATE _.	3RD CAT EFF DATE _.	
PREV CAT ACCTG DATE _.	3RD CAT ACCTG DATE -	
PREV VAR BASE RATE _.	3RD VAR BASE RATE _.	
UNIT XXX USER XXXXXXXXX		

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR=ACTIVITY

PF1=HELP

PF2=ADD

PF4=DELETE

PF5=REFRESH

PF24=KEYS

3.13.17 Screen MCMU015 - MEDCOR Previous Information Screen

Screen MCMU015 is a subordinate activity screen. Screen MCMU015 will display information that is not currently available to view on MOLI. This screen is for display only. The data displayed cannot be changed and will not be used to update MIRTEL.

Screen MCMU015 may only be accessed through one of the following main activity screens: Screens MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 or MCMU034 by pressing the PF15 key.

See Appendix E for an explanation of what is in the fields on Screen MCMU015.

Below is an example of Screen MCMU015.

<u>MCMU015</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>
<u>MCDU015</u>	<u>PREVIOUS INFORMATION</u>	<u>HH:MM</u>
A 000-00-0000 ACTIVITY INPUT 00		
PREV BEN SYM	ESR INDICATOR	
PREV RECORD STATUS	REFERRAL CODE	
PREV TYPE BEN	REFERRAL DATE	- -
PREV ABD	-	PREV REFERRAL CODE
PREV 1ST FULL MO DIS	-	PREV REFERRAL DATE - -
PREV PART A EFF DATE	-	SECTION/UNIT
PREV PART A TERM DATE	-	ARREARAGE DUE AMOUNT .
PREV PART B OPT FILE DATE	-	ARREARAGE DUE CODE
PREV PART B OPTION	YEAR END CODE	
PREV PART B EFF DATE	-	STOP BILL CODE
PREV PART B TERM DATE	-	TYPE APPLICATION
PREV PART B TERM CODE	PREV PART B PREM RATE	.
UNIT XXX USER XXXXXXXXX		

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR=ACTIVITY

PF1=HELP

PF24=KEYS

3.13.18 Screen MCMU016 - MEDCOR Address Screen

Screen MCMU016 is a subordinate activity screen. Screen MCMU016 allows the user to add, change or delete information about the address.

Screen MCMU016 is accessed through one of the following main activity screens: Screens MCMU012, MCMU013, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 or MCMU034 by pressing the PF16 key. If Screen MCMU022 is added with Screen MCMU014 to change the Part B premium, Screen MCMU016 must also be added.

Screen MCMU016 must be added when Screens MCMU012, MCMU013, MCMU031 and MCMU033 are added. Screen MCMU016 is optional when Screens MCMU021, MCMU022, MCMU032 and MCMU034 are added.

An entry should be made in the REP PAYEE CODE field on Screen MCMU016 only when a beneficiary has a representative payee. The NAME field on Screen MCMU016 should be filled with the beneficiary name or with the representative name if the REP PAYEE CODE field on Screen MCMU016 is completed. The first NAME/ADDRESS field on Screen MCMU016 should be completed. The second NAME/ADDRESS and the ADDRESS fields on Screen MCMU016 are optional depending on what information is required to complete the address.

The name entered on Screen MCMU016 will be carried over to the activity screens and cannot be changed on the activity screens. If the name is incorrect on an activity screen, user must change the name on MCMU016 and add the screen in order to update MIRTEL.

See Appendix F for valid entries for the edit fields on Screen MCMU016.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU016. PF2 will also add the changes made on Screen MCMU016 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU016.

MCMU016MEDCOR/MEDREFMM/DD/YYMCDU016ADDRESSHH:MM

A. GENERAL INFORMATION

Screen MCMU017 lists the claim numbers of activities that were added to MEDCOR which are being held in the MEDCOR/MEDREF database pending MIRTEL processing. The claim numbers will appear in ascending claim number order. The activity will remain on Screen MCMU017 until the next daily MIRTEL run.

Also displayed on this screen are the type of activity (22L, 22S 31S, 32L, etc), the status of the activity (pending or deleted), the unit and user id of the user who created the activity and the date the activity was created.

When a 62L activity is created, the activity will show on the Pending Activities List screen with an ACT STATUS code of "P" (Pending) and the ACT DATE will be the date it is created. Each day Program 26162 is run to generate the file that is used to print replacement Medicare cards, and the ACT STATUS will change to a

“G” (Card Generated). The ACT DATE will be the date the activity was created. The information will remain on Screen MCMU017 until the next MIRTEL run. Examiners cannot delete or view activities with a “G” status code. Note: If a 62L is created during the dark days, the ACT STATUS will not change to a “G” until the first MIRTEL run after MAMMA.

If a claim number appears on Screen MCMU017, the pending activity can be selected to be changed or deleted. Managers can delete any pending activity from Screen MCMU017. All other users can only delete their own pending activity from the pending activity screen.

To display a pending activity, the user must locate the claim number on Screen MCMU017 and enter a 'P' to the left of the claim number and then press ENTER. The main activity screen for the pending activity will then be displayed and can be deleted or changed. If a subordinate activity must be added, changed or deleted, the user would then access it from the pending main activity screen.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will add the changes made on pending activity screen. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU017.

<u>MCMU017</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>
<u>MCDU017</u>	<u>PENDING ACTIVITIES LIST</u>	<u>HH:MM</u>
	ACT ACT ACT ACT	
P/D CLAIM NUMBER	ACT	STATUS UNIT USER DATE
XCA000-00-0000	00X X XXX	XXXXXXXXX MM/DD/YY
XCA000-00-0000	00X X XXX	XXXXXXXXX MM/DD/YY
XCA000-00-0000	00X X XXX	XXXXXXXXX MM/DD/YY
XCA000-00-0000	00X X XXX	XXXXXXXXX MM/DD/YY
XCA000-00-0000	00X X XXX	XXXXXXXXX MM/DD/YY
XCA000-00-0000	00X X XXX	XXXXXXXXX MM/DD/YY
		USER XXXXXXXX

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MEDCOR PA2=RRAPID ENTER=PROCESS PF1=HELP
PF4=DELETE

PF7=PREV PF8=NEXT PF19=FIRST PF20=LAST PF24=KEYS

B. ACCESSING SCREEN MCMU017 WITH A CLAIM NUMBER THAT IS IN THE
MEDCOR/MEDREF DATABASE

If Screen MCMU017 is accessed using a claim number that is in the
MEDCOR/MEDREF database, only that number will be displayed on Screen
MCMU017 as shown below.

MCMU017 MEDCOR/MEDREF MM/DD/YY

MCDU017 PENDING ACTIVITIES LIST HH:MM

ACT ACT ACT ACT

P/D CLAIM NUMBER ACT STATUS UNIT USER DATE

MA123-45-6789 00X X XXX XXXXXXXX MM/DD/YY

USER XXXXXXXX

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MEDCOR PA2=RRAPID ENTER=PROCESS PF1=HELP
PF4=DELETE

PF7=PREV PF8=NEXT PF19=FIRST PF20=LAST PF24=KEYS

Then, when on Screen MCMU017, the PF7 key will bring up the previous screen
of information, the PF8 key will bring up the next screen of information, the PF19
key will bring up the first screen of information and the PF20 key will bring up the
last screen of information. If there is no pending activity in the database for the
claim number that was entered on Screen MCMM001, see C. below.

C. ACCESSING SCREEN MCMU017 WITHOUT A CLAIM NUMBER OR WITH A
CLAIM NUMBER THAT IS NOT IN THE MEDCOR/MEDREF DATABASE

If Screen MCMU017 is accessed without entering a claim number on Screen
MCMM001 or with a claim number that is not in the database, the screen will
appear as shown below.

MCMU017 MEDCOR/MEDREF MM/DD/YY

MCDU017 PENDING ACTIVITIES LIST HH:MM
 ACT ACT ACT ACT
 P/D CLAIM NUMBER ACT STATUS UNIT USER DATE
 USER XXXXXXXX

MESSAGE NO PENDING ACTIVITIES WERE FOUND WITH THE CLAIM NUMBER ENTERED

-----RESPONSES-----

CLEAR/PA1=MEDCOR PA2=RRAPID ENTER=PROCESS PF1=HELP
PF4=DELETE

PF7=PREV PF8=NEXT PF19=FIRST PF20=LAST PF24=KEYS

Then, when on Screen MCMU017, the PF7 and PF8 keys will not bring up the previous or next screen of information. Instead, the user will get a message that there are no previous or no more pending activities in the database. However, the PF19 key will bring up the first screen of information and the PF20 key will bring up the last screen of information.

3.13.20 Screen MCMI018 - MEDCOR Completed Activities List Screen

A. GENERAL INFORMATION

Screen MCMI018 will be displayed when the PF18 Key is pressed on Screen MCMU001.

Screen MCMI018 lists information about MEDCOR activities. The claim numbers will appear in ascending claim number order. Also displayed on this screen are the type of activity (22L, 22S 31S, 32L, etc), the unit and user id of the user who created the activity and the date of the MIRTEL run, or in the case of Activity 62L, the date the activity was created.

If the user wants to determine if an activity was created and processed in the daily MIRTEL run, the user can page through the claim numbers on Screen MCMI018.

Information for the completed activities will be created when the activities are processed into the daily MIRTEL run. The completed activities will remain on the Completed Activities screen MCMI018 until the end of the month when the data is written to MEDCOR reports. The completed activities will be purged from screen MCMI018 when the MEDCOR reports are generated on the first work day of the next month.

Below is an example of Screen MCMi018.

```

MCMi018          MEDCOR/MEDREF          MM/DD/YY
MCDi018          COMPLETED ACTIVITIES LIST  HH:MM

          ACT    ACT    ACT    RUN
CLAIM NUMBER  ACT  STATUS  UNIT  USER    DATE
XCA000-00-0000 00X  X      XXX   XXXXXXXXX MM/DD/YY
XCA000-00-0000 00X  X      XXX   XXXXXXXXX MM/DD/YY
XCA000-00-0000 00X  X      XXX   XXXXXXXXX MM/DD/YY
XCA000-00-0000 00X  X      XXX   XXXXXXXXX MM/DD/YY

          USER XXXXXXXXX

MESSAGE
MESSAGE

```

-----RESPONSES-----

```

CLEAR/PA1=MENU          PA2=RRAPID          PF1=HELP
PF7=PREV  PF8=NEXT  PF19=FIRST  PF20=LAST  PF24=KEYS

```

B. ACCESSING SCREEN MCMi018 WITH A CLAIM NUMBER THAT IS IN THE MEDCOR/MEDREF DATABASE

If Screen MCMi018 is accessed using a claim number that is in the database, only that number will be displayed on Screen MCMi018 as shown below.

```

MCMi018          MEDCOR/MEDREF          MM/DD/YY
MCDi018          COMPLETED ACTIVITIES LIST  HH:MM

          ACT    ACT    ACT    RUN
CLAIM NUMBER  ACT  STATUS  UNIT  USER    DATE
MA123-45-6789 00X  X      XXX   XXXXXXXXX MM/DD/YY

          USER XXXXXXXXX

MESSAGE

```

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP

PF7=PREV PF8=NEXT PF19=FIRST PF20=LAST PF24=KEYS

Then, when on Screen MCMI018, the PF7 key will bring up the previous screen of information, the PF8 key will bring up the next screen of information, the PF19 key will bring up the first screen of information and the PF20 key will bring up the last screen of information. If there is no completed activity in the database for the claim number that was entered on Screen MCMM001, see C. below.

C. ACCESSING SCREEN MCMI018 WITHOUT A CLAIM NUMBER OR WITH A CLAIM NUMBER THAT IS NOT IN THE MEDCOR/MEDREF DATABASE

If Screen MCMI018 is accessed without entering a claim number on Screen MCMM001 or with a claim number that is not in the database, the screen will appear as shown below.

MCMI018 MEDCOR/MEDREF MM/DD/YY

MCDI018 COMPLETED ACTIVITIES LIST HH:MM

ACT ACT ACT RUN

CLAIM NUMBER ACT STATUS UNIT USER DATE

USER XXXXXXXX

MESSAGE NO COMPLETED ACTIVITIES WERE FOUND WITH THE CLAIM NUMBER ENTERED

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP

PF7=PREV PF8=NEXT PF19=FIRST PF20=LAST PF24=KEYS

Then, when on Screen MCMI018, the PF7 and PF8 keys will not bring up the previous or next screen of information. Instead, user will get a message that there are no lower or no higher completed activities in the database. However, the PF19 key will bring up the first screen of information and the PF20 key will bring up the last screen of information.

3.13.21 Screen MCMU020 - MEDCOR Activity 20 Internal Change Screen

Screen MCMU020 is a main activity screen. Screen MCMU020 allows the user to make changes to the MIRTEL master record without sending information to CMS. This is used primarily to correct the paid thru date, to record State Buy-In information and remove a termination prior to the termination date. Screen MCMU020 is restricted to MS and OPRNS users.

Screen MCMU020 is accessed by entering 20 in the ACTIVITY INPUT field on the Screen MCMU001 for a new Activity 20 or selecting a pending Activity 20 from Screen MCMU017. Screen MCMU014 and Screen MCMU015 can be accessed for viewing only and cannot be added as part of the activity.

Valid data is required in the following edit fields on Screen MCMU020: RECORD STATUS, TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH and HI DATE OF BIRTH. Because the data in the TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH or HI DATE OF BIRTH fields on Screen MCMU020 are protected, if the information is incorrect, use Screen MCMU022. An entry is also mandatory in the RECORD STATUS field on Screen MCMU020.

The entry in the PSEUDO NUMBER field on Screen MCMU020 is carried over from Screen MCMU001 and cannot be changed on Screen MCMU020.

Based on the entries in other fields on Screen MCMU020, entries in the following edit fields on Screen MCMU020 are optional: ANN BEGIN DATE, 1ST FULL MO DIS, PART A TERM DATE, PART B OPTION, EQ RELIEF ENROLL, GEP CODE, PART B EFF DATE, PART B TERM DATE, PART B TERM CODE, PART B PREM RATE, PAID THRU DATE, EXCESS PREMIUM, ARREARAGE DUE CODE, SBI ACC DATE, SBI DEL DATE, 3RD PTY/PROT CODE, PAYEE CODE and ID ISSUE CODE. Entries in the EQ RELIEF ENROLL, GEP CODE, PART B TERM CODE and ARREARAGE DUE CODE fields will not be used to update MIRTEL.

No entries can be made in the BENEFICIARY NAME, DELINQUENCY DATE, PREV SBI ACC DATE and PREV SBI DEL DATE fields on Screen MCMU020. The data in the BENEFICIARY NAME, PREV SBI ACC DATE AND PREV SBI DEL DATE fields are for future use and will not be used for editing purposes or updating of the MIRTEL. The DELINQUENCY DATE field is calculated by MEDCOR. If a name change is required, use Screen MCMU022 and also add Screen MCMU016.

See Appendix C for valid entries for the edit fields on Screen MCMU020.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU020. PF2 will also add the changes made on Screen MCMU020 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU020.

MCMU020 MEDCOR/MEDREF MM/DD/YY
MCDU020 ACTIVITY 20 INTERNAL CHANGE HH:MM

XCA 000-00-0000

BENEFICIARY NAME

RECORD STATUS PART B TERM DATE -

TYPE BENEFICIARY PART B TERM CODE

SEX CODE PART B PREM RATE .

PYMT DATE OF BIRTH - - PAID THRU DATE -

HI DATE OF BIRTH - - EXCESS PREMIUM .

PSEUDO NUMBER - - DELINQUENCY DATE -

ANN BEGIN DATE - ARREARAGE DUE CODE

1ST FULL MO DIS - SBI ACC DATE -

PART A TERM DATE - SBI DEL DATE -

PART B OPTION PREV SBI ACC DATE -

EQ RELIEF ENROLL PREV SBI DEL DATE -

GEP CODE 3RD PTY/PROT CODE

PART B EFF DATE - PAYEE CODE

ID ISSUE CODE

UNIT XXX USER XXXXXXXXX

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP PF2=ADD PF4=DELETE
 PF5=REFRESH

Screen MCMU021 is a main activity screen. Screen MCMU021 allows an examiner to make limited changes to the MIRTEL master record and sends a new screening record to SSA. Screen MCMU021 is restricted to MS users.

Entries in the following edit fields on Screen MCMU021 are mandatory: RECORD STATUS, TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH, HI DATE OF BIRTH and FORMER SS CL NO. RECORD STATUS field is a protected field and cannot be changed. If MIRTEL has a record status of 31, MEDCOR will convert it to a 21 on the activity screen. If necessary to change the record status, use Screen MCMU022 first, then do your rescreening action.

Based on the entries in other fields on Screen MCMU021, entries in the following edit fields on Screen MCMU021 are optional: ANN BEGIN DATE, 1ST FULL MO DIS, PART A EFF DATE, PART B FILING DATE, PART B OPTION, EQ RELIEF ENROLL, PART B EFF DATE, PART B PREM RATE, PAYEE CODE and ID ISSUE CODE.

See Appendix C for valid entries for the edit fields on Screen MCMU021.

Below is an example of Screen MCMU021.

MCMD021 ACTIVITY 21 RESCREEN SS HH:MM

XCA 000-00-0000

BENEFICIARY NAME

RECORD STATUS _ PART A EFF DATE _-

TYPE BENEFICIARY _ PART B FILING DATE _-

SEX CODE _ PART B OPTION

PYMT DATE OF BIRTH _ - _ EQ RELIEF ENROLL

HI DATE OF BIRTH _ - _ PART B EFF DATE _-

PSEUDO NUMBER _ - _ PART B PREM RATE _.

BEN SSA NUMBER _ - _ PAYEE CODE

EE SSA NUMBER _ - _ ID ISSUE CODE

FORMER SS CL NO _ - - -

ANN BEGIN DATE _-

1ST FULL MO DIS _-

UNIT XXX USER XXXXXXXXX

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP PF2=ADD PF4=DELETE

PF5=REFRESH PF9=JUMP PF16=ADDR PF24=KEYS

3.13.23 Screen MCMU022 - MEDCOR Activity 22 Internal Change/URIC Screen

Screen MCMU022 is a main activity screen. Screen MCMU022 allows the user to make changes to the MIRTEL master record and sends a Universal RIC record to CMS. Screen MCMU022 is restricted to MS and OPRNS users.

When Screen MCMU022 is used and Screens MCMU014 and MCMU016 are added, former activity 17 will be created.

Screen MCMU022 is accessed by entering 22 in the ACTIVITY INPUT field on Screen MCMM001 for a new Activity 22 or selecting a pending Activity 22 from Screen MCMU017. Screen MCMU016 and Screen MCMU014 are optional. Screen MCMU015 can be accessed for viewing only and cannot be added as part of the activity.

Entries in the following edit fields on Screen MCMU022 are mandatory: RECORD STATUS, TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH and HI DATE OF BIRTH.

The entry in the PSEUDO NUMBER field on Screen MCMU022 is carried over from Screen MCMM001 and cannot be changed on Screen MCMU022.

Based on the entries in other fields on Screen MCMU022, entries in the following edit fields on Screen MCMU022 are optional: ANN BEGIN DATE, 1ST FULL MO DIS, PART A EFF DATE, PART A TERM DATE, PART B FILING DATE, PART B OPTION, EQ RELIEF ENROLL, PART B EFF DATE, PART B TERM DATE, PART B TERM CODE, PART B PREM RATE, PAID THRU DATE, EXCESS PREMIUM, ARREARAGE DUE CODE, SBI ACC DATE, SBI DEL DATE, 3RD PTY/PROT CODE, PAYEE CODE, ID ISSUE CODE and DATE OF DEATH. Entries in the EQ RELIEF ENROLL, ARREARAGE DUE CODE and PART B TERM CODE fields will not be used to update MIRTEL.

No entry can be made in the DELINQUENCY DATE field on Screen MCMU022. The DELINQUENCY DATE field is calculated by MEDCOR.

Entry in the BENEFICIARY NAME field is prefilled from MOLI is protected. If necessary to change the name, the change must be made on Screen MCMU016 and Screen MCMU016 must be added. When Screen MCMU016 is added, the change will be reflected on Screen MCMU022. If the name is incorrect after Screen MCMU016 was added, go back to Screen MCMU016, make correction and add the screen again.

See Appendix C for valid entries for the edit fields on Screen MCMU022.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU022. PF2 will also add the changes made on Screen MCMU022 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU022.

<u>MCMU022</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>
<u>MCDU022</u>	<u>ACTIVITY 22 INTERNAL CHANGE/URIC</u>	<u>HH:MM</u>
XCA 000-00-0000		

BENEFICIARY NAME

RECORD STATUS _ PART B TERM DATE _-
 TYPE BENEFICIARY _ PART B TERM CODE
 SEX CODE - PART B PREM RATE _- PYMT DATE OF BIRTH _-
 PAID THRU DATE _-
 HI DATE OF BIRTH _- - EXCESS PREMIUM _-
 PSEUDO NUMBER _- - DELINQUENCY DATE _-
 ANN BEGIN DATE _- ARREARAGE DUE CODE
 1ST FULL MO DIS _- SBI ACC DATE _-
 PART A EFF DATE _- SBI DEL DATE _-
 PART A TERM DATE _- 3RD PTY/PROT CODE
 PART B FILING DATE _- PAYEE CODE
 PART B OPTION _ ID ISSUE CODE
 EQ RELIEF ENROLL _ DATE OF DEATH _- -
 PART B EFF DATE _-
 UNIT XXX USER XXXXXXXXX

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP PF2=ADD PF4=DELETE
 PF5=REFRESH

PF9=JUMP PF14=VAR B PF15=PREV INF PF16=ADDR PF24=KEYS

3.13.24 Screen MCMU031 - MEDCOR Activity 31 Establish/Cross Refer SS Screen

Screen MCMU031 is a main activity screen. Screen MCMU031 allows the user to create a MIRTEL master record and sends a Universal RIC to transfer utilization from a SSA number to a RRB number. This screen is restricted to MS users.

Screen MCMU031 is accessed by entering 31 in the ACTIVITY INPUT field on Screen MCMU001 for a new Activity 31 or selecting a pending Activity 31 from Screen

MCMU017. When Screen MCMU031 is added to MEDCOR, Screen MCMU016 must also be added. Screen MCMU014 and Screen MCMU015 can be accessed, but cannot be added as part of the activity.

Entries in the following edit fields on Screen MCMU031 are mandatory: RECORD STATUS, TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH, HI DATE OF BIRTH, EE SSA NUMBER, FORMER SS CL NO, PART A EFF DATE, PART B OPTION and ID ISSUE CODE.

Entries in the PSEUDO NUMBER and BEN SSA NUMBER fields on Screen MCMU031 are carried over from Screen MCMM001 and cannot be changed on Screen MCMU031. Entry in BEN SSA NUMBER is required on Screen MCMM001. If establishing a MIRTEL record with a pseudo number, entries in both the BEN SSA NUMBER and PSEUDO NUMBER fields on Screen MCMM001 should be made.

Based on the entries in other fields on Screen MCMU031, entries in the following edit fields on Screen MCMU031 are optional: ANN BEGIN DATE, 1ST FULL MO DIS, PART B FILING DATE, EQ RELIEF ENROLL, PART B EFF DATE, PART B TERM DATE, PART B TERM CODE, PART B PREM RATE, PAID THRU DATE, EXCESS PREMIUM, SBI ACC DATE, SBI DEL DATE, PAYEE CODE and DATE OF DEATH. The entries made in the EQ RELIEF ENROLL and PART B TERM CODE will not be used to update the MIRTEL.

No entries can be made in the DELINQUENCY DATE and ARREARAGE DUE CODE fields of Screen MCMU031. The ARREARAGE DUE CODE field is for future use and will not be used for editing purposes or updating of the MIRTEL. The DELINQUENCY DATE field is calculated by MEDCOR.

BENEFICIARY NAME field is protected on the activity screen and will be blank until Screen MCMU016 is added. After Screen MCMU016 is added, the name entered there will be displayed on Screen MCMU031. If the name is incorrect after Screen MCMU016 was added, go back to Screen 16, make correction and add the screen again.

See Appendix C for valid entries for the edit fields on Screen MCMU031.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU031. PF2 will also add the changes made on Screen MCMU031 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU031.

<u>MCMU031</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>
<u>MCDU031</u>	<u>ACTIVITY 31 ESTABLISH/CROSS REFER SS</u>	<u>HH:MM</u>
XCA 000-00-0000		

BENEFICIARY NAME

RECORD STATUS _ EQ RELIEF ENROLL

TYPE BENEFICIARY _ PART B EFF DATE _-

SEX CODE _ PART B TERM DATE _-

PYMT DATE OF BIRTH _ - _ PART B TERM CODE

HI DATE OF BIRTH _ - _ PART B PREM RATE _.

PSEUDO NUMBER _ - _ PAID THRU DATE _-

BEN SSA NUMBER _ - _ EXCESS PREMIUM _.

EE SSA NUMBER _ - _ DELINQUENCY DATE _-

FORMER SS CL NO _ - _ ARREARAGE DUE CODE

ANN BEGIN DATE _ - _ SBI ACC DATE _-

1ST FULL MO DIS _ - _ SBI DEL DATE _-

PART A EFF DATE _ - _ PAYEE CODE

PART B FILING DATE _ - _ ID ISSUE CODE

PART B OPTION _ DATE OF DEATH _ - _

UNIT XXX USER XXXXXXXXX

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP PF2=ADD PF4=DELETE
 PF5=REFRESH

PF9=JUMP PF14=VAR B PF15=PREV INF PF16=ADDR PF24=KEYS

3.13.25 Screen MCMU032 - MEDCOR Activity 32 Correct/Cross Refer SS Screen

Screen MCMU032 is a main activity screen. This screen allows the user to make changes to the MIRTEL master record and sends a Universal RIC to transfer utilization from a SSA number to a RRB number. This screen is restricted to MS users.

Screen MCMU032 is accessed by entering 32 in the ACTIVITY INPUT field on Screen MCMM001 for a new Activity 32 or selecting a pending Activity 31 from Screen MCMU017. Screen MCMU016 is optional. Screen MCMU014 and Screen MCMU015 can be accessed, but cannot be added to the activity.

Entries in the following edit fields on Screen MCMU032 are mandatory: RECORD STATUS, TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH, HI DATE OF BIRTH and FORMER SS CL NO.

The entry in the PSEUDO NUMBER field on Screen MCMU032 is carried over from Screen MCMM001 and cannot be changed on Screen MCMU032.

Based on the entries in other fields on Screen MCMU032, entries in the following edit fields on Screen MCMU032 are optional: ANN BEGIN DATE, 1ST FULL MO DIS, PART A EFF DATE, PART B FILING DATE, PART B OPTION, EQ RELIEF ENROLL, PART B EFF DATE, PART B TERM DATE, PART B TERM CODE, PART B PREM RATE, PAID THRU DATE, EXCESS PREMIUM, ARREARAGE DUE CODE, SBI ACC DATE, SBI DEL DATE, 3RD PTY/PROT CODE, PAYEE CODE and ID ISSUE CODE. The entries made in the EQ RELIEF ENROLL, PART B TERM CODE and ARREARAGE DUE CODE will not be used to update the MIRTEL.

No entry can be made in the DELINQUENCY DATE field on Screen MCMU032. The DELINQUENCY DATE field is calculated by MEDCOR.

Entry in the BENEFICIARY NAME field is prefilled from MOLI is protected. If necessary to change the name, the change must be made on Screen MCMU016 and Screen MCMU016 must be added. When Screen MCMU016 is added, the change will be reflected on Screen MCMU032. If the name is incorrect after Screen MCMU016 was added, go back to Screen MCMU016, make correction and add the screen again.

See Appendix C for valid entries for the edit fields on Screen MCMU032.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU032. PF2 will also add the changes made on Screen MCMU032 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU032.

<u>MCMU032</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>
<u>MCDU032</u>	<u>ACTIVITY 32 CORRECT/CROSS REFER SS HH:MM</u>	
XCA 000-00-0000		

BENEFICIARY NAME

RECORD STATUS _ PART B EFF DATE _-
 TYPE BENEFICIARY _ PART B TERM DATE _-
 SEX CODE _ PART B TERM CODE
 PYMT DATE OF BIRTH _ - _ PART B PREM RATE _.
 HI DATE OF BIRTH _ - _ PAID THRU DATE _- PSEUDO NUMBER _-
 _- EXCESS PREMIUM _.
 FORMER SS CL NO _ - _ DELINQUENCY DATE _-
 ANN BEGIN DATE _- ARREARAGE DUE CODE
 1ST FULL MO DIS _- SBI ACC DATE _-
 PART A EFF DATE _- SBI DEL DATE _-
 PART B FILING DATE _- 3RD PTY/PROT CODE
 PART B OPTION _ PAYEE CODE
 EQ RELIEF ENROLL _ ID ISSUE CODE
 UNIT XXX USER XXXXXXXXX

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP PF2=ADD PF4=DELETE
 PF5=REFRESH

PF9=JUMP PF14=VAR B PF15=PREV INF PF16=ADDR PF24=KEYS

3.13.26 Screen MCMU033 - MEDCOR Activity 33 Establish/Cross Refer RR Screen

Screen MCMU033 is a main activity screen. Screen MCMU033 allows the user to create a MIRTEL master record and sends a Universal RIC to transfer utilization from a RRB number to a RRB number. This screen is restricted to MS users.

Screen MCMU033 is accessed by entering 33 in the ACTIVITY INPUT field on Screen MCMU001 for a new Activity 33 or selecting a pending Activity 33 from Screen MCMU017. When Screen MCMU033 is added to MEDCOR, Screen MCMU016 must

also be added. Screen MCMU014 and Screen MCMU015 can be accessed, but cannot be added as part of the activity.

Entries in the following edit fields on Screen MCMU033 are mandatory: RECORD STATUS, TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH, HI DATE OF BIRTH, EE SSA NUMBER, FORMER RR CL NO, PART A EFF DATE, PART B OPTION and ID ISSUE CODE.

Entries in the PSEUDO NUMBER and BEN SSA NUMBER fields on Screen MCMU033 are carried over from Screen MCMM001 and cannot be changed on Screen MCMU033. Entry in BEN SSA NUMBER is required on Screen MCMM001. If establishing a MIRTEL record with a pseudo number, entries in both the BEN SSA NUMBER and PSEUDO NUMBER fields on Screen MCMM001 should be made.

Based on the entries in other fields on Screen MCMU033, entries in the following edit fields on Screen MCMU033 are optional: ANN BEGIN DATE, 1ST FULL MO DIS, PART B FILING DATE, EQ RELIEF ENROLL, PART B EFF DATE, PART B TERM DATE, PART B TERM CODE, PART B PREM RATE, PAID THRU DATE, EXCESS PREMIUM, SBI ACC DATE, SBI DEL DATE and PAYEE CODE. The entries made in the EQ RELIEF ENROLL and PART B TERM CODE will not be used to update the MIRTEL.

No entries can be made in the DELINQUENCY DATE and ARREARAGE DUE CODE fields of Screen MCMU033. The data in the ARREARAGE DUE CODE field is for future use will not be used for editing purposes or updating of the MIRTEL. The DELINQUENCY DATE field is calculated by MEDCOR.

BENEFICIARY NAME field is protected on the activity screen and will be blank until Screen MCMU016 is added. After Screen MCMU016 is added, the name entered there will be displayed on Screen MCMU033. If the name is incorrect after Screen MCMU016 was added, go back to Screen 16, make correction and add the screen again.

See Appendix C for valid entries for the edit fields on Screen MCMU033.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU033. PF2 will also add the changes made on Screen MCMU033 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU033.

<u>MCMU033</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>
<u>MCDU033</u>	<u>ACTIVITY 33 ESTABLISH/CROSS REFERRR</u>	<u>HH:MM</u>
WCA 000-00-0000		

BENEFICIARY NAME

RECORD STATUS _ EQ RELIEF ENROLL

TYPE BENEFICIARY _ PART B EFF DATE _-

SEX CODE _ PART B TERM DATE _-

PYMT DATE OF BIRTH _ - _ PART B TERM CODE

HI DATE OF BIRTH _ - _ PART B PREM RATE _.

PSEUDO NUMBER _ - _ PAID THRU DATE _-

BEN SSA NUMBER _ - _ EXCESS PREMIUM _.

EE SSA NUMBER _ - _ DELINQUENCY DATE _-

FORMER RR CL NO _ - _ ARREARAGE DUE CODE

ANN BEGIN DATE _ - _ SBI ACC DATE _-

1ST FULL MO DIS _ - _ SBI DEL DATE _-

PART A EFF DATE _ - _ PAYEE CODE

PART B FILING DATE _ - _ ID ISSUE CODE

PART B OPTION

UNIT XXX USER XXXXXXXXX

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP PF2=ADD PF4=DELETE
 PF5=REFRESH

PF9=JUMP PF14=VAR B PF15=PREV INF PF16=ADDR PF24=KEYS

3.13.27 Screen MCMU034 - MEDCOR Activity 34 Correct/Cross Refer RR Screen

Screen MCMU034 is a main activity screen. This screen allows the user to make changes to the MIRTEL master record and sends a Universal RIC to transfer utilization from a RRB number to a RRB number. This screen is restricted to MS users.

Screen MCMU034 is accessed by entering 34 in the ACTIVITY INPUT field on Screen MCMM001 for a new Activity 34 or selecting a pending Activity 33 from Screen MCMU017. Screen MCMU016 is optional. Screen MCMU014 and Screen MCMU015 can be accessed, but cannot be added as part of the activity.

Entries in the following edit fields on Screen MCMU034 are mandatory: RECORD STATUS, TYPE BENEFICIARY, SEX CODE, PYMT DATE OF BIRTH, HI DATE OF BIRTH and FORMER RR CL NO.

The entry in the PSEUDO NUMBER field on Screen MCMU034 is carried over from Screen MCMM001 and cannot be changed on Screen MCMU034.

Based on the entries in other fields on Screen MCMU034, entries in the following edit fields on Screen MCMU034 are optional: ANN BEGIN DATE, 1ST FULL MO DIS, PART A EFF DATE, PART B FILING DATE, PART B OPTION, EQ RELIEF ENROLL, PART B EFF DATE, PART B TERM DATE, PART B TERM CODE, PART B PREM RATE, PAID THRU DATE, EXCESS PREMIUM, ARREARAGE DUE CODE, SBI ACC DATE, SBI DEL DATE, 3RD PTY/PROT CODE, PAYEE CODE and ID ISSUE CODE. The entries made in the EQ RELIEF ENROL, PART B TERM CODE and ARREARAGE DUE CODE will not be used to update the MIRTEL.

No entry can be made in the DELINQUENCY DATE field on Screen MCMU034. The DELINQUENCY DATE field is calculated by MEDCOR.

Entry in the BENEFICIARY NAME field is prefilled from MOLI is protected. If necessary to change the name, the change must be made on Screen MCMU016 and Screen MCMU016 must be added. When Screen MCMU016 is added, the change will be reflected on Screen MCMU034. If the name is incorrect after Screen MCMU016 was added, go back to Screen MCMU016, make correction and add the screen again.

See Appendix C for valid entries for the edit fields on Screen MCMU034.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU034. PF2 will also add the changes made on Screen MCMU034 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Below is an example of Screen MCMU034.

<u>MCMU034</u>	<u>MEDCOR/MEDREF</u>	<u>MM/DD/YY</u>
<u>MCDU034</u>	<u>ACTIVITY 34 CORRECT/CROSS REFER RR</u>	<u>HH:MM</u>
XCA 000-00-0000		

BENEFICIARY NAME

RECORD STATUS _ PART B EFF DATE _-
 TYPE BENEFICIARY _ PART B TERM DATE _-
 SEX CODE _ PART B TERM CODE
 PYMT DATE OF BIRTH _ - _ PART B PREM RATE _.
 HI DATE OF BIRTH _ - _ PAID THRU DATE _-
 PSEUDO NUMBER _ - _ EXCESS PREMIUM _.
 FORMER RR CL NO _ - _ DELINQUENCY DATE _-
 ANN BEGIN DATE _ - _ ARREARAGE DUE CODE _ 1ST FULL MO DIS _-
 SBI ACC DATE _-
 PART A EFF DATE _ - _ SBI DEL DATE _-
 PART B FILING DATE _ - _ 3RD PTY/PROT CODE
 PART B OPTION _ PAYEE CODE
 EQ RELIEF ENROLL _ ID ISSUE CODE
 UNIT XXX USER XXXXXXXXX

MESSAGE

MESSAGE

-----RESPONSES-----

CLEAR/PA1=MENU PA2=RRAPID PF1=HELP PF2=ADD PF4=DELETE
PF5=REFRESH

PF9=JUMP PF14=VAR B PF15=PREV INF PF16=ADDR PF24=KEYS

3.13.28 Screen MCMU162 - Activity 62L - Duplicate Medicare Card Request

Screen MCMU162 is a main activity screen. Screen MCMU162 allows an examiner or contact representative to request a duplicate Medicare card and to change the address to which the card is mailed. Screen MCMU162 is restricted to MS and Field Service users.

Screen MCMU162 is accessed by entering 62 in the ACTIVITY INPUT field on Screen MCMU001, or selecting a pending Activity 62 from Screen MCMU017. The claim

number and pseudo number are carried over from the MEDCOR MENU screen and cannot be changed. The beneficiary name, record status, type beneficiary, sex code, HI date of birth, Part A eff date, Part B option, Part B eff date, ID issue code, ID issue date, rep payee code, name and name/address are pre-filled with MOLI data.

If the address is not on MOLI, it will pre-fill with DATAQ data. The only field that can be changed is the address field. If the address on record is incorrect or the annuitant requests that the duplicate Medicare card be mailed to a temporary address, you can enter a new address. **This will only change where the card is mailed.**

CHICO/DATAQ and MIRTEL/MOLI will not be updated. If the address is changed, you will receive a warning message stating "FAST/COA AND OR MEDCOR ACTIVITY 22L REQ TO CHANGE ADDRESS PF2-03 TO ADD, PRESS PF2 AGAIN. If the address is changed, carefully review the entry for accuracy. The PF2 key must be hit twice to add the activity.

Below is an example of Screen MCMU162:

MCMU162	MEDCOR/MEDREF	MM/DD/YY
MCMU162	ACTIVITY 62 DUPLICATE MEDICARE CARD REQUEST	HH:MM
A XXX-XX-XXXX		
PSEUDO NUMBER	XXX-XX-XXXX	
BENEFICIARY NAME		
RECORD STATUS	TYPE BENEFICIARY	
SEX CODE	HI DATE OF BIRTH	
PART A EFF DATE	PART B OPTION	
PART B EFF DATE	ID ISSUE CODE	
ID ISSUE DATE		
REP PAYEE CODE	(1=LEGAL, 2=BOARD, 3=PARENT)	
NAME		
NAME/ADDRESS		
NAME/ADDRESS		
ADDRESS		
ADDRESS		

ADDRESS

UNIT XXX

USER XXXXXXXX

RESPONSES

CLEAR/PA1=MENU

PA2=RRAPID

PF1=HELP

PF2=ADD

PF4=DELETE

PF5=REFRESH

PF9=JUMP

PF24=KEYS

When a 62L is created, the activity will show on the Pending Activities List screen with an ACT STATUS code of "P" (Pending) and the ACT DATE will be the date it is created. Program 26162 will be run daily to generate the file used to print the duplicate Medicare cards, and the ACT STATUS code will be changed to a "G" (Card Generated). The ACT DATE will be the date the activity was created. The information about the activity will remain on the PENDING ACTIVITIES LIST screen until the next MIRTEL run. When MIRTEL runs, the activity information will be moved to the COMPLETED ACTIVITIES LIST screen and the ACT STATUS CODE will be changed to a "C" (Completed). The ACT DATE will be the date the activity was created. At this time, MIRTEL and MOLI will also be updated. The activity to update MIRTEL/MOLI will contain the name and address as well as other data. The only fields that will be updated on MIRTEL/MOLI are the last activity code, last activity date, ID issue code, ID issue date, the previous activity code and the previous activity code date.

3.13.29 Screen MCMU214 – MEDCOR Part B Premium Reduction / IRMAA Screen

Screen MCMU214 is a subordinate activity screen. Screen MCMU214 allows the user to create an activity with information about the Medicare Part B premium, Medicare Advantage Part B premium reduction (MCR) (see FOM-I-820.10.5) or Income-Related Monthly Adjustment Amount (IRMAA) (see FOM-I-820.10.6). The screen is optional. This screen, added with Screens MCMU022 and MCMU016, will create one of three activities – a 17L, 17E, or 17I.

Screen MCMU214 may only be accessed through the main activity MCMU022, by pressing PF17, PF18, or PF19.

Press this PF Key:	To Create Activity:	To Do The Following:
PF17	17L	Establish or change the current Part B premium amount, residency code, variable rate code, penalty percentage, and/or premium effective date.

PF18	17E	Add, stop, change or cancel a Medicare Advantage Part B premium reduction.
PF19	17I	Add, change or cancel an Income-Related Monthly Adjustment Amount (IRMAA).

The data on Screen MCMU214 will only be added to an activity record when screens MCMU022 and MCMU016 are added.

The CURR PT B PREM AMT field on Screen MCMU214 will always be carried over from the main activity. If an entry is made in the CURR PT B PREMIUM AMT field on Screen MCMU214 that is different from what was entered on the main activity screen, the corresponding field on the main activity field will also be changed. When the main activity appears, the PART B PREMIUM RATE field on the main activity screen will be protected. If a change in the Part B premium rate is necessary, the change must be made on Screen MCMU214.

If Screen MCMU214 is added to MEDCOR, entries in the following 17L fields on Screen MCMU214 are mandatory: CURR RESIDENCY CD, CURR VAR RATE CD, CURR PEN PERCENT, CURR CAT EFF DATE and CURR VAR BASE RATE (if the entry in the CURR VAR RATE CD field is a V). For a 17E, entries in the following fields are mandatory: MCR TOA CD, MCR PLAN NO and MCR PT B RED AMT, and the MCR START DATE. For a 17I, entries in the following fields are mandatory: IRMAA PREM AMT, IRMAA EFF DATE, IRMAA ILC, and CEC. The entries in these fields will only be used to update MIRTEL when Screen MCMU022 and Screen MCM016 are added.

No entries or changes can be made to the CURR MCR TOA CD, CURR MCR PLAN NO, CURR MCR PT B RED AMT, CURR MCR START DATE, CURR MCR STOP DATE, CURR IRMAA AMT, CURR IRMAA EFF DATE, and CURR IRMAA ILC and CEC. These fields are for information only and are not used for editing purposes or updating of the MIRTEL.

The add and delete functions work with individual screens and must be pressed twice to complete the processing for an activity. PF2 will, in a newly created activity, add the entries made on Screen MCMU214. PF2 will also add the changes made on Screen MCMU214 for a pending activity. Edits for the fields will be complete. PF4 will delete a pending activity.

Activity 17L – Instructions for completion of the Part B premium fields (17L) are as follows:

--	--

Field	Completion Instructions												
CURR PT B PREM AMT	<p>Enter current Part B premium amount. The amount entered should be the:</p> <ul style="list-style-type: none"> • Base Rate or Variable Rate premium, plus • Surcharges (Penalty Rate) (if applicable), plus • Income Related Monthly Adjustment Amount (IRMAA) (if applicable), minus • Medicare Advantage premium reduction (if applicable). 												
CURR RESIDENCY CD	<p>Enter current residency code. Acceptable codes are:</p> <table border="1"> <tr> <td>S</td><td>Standard Table</td></tr> <tr> <td>P</td><td>Puerto Rico Table</td></tr> <tr> <td>C</td><td>Commonwealth/Territory Table</td></tr> </table>	S	Standard Table	P	Puerto Rico Table	C	Commonwealth/Territory Table						
S	Standard Table												
P	Puerto Rico Table												
C	Commonwealth/Territory Table												
CURR VAR RATE CD	<p>Enter current variable rate code. Acceptable codes are:</p> <table border="1"> <tr> <td>N</td><td>Table Rate – may have IRMAA</td></tr> <tr> <td>R</td><td>Table Rate with a Part B reduction amount and base premium is not zero – may have IRMAA</td></tr> <tr> <td>Z</td><td>Table Rate with a Part B reduction amount and base premium is zero – may have IRMAA</td></tr> <tr> <td>V</td><td>Variable Rate</td></tr> <tr> <td>C</td><td>Variable Rate with a Part B reduction amount and base premium is not zero</td></tr> <tr> <td>D</td><td>Variable Rate with Part B reduction amount and base premium is zero</td></tr> </table>	N	Table Rate – may have IRMAA	R	Table Rate with a Part B reduction amount and base premium is not zero – may have IRMAA	Z	Table Rate with a Part B reduction amount and base premium is zero – may have IRMAA	V	Variable Rate	C	Variable Rate with a Part B reduction amount and base premium is not zero	D	Variable Rate with Part B reduction amount and base premium is zero
N	Table Rate – may have IRMAA												
R	Table Rate with a Part B reduction amount and base premium is not zero – may have IRMAA												
Z	Table Rate with a Part B reduction amount and base premium is zero – may have IRMAA												
V	Variable Rate												
C	Variable Rate with a Part B reduction amount and base premium is not zero												
D	Variable Rate with Part B reduction amount and base premium is zero												
CURR PEN PERCENT	<p>Entry must be numeric; the last position of the entry must be 0; and the entry must be either 000, 010, 020, 030, etc., through the maximum percent on the current premium rate table.</p>												
CURR CAT EFF DATE	<p>Entry should be numeric, in format of month (01 – 12), century (19 or 20) and year (00 – 99). Entry must be January of a year or equal to or greater than the Part B</p>												

	effective date. If the entry in the CURR VAR RATE CD field is a V, the CURR CAT EFF DATE should be January of the current year.
CURR VAR BASE RATE	<p>If the CURR VAR RATE CD is V, C or D, a valid entry must be made in CURR VAR BASE RATE field.</p> <p>Entry must be numeric; and be equal to or greater than 24.80, and less than the current basic rate table of the year of the CURR CAT EFF DATE field. The last position must always be 0.</p>

Activity 17E – Here are instructions for completion of the Part B premium reduction fields (17E activity).

Note: All entries on the 17E activity must be supported by information on the Medicare Beneficiary Database (MBD) MARx Premium screen, or otherwise verified by the Centers for Medicare & Medicaid Services. If the Part B premium reduction is for year before 2006, Part B premium reduction information may not be available on the MBD. In that case, use the BERT 18A screen (Managed Care Reduced-Premium Enrollment Periods).

Field	Completion Instructions								
MCR TOA CD	<p>Enter the 1-character Type of Action (TOA) code. Acceptable codes are:</p> <table border="1"> <tr> <td>B</td><td>Begin a new Part B premium reduction. Also use code B to replace a current year Part B premium reduction with a Part B premium reduction for a different plan, or to change the Start Date of an existing plan. (See Note below.)</td></tr> <tr> <td>C</td><td>Begin or replace a Part B premium reduction for a prior year (closed period).</td></tr> <tr> <td>E</td><td>End a current or prior year Part B premium reduction.</td></tr> <tr> <td>W</td><td>Cancel (wipe-out) a current or prior year</td></tr> </table>	B	Begin a new Part B premium reduction. Also use code B to replace a current year Part B premium reduction with a Part B premium reduction for a different plan, or to change the Start Date of an existing plan. (See Note below.)	C	Begin or replace a Part B premium reduction for a prior year (closed period).	E	End a current or prior year Part B premium reduction.	W	Cancel (wipe-out) a current or prior year
B	Begin a new Part B premium reduction. Also use code B to replace a current year Part B premium reduction with a Part B premium reduction for a different plan, or to change the Start Date of an existing plan. (See Note below.)								
C	Begin or replace a Part B premium reduction for a prior year (closed period).								
E	End a current or prior year Part B premium reduction.								
W	Cancel (wipe-out) a current or prior year								

	Part B premium reduction.
MCR PLAN NO	Enter the 11-position Medicare Advantage plan number. The first position must be an E, H or R. <u>Note:</u> This is shown on the MBD MARx Premium Detail Data screen in 3 separate fields. The first 4 positions of the plan number are in the Contract Number (Cntr Num) field, the next 3 positions are in the Plan Benefit Package (PBP Num) field, and the last 3 positions are in the Segment Number (Sgmt Num) field.
MCR PT B RED AMT	Enter the Part B premium reduction amount. Enter the amount in dollars and cents with a decimal, e.g. 96.40. Do not enter a dollar (\$) sign. An entry in this field is required, regardless of the TOA code.
MCR START DATE	Enter the Part B premium reduction start date. An entry in this field is always required. Enter date as MM-CCYY, e.g. 01-2008.
MCR STOP DATE	If the TOA is C, E or W, enter the Part B premium reduction stop date. If required, enter date as MM-CCYY, e.g. 12-2008.

Note: In order to change the Part B reduction amount for a current year plan, i.e. a beneficiary remains enrolled in the same plan, but the Part B reduction amount on record is incorrect, two 17E activities are required. First, prepare a 17E activity to cancel (wipe-out) (TOA CD = W) the current year enrollment. After this activity has processed, prepare a second activity to begin (TOA CD = B) the enrollment with the correct Part B premium reduction. Be sure to process both activities before the next scheduled MAMMA run.

Examples:

Note: In the following examples, the current year is considered to be 2008.

1. Begin Part B Premium Reduction – Current Year - The beneficiary enrolled in Plan H1032097000 beginning 02/2008, his Part B effective date. The plan offers enrollees a monthly Part B premium reduction of \$89.00. To begin the Part B premium reduction, a 17E activity is created with the following data fields:

MCR TOA CD	B
------------	---

MCR PLAN NO	H1032097000
MCR PT B RED AMT	89.00
MCR START DATE	02-2008
MCR STOP DATE	

2. Replace Current Year Enrollment With New Enrollment - Beneficiary was enrolled in Plan H5820002000 in 2007, and CMS automatically extends her enrollment in the same plan for 2008. Enrollment in Plan H5820002000 with a \$40.00 Part B premium reduction beginning 01-2008 is shown on MOLI. However, the beneficiary decides to change plans and enrolls in Plan H5404086000 during the Annual Enrollment Period. Plan H5404086000 provides a monthly Part B premium reduction of \$96.40. The enrollment is effective 01-2008. To begin the new Part B premium reduction, a 17E activity is created with the following data fields:

MCR TOA CD	B
MCR PLAN NO	H5404086000
MCR PT B RED AMT	96.40
MCR START DATE	01-2008
MCR STOP DATE	

Processing of the 17E activity will cancel (wipe-out) the 2008 enrollment in Plan H5820002000, and begin the new Part B premium reduction for Plan H5404086000.

3. Replace Prior Year Enrollment With New Enrollment - MOLI shows that beneficiary was enrolled in Plan H5820002000 for all months in 2007, with a monthly Part B premium reduction of \$93.50. A recent reconciliation of RRB records and CMS records shows that beneficiary was actually enrolled in Plan H5404086000 for all months in 2007, with a monthly Part B premium reduction of \$50.00. In order to correct the 2007 enrollment records, a 17E activity is created with the following data fields:

MCR TOA CD	C
------------	---

MCR PLAN NO	H5404086000
MCR PT B RED AMT	50.00
MCR START DATE	01-2007
MCR STOP DATE	12-2007

Processing of the 17E activity will cancel (wipe-out) the 2007 enrollment in Plan H5820002000, and replace it with the Part B premium reduction for Plan H5404086000. Reason 2122 and 2124 referrals will be generated as a result of the processing.

4. Cancel (Wipe-Out) Prior Year Enrollment - MOLI shows that beneficiary was enrolled in Plan H5404062000 for all months in 2007, with a monthly Part B premium reduction of \$93.50. A recent reconciliation of RRB records and CMS records shows that beneficiary cancelled her enrollment in the plan, and enrolled in the Original Medicare Plan. In order to correct the 2007 enrollment records, a 17E activity is created with the following data fields:

MCR TOA CD	W
MCR PLAN NO	H5404062000
MCR PT B RED AMT	93.50
MCR START DATE	01-2007
MCR STOP DATE	12-2007

Processing of the 17E activity will cancel (wipe-out) the 2007 enrollment in Plan H5404062000. A reason 2122 referral will be generated as a result of the processing.

5. End Current Year Enrollment - MOLI shows that beneficiary is enrolled in Plan H5696002000 for all months in 2008, with a monthly Part B premium reduction of \$96.40. Because the beneficiary moves to another state that is outside of the service area for Plan H5696002000, she cancels her enrollment in the plan in

February 2008. To end the Part B premium reduction, a 17E activity is created with the following data fields:

MCR TOA CD	E
MCR PLAN NO	H5696002000
MCR PT B RED AMT	94.40
MCR START DATE	01-2008
MCR STOP DATE	02-2008

6. Change Start Date of Current Year Enrollment - MOLI shows that beneficiary is enrolled in Plan H5404016000 for all months in 2008, with a Part B premium reduction of \$30.00. We receive information from CMS that the start date of the enrollment should be 02-2008, instead of 01-2008. In order to correct the record, prepare a 17E activity with the following data fields:

MCR TOA CD	B
MCR PLAN NO	H5404016000
MCR PT B RED AMT	30.00
MCR START DATE	02-2008
MCR STOP DATE	

Processing of the 17E activity will cancel (wipe-out) the enrollment beginning 01-2008, and replace it with an enrollment beginning 02-2008. Reason 2118 and 2120 referrals will be generated as a result of the processing. An arrearage will be due for 01-2008.

7. Cancel (Wipe-Out) Current Year Enrollment - MOLI shows that beneficiary is enrolled in Plan H5594001000 for all months in 2008, with a monthly Part B premium reduction of \$96.40. A reconciliation of RRB records and CMS records shows that beneficiary cancelled his enrollment in the plan, and enrolled in the Original Medicare Plan. In order to correct the 2008 enrollment records, a 17E activity is created with the following data fields:

MCR TOA CD	W
MCR PLAN NO	H5594001000
MCR PT B RED AMT	96.40
MCR START DATE	01-2008
MCR STOP DATE	12-2008

Processing of the 17E activity will cancel (wipe-out) the 2008 enrollment in Plan H5594001000. A reason 2122 referral will be generated as a result of the processing.

8. End Prior Year Enrollment - MOLI shows that beneficiary was enrolled in Plan H1032032000 for all months in 2007, with a monthly Part B premium reduction of \$89.00. A reconciliation of RRB and CMS records shows that the beneficiary's enrollment in the plan ended in 10-2007. To correct the record, a 17E activity is created with the following data fields:

MCR TOA CD	E
MCR PLAN NO	H1032032000
MCR PT B RED AMT	89.00
MCR START DATE	01-2007
MCR STOP DATE	10-2007

Activity 17I – Here are instructions for completion of the IRMAA fields (17I activity).

Note: All entries on the 17I activity must be supported by information from a MEDREF referral or documentation from the Social Security Administration (SSA). Acceptable documentation from SSA includes IRMAA information obtained from an MBR or a copy of a letter to the beneficiary from SSA showing the results of a new IRMAA determination.

Field	Completion Instructions
-------	-------------------------

IRMAA PREM AMT	Enter the Income-Related Monthly Adjustment Amount. Enter amount is dollars and cents with a decimal, e.g. 103.30.
IRMAA EFF DATE	Enter the effective date (month and year) of the IRMAA entered in the IRMAA Premium Amount field. This will always be January of the IRMAA year, or if later, the beneficiary's Part B effective date.
IRMAA ILC	Enter the 1-digit IRMAA Income Level Code associated with the IRMAA Premium Amount. See FOM-I-820.10.6.2. Acceptable codes are 0, 1, 2, 3 or 4. A zero (0) is to be used if a previous IRMAA is cancelled, e.g. changed to zero.
IRMAA CEC	Enter the 3-character IRMAA Change Event Code. Use CEC code INI (Initial Determination) to add an IRMAA. See FOM-I-820.10.6.8 for a complete list of Change of Event Codes.

Examples:

1. A Screening Reject Referral for reason 5551 (ECRUT Record With IRMAA – Create Act 32 To Clear, Then Act 17I To Update IRMAA Info) is generated upon screening of record with SSA. Information from the referral shows an IRMAA Premium of \$103.30, the IRMAA Year as 2008, and the IRMAA Level as 3. The beneficiary's Part B effective date is 06-2008. After the screening reply is cleared, create a 17I with the following data fields:

IRMAA PREM AMT	103.30
IRMAA EFF DATE	06-2008
IRMAA ILC	3
IRMAA CEC	INI

2. A Congressional inquiry is received on behalf of a beneficiary whose MOLI record shows an IRMAA of \$25.80 effective 01-2008. The Congressman's office provides a copy of letter from SSA to the beneficiary advising him that the 2008 IRMAA has been removed effective 01-2008 because of an unanticipated loss of pension income. In order to remove the IRMAA, prepare a 17I with the following data fields:

IRMAA PREM AMT	0.00
IRMAA EFF DATE	01-2008
IRMAA ILC	0
IRMAA CEC	PIL

Below is an example of Screen MCMU214:

Session1 - myEXTRA! Enterprise

MCMU214 MEDCOR/MEDREF 02-08-08
MCDU214 PART B PREMIUM REDUCTION/IRMAA 01:13

ACTIVITY INPUT 22

CURR PT B PREM AMT 096.40
CURR RESIDENCY CD S
CURR VAR RATE CD N
CURR PEN PERCENT 000
CURR CAT EFF DATE 01-2008
CURR VAR BASE RATE .

CURR MCR TOA CD MCR TOA CD
CURR MCR PLAN NO MCR PLAN NO
CURR MCR PT B RED AMT MCR PT B RED AMT
CURR MCR START DATE MCR START DATE
CURR MCR STOP DATE MCR STOP DATE

CURR IRMAA PREM AMT IRMAA PREM AMT
CURR IRMAA EFF DATE IRMAA EFF DATE
CURR IRMAA ILC & CEC IRMAA ILC & CEC

UNIT HB5 USER

A 17E (17 MCR ENROLLMENT) ACTIVITY CAN NOW BE CREATED

-----RESPONSES-----
CLEAR=ACTIVITY PF1=HELP PF2=ADD
PF4=DELETE PF5=REFRESH PF24=KEYS

10/69

Connected to host chilpar1 [172.16.1.228] (RRB1I507)

Start RCM-3-13.doc - Microsoft... Session1 - myEXTRA! Ent... 1:12 PM

3.13.50 MEDREF

The on-line Medicare Referral (MEDREF) system replaced paper alerts, rejects, referrals and attainment listings produced by the Medicare Information Recorded, Transmitted, Edited and Logged (MIRTEL) system. The on-line information and new reports from MEDREF improved internal controls and management information.

The MEDREF screens contain information from the On-Line Medicare Correction system (MEDCOR), MEDREF, DATAQ and the MIRTEL On-line Inquiry (MOLI) database at the time the referral is created.

Although planned, the FOLDER NOTICE REFERRAL and the DATABASE REFERRAL are not yet on MEDREF. Referrals produced for the Medicare Section (MS) from other systems are not on MEDREF.

Enhancements were made to MEDREF in August 2001 to indicate what type of referral is being generated. For example, if the referral is an initial referral, INIT is displayed on the MEDCOR/MEDREF PENDING REFERRALS LIST and on the referral itself. There are several different kinds of flags that may appear on the screens. The displays and the interpretation of each display are shown below:

Display	Interpretation
INIT	Initial, No Tracers, No Others
INIT-TRAC	Initial with Tracer(s), No Others
INIT-TRAC-OTHR	Initial with Tracer(s) and Others
TRAC-INIT	Tracer to an Initial, No Others
TRAC-INIT-OTHR	Tracer to an Initial, with Other(s)
TRAC-OTHR-INIT	Tracer to an Other, with an Initial
OTHR-INIT	Other with Initial, No Tracers
OTHR-TRAC-INIT	Other with Tracer(s) and an Initial

3.13.51 MEDCOR/MEDREF Database

MEDREF referral information is kept in a combined MEDCOR/MEDREF database and resides on the Railroad Automated Processing Integrated Database (RRAPID). Referrals are added to the MEDCOR/MEDREF database after MIRTEL generates the data.

Pending referrals may be viewed only, or viewed and deleted. Selected information on deleted referrals is retained until written to reports. The reports are run on the first work day of the month and are produced on the 11th floor printer.

3.13.52 MEDREF Security

Access to MEDREF is limited by levels of security established for MEDCOR through ACF2. Each level allows the user to view only, or view and delete referrals.

The USER field is the user's signon ID and is displayed on all MEDREF screens. The USER field cannot be changed by the user and is included if a referral is deleted. An audit trail is established based on the user signon. MEDREF's levels of security are:

MEDCORSEE - SEE - G-810: none - G-811: 98, 99

MEDCORSEE allows users access to create, view and delete limited MEDCOR activities. MEDCORSEE also allows users to view pending referrals. If someone wants access to MEDCOR or MEDREF, they must have this basic level of access. Users may have an additional level of security if they are required to do certain other activities or delete certain referrals.

MEDCORBFS - BFS - G-810: none - G-811: 62, 98, 99

MEDCORSEE and MEDCORBFS provide users in the Field Service access to create, view and delete specific MEDCOR activities; and view pending MEDREF referrals.

MEDCORDPS - DPI, DPP - G-810: 20 - G-811: 51, 98, 99

MEDCORSEE and MEDCORDPS allow disability examiners access to create, view and delete specific MEDCOR activities; and view pending MEDREF referrals.

MEDCORORS - DOC, BRB, BSB - G-810: 12, 20 - G-811: 50, 52, 60, 61, 98, 99

MEDCORSEE and MEDCORORS allow retirement, survivor and other examiners in Operations access to create, view and delete specific MEDCOR activities; and view pending MEDREF referrals.

MEDCORMPS - HB1 THRU HB9 - G-810: 12, 13, 17, 20, 21, 22, 31, 32, 33, 34 - G-811: 05, 06, 21, 22, 23, 24, 25, 26, 27, 30, 32, 34, 35, 36, 50, 51, 52, 60, 61, 62, 98, 99

MEDCORSEE and MEDCORMPS allow Medicare examiners access to create all activities, view all activities, and delete specific MEDCOR activities; and to view and delete pending MEDREF referrals.

MEDCORMNG - MNG, SUP, CPS, BDP - G-810: 12, 13, 17, 20, 21, 22, 31, 32, 33, 34 - G-811: 05, 06, 21, 22, 23, 24, 25, 26, 27, 30, 32, 34, 35, 36, 50, 51, 52, 60, 61, 62, 98, 99 - Delete activities and referrals from pending lists

MEDCORSEE and MEDCORMNG allow users access to create, view and delete all MEDCOR activities; and to view and delete pending referrals. There is also an additional delete function. Users with this level of access are normally supervisors in the Medicare Section.

MEDCORDEL - DOC - G-810: none - G-811: 98, 99 - Delete certain referrals

MEDCORSEE and MEDCORDEL allow users in Assessment and Training access to create, view and delete specific MEDCOR activities; and view and delete specific

referrals. This security level was created for individuals responsible for handling Death Match Referrals.

MEDCORREM - No Unit - G-810 none - G-811: 98, 99 - Mass delete referrals
MEDCORSEE and MEDCORREM allow selected users access to create, view and delete limited MEDCOR activities; view pending referrals; and do mass deletions of certain referrals.

MEDCORSMB - MNG, SUP, CPS, BDP - G-810: none - G-811: 98, 99 - Update SMIB Table

MEDCORSEE and MEDCORSMB allow users access to create, view and delete limited MEDCOR activities, view pending referrals, and update the Part B premium table in MEDCOR.

3.13.53 MEDREF Screens - General

MEDREF has 12 screens - 1 menu screen, 1 list screen and 10 referral screens. Screen MCMU060, the MEDREF Pending Referrals Menu screen, is the first screen displayed when entering MEDREF and allows users access to the various MEDREF screens. No information can be changed by the user on any MEDREF screen.

The following are the other MEDREF screens:

- Screen MCMU061 - PENDING REFERRALS LIST;
- Screen MCMU062 - ATTAINMENT LISTING;
- Screen MCMU063 - STATE BUY IN REFERRAL;
- Screen MCMU064 - DOD ALERT REFERRAL;
- Screen MCMU065 - SSA-EDB ALERT OR EXCEPTION;
- Screen MCMU066 - SCREENING REJECT REFERRAL (up to 3 screens per referral);
- Screen MCMU067 - DAILY REFERRAL;
- Screen MCMU068 - FOLDER NOTICE REFERRAL;
- Screen MCMU069 - MONTHLY REFERRAL;
- Screen MCMU070 - PAM REFORMAT REJECT; and
- Screen MCMU072 - DATABASE REFERRAL;

3.13.54 Colors On MEDREF Screens

Colors are consistent on all MEDREF screens. The following colors are used:

- Blue is used for program names, map name, current date, page, time, directional messages and field labels.
- White is used for screen title, variable messages and user entered data.
- Red is used for error messages.
- Green is used for data fields which cannot be changed.

3.13.55 Layout Of MEDREF Screens

The layout of the MEDREF screens is consistent. The following applies:

- Row 1 has the screen id (map name), title and date which cannot be changed by the user.
- Row 2 has the dialog name, title and time which cannot be changed by the user.
- Rows 3 thru 19 contain the referral message, referral information and the user id which cannot be changed by the user.
- Rows 20 and 21 display system generated information or error messages which cannot be changed by the user.
- Row 22 will display '----RESPONSES----'.
- Rows 23 and 24 display valid key functions.

3.13.56 Help Screen On MEDREF

The Help Message system will be added to MEDREF in the future using On-line Help (OLH). The Help Message will allow users to view instructions and examples by pressing the PF1 key. Help information will be displayed for a screen. In addition, if the cursor is placed on a specific field where help information is defined, help information will be displayed for that field. Currently, the help feature is not available on MEDREF.

3.13.57 Function Keys On MEDREF

The following function keys are the same for all MEDREF screens:

- CLEAR exits a screen and goes to the previous screen within MEDREF.
- PF24 displays a list of all key functions even if not applicable for the screen.

The following function keys are used on selected MEDREF screens:

- ENTER processes the selection made on Screen MCMM060, the Pending Referrals Menu screen and Screen MCMU061, the Pending Referrals List screen.
- PA1 goes to Screen MCMM060, the Pending Referrals Menu screen.
- PA2 exits MEDREF and returns to the RRAPID MENU SCREEN.
- PF1 displays the HELP SCREEN associated with the screen or field which the cursor is on.
- PF4 deletes a referral on MEDREF. If referral deleted from the referral screen, the user will return to Screen MCMU061, the Pending Referrals List screen. Any authorized user may delete a referral from the referral screen. Only a manager can delete a referral from Screen MCMU061, the Pending Referrals List screen. If a referral is deleted from Screen MCMU061, the Pending Referrals List screen user will remain on Screen MCMU061, the Pending Referrals List screen when the referral is deleted.
- PF5 refreshes Screen MCMM060, the Pending Referrals Menu screen.
- PF7 pages to a previous page of information on Screen MCMU061, the Pending Referrals List screen.
- PF8 pages to the next page of information on Screen MCMU061, the Pending Referrals List screen.
- PF9 displays Screen MCMM001, the MEDCOR Menu screen. If user accessed MEDCOR using the PF9 key while on a referral screen in MEDREF, if the PF9 key is used again on the MEDCOR activity screen, user will return to the referral screen.

If MEDCOR was accessed from a MEDREF referral screen, if an activity is added to MEDCOR from the MEDCOR activity screen, the user will automatically return to the referral screen in MEDREF. If an activity is not added to MEDCOR, the PF9 key will return the user to the referral screen in MEDREF.

- PF19 pages to the first page of information on Screen MCMU061, the Pending Referrals List screen.
- PF20 pages to the last page of information on Screen MCMU061, the Pending Referrals List screen.

3.13.58 Accessing MEDREF

Access to MEDREF is through RRAPID. Access the RRAPID MAIN MENU as instructed in RCM 16.2.5. When the RRAPID MAIN MENU is displayed, type "30" in the

NEXT SELECTION field on the RRAPID MAIN MENU screen and press Enter. Screen MCMM060 - the MEDREF Pending Referrals Menu will be displayed.

MEDREF utilizes the "Hot Key" function. The user can go to other systems on RRAPID without having to reenter the identifying data. Each system allows the user to change the identifying data.

3.13.59 Screen MCMM060 - MEDREF Pending Referrals Menu

Screen MCMM060 is the first screen displayed when entering MEDREF. This screen allows the user to access Screen MCMU061, the MEDREF Pending Referrals List, which allows the user to access a referral screen.

If MEDREF was entered via the "Hot Key" function, the claim number may be carried over and inserted in the CLAIM NUMBER field on the screen. This field may be typed over or if the PF5 key is pressed, the data will be removed.

From this screen the user is able to select a group of referrals within a certain range by the last two digits of the RRB claim number, or all referrals for a specific RRB claim number. This selection can be based on claim number, referral code, referral date or referral type. Only those referrals in the database that match the criteria entered on Screen MCMM060 are displayed. If there are no referrals in the database for the criteria entered, a message will be displayed that no referrals were found. If there are referrals in the system for the selection entry made, Screen MCMU061 will be displayed. A message will also appear if the user did not enter sufficient information or incorrect information on Screen MCMM060. Refer to RCM 3.3, Exhibit 1a for referral codes. Refer to RCM 3.6 for handling of some of the referral messages. See 3.13.61 - SECURING A REFERRAL SCREEN for the various combinations on how a user can obtain the referrals.

Screen MCMM060 is shown below:

```

MCMM060          MEDCOR/MEDREF          07/30/01
MCDM060          PENDING REFERRALS MENU    09:28:52
                CLAIM NUMBER 000000000
                REFERRAL CODE 0000
                REFFERAL DATE MMDDCCYY

                BEG RANGE LAST TWO DIGITS XX
                END RANGE LAST TWO DIGITS XX

                ATTAINMENT REFERRAL          STATE BUY IN/PARS REFERRAL
                DOD ALERT REFERRAL          HCFA-EDB ALERT OR EXCEPTION
                SCREENING REJECT REFERRAL    DAILY REFERRAL
                FOLDER NOTICE REFERRAL     MONTHLY REFERRAL
                PAM REFORMAT REJECT          DATABASE REFERRAL
                                           USER MORRISA

```

-----RESPONSES-----

ENTER=PROCESS PA2=RRAPID PF1=HELP
 PF4=DELETE PF5=REFRESH F9=MEDCOR

3.13.60 Screen MCMU061 - MEDREF Pending Referrals List

Screen MCMU061 is accessed from Screen MCMM060. This screen lists the selected referrals from the database. This screen allows referrals to be selected for viewing or deletion. Only authorized users are allowed to delete referrals.

A referral screen is accessed by entering a 'P' to the left of the claim number and pressing Enter. This action displays the referral screen corresponding with the claim number.

Referrals on this screen can be deleted by a manager placing a 'D' to the left of a claim number and pressing PF4. PF4 must be pressed twice to complete the deletion of the referral. The user will remain on Screen MCMU061.

Screen MCMU061 is shown below:

```

MCMU061          MEDCOR/MEDREF          07/30/01
MCDU061          PENDING REFERRALS LIST    09:47:51
                REFERRAL REFERRAL
  CLAIM NUMBER FLAG      TYPE OF REFERRAL      CODE   DATE
  A 123-45-6789 INIT-TRAC    DAILY REFERRAL      1029 05/15/2001
  A 123-45-6789 TRAC-INIT    DAILY REFERRAL      1029 06/15/2001
  MA 123-45-6789 INIT-TRAC   DAILY REFERRAL      1043 05/15/2001
  MA 123-45-6789 TRAC-INIT   DAILY REFERRAL      1043 06/15/2001
  A 123-45-6789 INIT-TRAC-OTHR DAILY REFERRAL      1075 05/15/2001
  A 123-45-6789 TRAC-INIT-OTHR DAILY REFERRAL      1075 06/15/2001
  A 123-45-6789 INIT-TRAC-OTHR DAILY REFERRAL      1075 05/15/2001
  A 123-45-6789 TRAC-INIT-OTHR DAILY REFERRAL      1075 06/15/2001
  A 123-45-6789 INIT-TRAC-OTHR DAILY REFERRAL      1075 05/15/2001
  A 123-45-6789 TRAC-INIT-OTHR DAILY REFERRAL      1075 06/15/2001
  A 123-45-6789 INIT-TRAC-OTHR DAILY REFERRAL      1075 05/15/2001
  A 123-45-6789 TRAC-INIT-OTHR DAILY REFERRAL      1075 06/15/2001
  A 123-45-6789 INIT-TRAC-OTHR DAILY REFERRAL      1075 05/15/2001
                                USER MORRISA

```

-----RESPONSES-----

ENTER=PROCESS CLEAR=REFMENU PA1=REFMENU PA2=RRAPID
 PF1=HELP
 PF4=DELETE PF7=PREV PF8=NEXT PF19=FIRST PF20=LAST

3.13.61 Securing A Referral Screen

Referral screens can be accessed by making an entry in one of the following fields on Screen MCMM060: CLAIM NUMBER, REFERRAL CODE, REFERRAL DATE or by entering a "P" by the left side of the type of referral. If a specific RRB claim number is not entered in the CLAIM NUMBER field, an entry must also be made in the BEG RANGE LAST TWO DIGITS and the END RANGE LAST TWO DIGITS fields. If an incorrect entry or incomplete entries are made, the user will get an error message.

After correct entries are made and the Enter key is pressed on Screen MCMM060, Screen MCMU061 will be displayed. When on Screen MCMU061, enter a "P" to the left of the claim number and press Enter. Then, the referral screen will be displayed.

Following are examples of how a referral screen can be accessed.

A. SECURING A REFERRAL SCREEN USING THE CLAIM NUMBER

A specific claim number or 999999999 can be entered as the claim number and a beginning and ending range of the last two digits of the claim number on Screen MCMM060.

1. SPECIFIC CLAIM NUMBER - Enter a specific claim number on Screen MCMM060 and press the Enter key to see all the pending referrals for the claim number on Screen MCMU061. If the beneficiary has a six-digit claim number, use preceding zeros. An example of a specific claim number entry on Screen MCMM060 is shown below:

```
MCMM060      MEDCOR/MEDREF      07/30/01
MCDM060      PENDING REFERRALS MENU      09:43:08
              CLAIM NUMBER 123456789
              REFERRAL CODE 0000
              REFFERAL DATE MMDDCCYY
```

```
BEG RANGE LAST TWO DIGITS  XX
END RANGE LAST TWO DIGITS  XX
```

```
ATTAINMENT REFERRAL      STATE BUY IN/PARS REFERRAL
DOD ALERT REFERRAL      HCFA-EDB ALERT OR EXCEPTION
SCREENING REJECT REFERRAL  DAILY REFERRAL
FOLDER NOTICE REFERRAL  MONTHLY REFERRAL
PAM REFORMAT REJECT      DATABASE REFERRAL
```

USER

MORRISA

-----RESPONSES-----

```
ENTER=PROCESS      PA2=RRAPID      PF1=HELP
PF4=DELETE         PF5=REFRESH      PF9=MEDCOR
```

All pending referrals in the database for the claim number entered on Screen MCMM060 will appear on Screen MCMU061. Referrals are sorted by the referral date.

To access a referral screen, enter a "P" on the left side of the claim number as shown below and press Enter. The referral screen will then be displayed. Refer to RCM 3.13.64 through 3.13.74 for the various referral screens.

```

MCMU061          MEDCOR/MEDREF          07/30/01
MCDU061          PENDING REFERRALS LIST    09:44:38
  
```

```

                                REFERRAL REFERRAL
                                TYPE OF REFERRAL  CODE
CLAIM NUMBER  FLAG
DATE
  P A 123-45-6789 INIT-TRAC  MONTHLY REFERRAL  8907
05/24/2001
    A 123-45-6789 TRAC-INIT  MONTHLY REFERRAL  8907
06/24/2001
  
```

USER MORRISA

-----RESPONSES-----

```

ENTER=PROCESS  CLEAR=REFMENU  PA1=REFMENU
PA2=RRAPID  PF1=HELP
PF4=DELETE    PF7=PREV      PF8=NEXT  PF19=FIRST
PF20=LAST
  
```

2. 999999999 AS CLAIM NUMBER AND RANGE - Enter 999999999 as the claim number and a two digit BEG RANGE LAST TWO DIGITS and an END RANGE LAST TWO DIGITS (of the RRB claim number) on Screen MCMM060 and press the Enter key to see all the pending referrals within the beginning and ending range entered. If the beginning range is 00 and the ending range is 99, all pending referrals in the database will be displayed. If the beginning or ending range is a single digit, precede with a zero. An example of 999999999 as claim number and a beginning and ending range being entered on Screen MCMM060 is shown below:

```

MCMM060          MEDCOR/MEDREF          07/30/01
MCDM060          PENDING REFERRALS MENU    09:45:02
  
```

```

CLAIM NUMBER 999999999
REFERRAL CODE 0000
REFERRAL DATE MMDDCCYY
  
```

```

BEG RANGE LAST TWO DIGITS 00
END RANGE LAST TWO DIGITS 99
  
```

ATTAINMENT REFERRAL	STATE BUY IN/PARS REFERRAL
DOD ALERT REFERRAL	HCFA-EDB ALERT OR
EXCEPTION	
SCREENING REJECT REFERRAL	DAILY REFERRAL
FOLDER NOTICE REFERRAL	MONTHLY REFERRAL
PAM REFORMAT REJECT	DATABASE REFERRAL

USER MORRISA

-----RESPONSES-----

ENTER=PROCESS	PA2=RRAPID	PF1=HELP
PF4=DELETE	PF5=REFRESH	PF9=MEDCOR

All pending referrals in the database for the range entered on Screen MCMU060 will be shown. To page between the screens, use the PF7 and PF8 keys. Referrals are sorted by the last two digits of the claim number.

To access the referral screen, enter a "P" on the left side of the claim number as shown below and press the Enter key. The referral screen will then be displayed. Refer to RCM 3.13.64 through 3.13.74 for the various referral screens.

MCMU061	MEDCOR/MEDREF	07/30/01
MCDU061	PENDING REFERRALS LIST	09:45:30

		REFERRAL	REFERRAL		
	CLAIM NUMBER	FLAG	TYPE OF REFERRAL	CODE	DATE
<u>P</u>	A 123-45-6789	INIT-OTHR	SCREENING REJECT	5070	
	05/10/2001				
	A 123-45-6789	OTHR-INIT	SCREENING REJECT	5401	
	05/10/2001				
	MA 123-45-6789	INIT	SCREENING REJECT	5525	05/10/2001
	A 123-45-6789	INIT-TRAC	MONTHLY REFERRAL	8907	
	05/24/2001				
	A 123-45-6789	TRAC-INIT	MONTHLY REFERRAL	8907	
	06/24/2001				
	A 123-45-6789	INIT	SCREENING REJECT	5525	05/10/2001
	A 123-45-6789	INIT-TRAC	MONTHLY REFERRAL	8907	
	05/24/2001				
	A 123-45-6789	TRAC-INIT	MONTHLY REFERRAL	8907	
	06/24/2001				
	A 123-45-6789	INIT-TRAC	MONTHLY REFERRAL	8907	
	05/24/2001				
	A 123-45-6789	TRAC-INIT	MONTHLY REFERRAL	8907	
	06/24/2001				
	A 123-45-6789	INIT-TRAC	MONTHLY REFERRAL	8907	
	05/24/2001				

A 123-45-6789 TRAC-INIT MONTHLY REFERRAL 8907
 06/24/2001
 MA 123-45-6789 INIT STATE BUY IN/PARS 6302 05/24/2001
 USER MORRISA

-----RESPONSES-----
 ENTER=PROCESS CLEAR=REFMENU PA1=REFMENU
 PA2=RRAPID PF1=HELP
 PF4=DELETE PF7=PREV PF8=NEXT PF19=FIRST
 PF20=LAST

B. SECURING A REFERRAL SCREEN USING THE REFERRAL CODE

A referral code and a beginning and ending range of the last two digits of the claim number, or 9999 as the referral code and a beginning and ending range of the last two digits of the claim number can be entered on Screen MCMM060.

1. SPECIFIC REFERRAL CODE AND RANGE - Enter a specific referral code and a two digit BEG RANGE LAST TWO DIGITS and an END RANGE LAST TWO DIGITS (of the claim number) on Screen MCMM060 and press Enter to see all the pending referrals in the database with that referral code within the beginning and ending range entered. If the beginning range is 00 and the ending range is 99, all pending referrals with the selected referral code will be displayed. If the beginning or ending range is a single digit, precede with a zero. An example of a specific referral code and a beginning and ending range being entered on Screen MCMM060 is shown below:

MCMM060 MEDCOR/MEDREF 07/30/01
 MCDM060 PENDING REFERRALS MENU 09:46:29

CLAIM NUMBER 000000000
 REFERRAL CODE 1155
 REFFERAL DATE MMDDCCYY

BEG RANGE LAST TWO DIGITS 00
 END RANGE LAST TWO DIGITS 99

ATTAINMENT REFERRAL	STATE BUY IN/PARS REFERRAL
DOD ALERT REFERRAL	HCFA-EDB ALERT OR EXCEPTION
SCREENING REJECT REFERRAL	DAILY REFERRAL
FOLDER NOTICE REFERRAL	MONTHLY REFERRAL
PAM REFORMAT REJECT	DATABASE REFERRAL
	USER

MORRISA

-----RESPONSES-----
 ENTER=PROCESS PA2=RRAPID PF1=HELP
 PF4=DELETE PF5=REFRESH F9=MEDCOR

All pending referrals in the database with the specific referral code for the range entered on Screen MCMM060 will be displayed. To page between the screens, use the PF7 and PF8 keys. Referrals are sorted by the last two digits of the RRB claim number.

To access the referral screen, enter a "P" on the left side of the claim number as shown below and press Enter. The referral screen will then be displayed. Refer to RCM 3.13.64 through 3.13.74 for the various referral screens.

MCMU061 MEDCOR/MEDREF 07/30/01
MCDU061 PENDING REFERRALS LIST 09:47:15

CLAIM NUMBER	FLAG	REFERRAL TYPE OF REFERRAL	REFERRAL CODE	DATE
<u>P</u> MA 123-45-6789	INIT-TRAC	DAILY REFERRAL	1155	05/15/2001
MA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1155	06/15/2001
WA 123-45-6789	INIT-TRAC	DAILY REFERRAL	1155	05/15/2001
WA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1155	06/15/2001
MA 123-45-6789	INIT-TRAC	DAILY REFERRAL	1155	05/15/2001
MA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1155	06/15/2001
MA 123-45-6789	INIT-TRAC	DAILY REFERRAL	1155	05/15/2001
MA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1155	06/15/2001

USER

MORRISA

-----RESPONSES-----
 ENTER=PROCESS CLEAR=REFMENU PA1=REFMENU
 PA2=RRAPID PF1=HELP
 PF4=DELETE PF7=PREV PF8=NEXT PF19=FIRST
 PF20=LAST

2. 9999 AS REFERRAL CODE AND RANGE - Enter 9999 as the referral code and a two digit BEG RANGE LAST TWO DIGITS and an END RANGE LAST TWO DIGITS (of the claim number) on Screen MCMM060 and press Enter to see all the pending referrals in the database within the beginning and ending range entered. If the beginning range is 00 and the ending range is 99, all pending referrals will be displayed. If the beginning or ending range is a single digit, precede with a zero. An example of 9999

as the referral code and a beginning and ending range being entered on Screen MCMM060 is shown below:

MCMM060 MEDCOR/MEDREF 07/30/01
MCDM060 PENDING REFERRALS MENU 09:47:30

CLAIM NUMBER 000000000
REFERRAL CODE 9999
REFERRAL DATE MMDDCCYY

BEG RANGE LAST TWO DIGITS 00
END RANGE LAST TWO DIGITS 99

ATTAINMENT REFERRAL	STATE BUY IN/PARS REFERRAL
DOD ALERT REFERRAL	HCFA-EDB ALERT OR EXCEPTION
SCREENING REJECT REFERRAL	DAILY REFERRAL
FOLDER NOTICE REFERRAL	MONTHLY REFERRAL
PAM REFORMAT REJECT	DATABASE REFERRAL

USER MORRISA

-----RESPONSES-----

ENTER=PROCESS	PA2=RRAPID	PF1=HELP
PF4=DELETE	PF5=REFRESH	PF9=MEDCOR

All pending referrals in the database for the range entered on Screen MCMM060 will be shown. To page between the screens, use the PF7 and PF8 keys. Referrals are sorted by the referral code.

To access the referral screen, enter a "P" on the left side of the claim number as shown below and press Enter. The referral screen will then be displayed. Refer to RCM 3.13.64 through 3.13.74 for the various referral screens.

MCMU061	MEDCOR/MEDREF	07/30/01
MCDU061	PENDING REFERRALS LIST	09:47:51

CLAIM NUMBER	FLAG	REFERRAL TYPE OF REFERRAL	REFERRAL CODE
<u>P</u> A 123-45-6789	INIT-TRAC	DAILY REFERRAL	1029
05/15/2001			
A 123-45-6789	TRAC-INIT	DAILY REFERRAL	1029
05/15/2001			
MA 123-45-6789	INIT-TRAC	DAILY REFERRAL	1043
05/15/2001			
MA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1043
06/15/2001			
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075
05/15/2001			

A 123-45-6789 TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001		
A 123-45-6789 INIT-TRAC-OTHR	DAILY REFERRAL	1075
05/15/2001		
A 123-45-6789 TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001		
A 123-45-6789 INIT-TRAC-OTHR	DAILY REFERRAL	1075
05/15/2001		
A 123-45-6789 TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001		
A 123-45-6789 INIT-TRAC-OTHR	DAILY REFERRAL	1075
05/15/2001		
A 123-45-6789 TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001		
A 123-45-6789 INIT-TRAC-OTHR	DAILY REFERRAL	1075
05/15/2001		

USER MORRISA

-----RESPONSES-----

ENTER=PROCESS CLEAR=REFMENU PA1=REFMENU
 PA2=RRAPID PF1=HELP
 PF4=DELETE PF7=PREV PF8=NEXT PF19=FIRST
 PF20=LAST

C. SECURING A REFERRAL SCREEN USING A DATE

A referral date and a beginning and ending range of the last two digits of the claim number, or 99999999 as the referral date and a beginning and ending range of the last two digits of the claim number, can be entered on Screen MCMM060.

1. SPECIFIC REFERRAL DATE AND RANGE - Enter a specific referral date and a two digit BEG RANGE LAST TWO DIGITS and an END RANGE LAST TWO DIGITS (of the claim number) on Screen MCMM060 and press Enter to see all the pending referrals in the database with that referral date within the beginning and ending range entered. If the beginning range is 00 and the ending range is 99, all pending referrals with that referral date will be displayed. If the beginning or ending range is a single digit, precede with a zero. An example of a specific referral date and a beginning and ending range being entered on Screen MCMM060 is shown below:

MCMM060	MEDCOR/MEDREF	07/30/01
MCDM060	PENDING REFERRALS MENU	09:48:25

CLAIM NUMBER 000000000
 REFERRAL CODE 0000

REFERRAL DATE **06152001**BEG RANGE LAST TWO DIGITS **00**END RANGE LAST TWO DIGITS **99**

ATTAINMENT REFERRAL

STATE BUY IN/PARS REFERRAL

DOD ALERT REFERRAL

HCFA-EDB ALERT OR

EXCEPTION

SCREENING REJECT REFERRAL

DAILY REFERRAL

FOLDER NOTICE REFERRAL

MONTHLY REFERRAL

PAM REFORMAT REJECT

DATABASE REFERRAL

USER MORRISA

-----RESPONSES-----

ENTER=PROCESS

PA2=RRAPID

PF1=HELP

PF4=DELETE

PF5=REFRESH

PF9=MEDCOR

All pending referrals in the database for the range entered on Screen MCMU060 will be shown. To page between the screens, use the PF7 and PF8 keys. Referrals are sorted by the last two digits of the claim number.

To access the referral screen, enter a "P" on the left side of the claim number as shown below and press Enter. The referral screen will then be displayed. Refer to RCM 3.13.64 through 3.13.74 for the various referral screens.

MCMU061

MEDCOR/MEDREF

07/30/01

MCDU061

PENDING REFERRALS LIST

09:49:27

CLAIM NUMBER	FLAG	REFERRAL TYPE OF REFERRAL	REFERRAL CODE
P A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001			
MA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1155
06/15/2001			
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001			
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001			
MA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1301
06/15/2001			
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001			
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001			
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075
06/15/2001			

MA 123-45-6789 TRAC-INIT DAILY REFERRAL 1400
 06/15/2001
 MA 123-45-6789 TRAC-INIT DAILY REFERRAL 1043
 06/15/2001
 WA 123-45-6789 TRAC-INIT DAILY REFERRAL 1155
 06/15/2001
 A 123-45-6789 TRAC-INIT-OTHR DAILY REFERRAL 1075
 06/15/2001
 MA 123-45-6789 TRAC-INIT DAILY REFERRAL 1155
 06/15/2001

USER MORRISA

-----RESPONSES-----

ENTER=PROCESS CLEAR=REFMENU PA1=REFMENU
 PA2=RRAPID PF1=HELP
 PF4=DELETE PF7=PREV PF8=NEXT PF19=FIRST
 PF20=LAST

2. 99999999 AS REFERRAL DATE AND RANGE - Enter 99999999 as the referral date code and a two digit BEG RANGE LAST TWO DIGITS and an END RANGE LAST TWO DIGITS (of the claim number) on Screen MCMM060 and press Enter to see all the pending referrals in the database within the beginning and ending range entered. If the beginning range is 00 and the ending range is 99, all pending referrals will be displayed. If the beginning or ending range is a single digit, precede with a zero. An example of 99999999 as the referral date and a beginning and ending range being entered on Screen MCMM060 is shown below:

MCMM060 MEDCOR/MEDREF 07/30/01
 MCDM060 PENDING REFERRALS MENU 09:49:43

CLAIM NUMBER 000000000
 REFERRAL CODE 0000
 REFFERAL DATE 99999999

BEG RANGE LAST TWO DIGITS 00
 END RANGE LAST TWO DIGITS 99

ATTAINMENT REFERRAL	STATE BUY IN/PARS REFERRAL
DOD ALERT REFERRAL	HCFA-EDB ALERT OR EXCEPTION
SCREENING REJECT REFERRAL	DAILY REFERRAL
FOLDER NOTICE REFERRAL	MONTHLY REFERRAL
PAM REFORMAT REJECT	DATABASE REFERRAL

USER

MORRISA

-----RESPONSES-----

ENTER=PROCESS PA2=RRAPID PF1=HELP
 PF4=DELETE PF5=REFRESH PF9=MEDCOR

All pending referrals in the database for the range entered on Screen MCMU060 will be shown. To page between the screens, use the PF7 and PF8 keys. Referrals are sorted by the last two digits of the claim number.

To access the referral screen, enter a "P" on the left side of the claim number as shown below and press Enter. The referral screen will then be displayed. Refer to RCM 3.13.64 through 3.13.74 for the various referral screens.

MCMU061 MEDCOR/MEDREF 07/30/01
 MCDU061 PENDING REFERRALS LIST 09:50:06

CLAIM NUMBER	FLAG	REFERRAL TYPE OF REFERRAL	REFERRAL CODE
<u>P</u> A 123-45-6789	INIT-OTHR	SCREENING REJECT REFERRAL	
5070 05/10/2001			
A 123-45-6789	OTHR-INIT	SCREENING REJECT REFERRAL	5401
05/10/2001			
MA 123-45-6789	INIT	SCREENING REJECT REFERRAL	5525
05/10/2001			
A 123-45-6789	INIT	SCREENING REJECT REFERRAL	5525
05/10/2001			
MA 123-45-6789	INIT	SCREENING REJECT REFERRAL	5525
05/10/2001			
A 123-45-6789	INIT-OTHR	SCREENING REJECT REFERRAL	5070
05/10/2001			
A 123-45-6789	OTHR-INIT	SCREENING REJECT REFERRAL	5401
05/10/2001			
A 123-45-6789	INIT-OTHR	SCREENING REJECT REFERRAL	5070
05/10/2001			
A 123-45-6789	OTHR-INIT	SCREENING REJECT REFERRAL	5401
05/10/2001			
WA 123-45-6789	INIT	SCREENING REJECT REFERRAL	5525
05/10/2001			
A 123-45-6789	INIT-OTHR	SCREENING REJECT REFERRAL	5070
05/10/2001			
A 123-45-6789	OTHR-INIT	SCREENING REJECT REFERRAL	5401
05/10/2001			
A 123-45-6789	INIT-OTHR	SCREENING REJECT REFERRAL	5070
05/10/2001			

USER MORRISA

-----RESPONSES-----

ENTER=PROCESS CLEAR=REFMENU PA1=REFMENU
 PA2=RRAPID PF1=HELP
 PF4=DELETE PF7=PREV PF8=NEXT PF19=FIRST
 PF20=LAST

D. SECURING A REFERRAL SCREEN BY TYPE OF REFERRAL

Enter a "P" next to the name of the type of referral and enter a two digit BEG RANGE LAST TWO DIGITS and an END RANGE LAST TWO DIGITS (of the claim number) on Screen MCMU060 and press Enter to see all the pending referrals in the database for that type of referral within the beginning and ending range entered. The pending referrals will be displayed on Screen MCMU061. If the beginning range is 00 and the ending range is 99, all pending referrals will be displayed. If the beginning or ending range is a single digit, precede with a zero. An example of a "P" being entered by the type of referral and a beginning and ending range being entered on Screen MCMU060 is shown below:

MCMU060 MEDCOR/MEDREF 07/30/01
 MCDM060 PENDING REFERRALS MENU 09:50:25

CLAIM NUMBER 000000000
 REFERRAL CODE 0000
 REFFERAL DATE MMDDCCYY

BEG RANGE LAST TWO DIGITS 00
 END RANGE LAST TWO DIGITS 99

ATTAINMENT REFERRAL	STATE BUY IN/PARS REFERRAL
DOD ALERT REFERRAL	HCFA-EDB ALERT OR EXCEPTION
SCREENING REJECT REFERRAL	<u>p</u> DAILY REFERRAL
FOLDER NOTICE REFERRAL	MONTHLY REFERRAL
PAM REFORMAT REJECT	DATABASE REFERRAL

USER MORRISA

-----RESPONSES-----

ENTER=PROCESS PA2=RRAPID PF1=HELP
 PF4=DELETE PF5=REFRESH PF9=MEDCOR

All pending referrals in the database for the type selected within the range entered on Screen MCMU060 will be shown. To page between the screens, use the PF7 and PF8 keys. Referrals are sorted by the last two digits of the claim number.

To access the referral screen, enter a "P" on the left side of the claim number as shown below and press Enter. The referral screen will then be displayed. Refer to RCM 3.13.64 through 3.13.74 for the various referral screens.

MCMU061 MEDCOR/MEDREF 07/30/01
MCDU061 PENDING REFERRALS LIST 09:52:34

CLAIM NUMBER	FLAG	TYPE OF REFERRAL	CODE	DATE
P A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075	06/15/2001
MA 123-45-6789	INIT-TRAC	DAILY REFERRAL	1155	05/15/2001
MA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1155	06/15/2001
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075	06/15/2001
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075	06/15/2001
MA 123-45-6789	INIT-TRAC	DAILY REFERRAL	1301	05/15/2001
MA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1301	06/15/2001
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075	06/15/2001
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001

USER

MORRISA

-----RESPONSES-----

ENTER=PROCESS CLEAR=REFMENU PA1=REFMENU PA2=RRAPID
PF1=HELP
PF4=DELETE PF7=PREV PF8=NEXT PF19=FIRST PF20=LAST

3.13.62 Deleting A Referral On MEDREF

Once a referral is on MEDREF, the referral remains until it is deleted.

A. DELETING A REFERRAL FROM THE REFERRAL SCREEN

After the referral screen is accessed, the referral will be deleted by pressing PF4 twice. When the deletion is complete, the user will return to Screen MCMU061 and a message will appear to advise that the deletion was completed.

MCMU067 MEDCOR/MEDREF 07/30/01
MCDU067 DAILY REFERRAL 09:55:08
INIT-TRAC-OTHR REF CODE 1075 A 123-45-6789 REF DATE 05-15-2001

NO CHICO MASTER PRESENT ON INQUIRY REPLY
ACCTG DT UNIT RUN ACT RR CLM NO RR BEN NAME RS
SEX
05-11-9999 ESA 193 03M A 123-45-6789 M
TYP BEN PYMT DOB HI DOB PSEUDO NO BEN SSA NO EE SSA
NO DOF
06-00-1912

SSA CLM NO/SUF FORMER SSA/RR NO ABD FF MO DIS PT A EFF PT A
TRM SOC

EQR GEP PT B EFF PT B TRM CD/DT PT B RT PTD EXC PREM ARR
DUE CD/AMT

DELQ DT SBI AD SBI DD P SBI AD P SBI DD TP PR ID NAME/ADDRESS
NEVA R JONES

PYMT DT/BCH NO TYP BILL PAID A/D CD POSTMK REFUND |7196
ROBINWOOD DRAW

ANYBURY MN 55125 \

PC RP DOD PROV NO VAR DATA/EFF DT EVENT CD/DT
1

USER

MORRISA

-----RESPONSES-----

CLEAR=REFLIST PA1=REFMENU PA2=RRAPID
PF1=HELP **PF4=DELETE** PF9=MEDCOR

B. DELETING A REFERRAL FROM SCREEN MCMU061 - PENDING
REFERRALS LIST SCREEN

Managers can also delete referrals on Screen MCMU061 by entering a "D" on the left side of a specific claim number on Screen MCMU061 and pressing PF4 twice. When the deletion is complete, the user will remain on Screen MCMU061 and a message will appear to advise that the deletion was successfully completed. This feature is for manager's use only.

MCMU061 MEDCOR/MEDREF 07/30/01
MCDU061 PENDING REFERRALS LIST 09:47:51

REFERRAL REFERRAL

CLAIM NUMBER	FLAG	TYPE OF REFERRAL	CODE	DATE
D A 123-45-6789	INIT-TRAC	DAILY REFERRAL	1029	05/15/2001
A 123-45-6789	TRAC-INIT	DAILY REFERRAL	1029	06/15/2001
MA 123-45-6789	INIT-TRAC	DAILY REFERRAL	1043	05/15/2001
MA 123-45-6789	TRAC-INIT	DAILY REFERRAL	1043	06/15/2001
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075	06/15/2001
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075	06/15/2001
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075	06/15/2001
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001
A 123-45-6789	TRAC-INIT-OTHR	DAILY REFERRAL	1075	06/15/2001
A 123-45-6789	INIT-TRAC-OTHR	DAILY REFERRAL	1075	05/15/2001

USER MORRISA

-----RESPONSES-----

ENTER=PROCESS CLEAR=REFMENU PA1=REFMENU PA2=RRAPID
 PF1=HELP
 PF4=DELETE PF7=PREV PF8=NEXT PF19=FIRST PF20=LAST

3.13.63 Accessing MEDCOR From A Referral Screen

After a referral screen is accessed and it is determined that a MEDCOR activity should be created, press the PF9 key. Screen MCMU001, the MEDCOR Menu screen will be displayed.

MCMU067 MEDCOR/MEDREF 07/30/01
 MCDU067 DAILY REFERRAL 09:55:08
 INIT-TRAC-OTHR REF CODE 1075 A 123-45-6789 REF DATE 05-15-2001
 NO CHICO MASTER PRESENT ON INQUIRY REPLY

ACCTG DT UNIT RUN ACT RR CLM NO RR BEN NAME RS SEX
 05-11-2001 ESA 193 03M A 123-45-6789 M

TYP BEN PYMT DOB HI DOB PSEUDO NO BEN SSA NO EE SSA NO DOF
 01 06-00-1912

SSA CLM NO/SUF FORMER SSA/RR NO ABD FF MO DIS PT A EFF PT A TRM
 SOC

EQR GEP PT B EFF PT B TRM CD/DT PT B RT PTD EXC PREM ARR DUE
 CD/AMT

DELQ DT SBI AD SBI DD P SBI AD P SBI DD TP PR ID NAME/ADDRESS
 NEVA R JONES

PYMT DT/BCH NO TYP BILL PAID A/D CD POSTMK REFUND |7196
 ROBINWOOD DRAW

ANYBURY MN 55125 \

PC RP DOD PROV NO VAR DATA/EFF DT EVENT CD/DT
 1

USER MORRISA

-----RESPONSES-----

CLEAR=REFLIST PA1=REFMENU PA2=RRAPID
 PF1=HELP PF4=DELETE **PF9=MEDCOR**
MCMU001 MEDCOR/MEDREF MM/DD/YY
MCDM001 MEDCOR MENU HH/MM
 UNIT HB1
 CLAIM NUMBER A 123-45-6789
 BEN SSA NUMBER _____
 PSEUDO NUMBER ___-__-___
 ACTIVITY INPUT 22

VALID ACTIVITIES 12, 13, 20, 21, 22, 31, 32, 33, 34, 11 MISC. INPUT
USER XXXXXXXX

PREFILLED SSA NUMBER OR PSEUDO NUMBER FROM MOLI

-----RESPONSES-----

ENTER=PROCESS CLEAR/PA2=RRAPID PF1=HELP PF5 REFRESH
PF9=MEDREF PF17=PACTL PF18=CACTL PF24=KEYS

In most cases, the beneficiary's social security number or pseudo number will be carried over to Screen MCMU001. If it is not, go to MOLI to secure the social security number or pseudo number. If you are creating an activity on MEDCOR and receive a message that there is no MOLI record, but you know that a MOLI record exists, go to MOLI to secure the social security number or pseudo number before exiting. In addition, you must enter your unit and the activity number you want to create.

The MEDCOR activity screen will then be displayed. If the MEDCOR activity screen is added, the MEDREF referral screen will then be displayed. If the MEDCOR activity screen is not added, use the PF9 key to return to the referral screen.

After action is taken to handle a referral, go to the referral screen and press PF4 twice to delete the referral.

3.13.64 Screen MCMU062 - Attainment Referral Screen

Below is an example of Screen MCMU062, the Attainment Referral Screen. See RCM 3.3 Exhibit 1a for the messages.

MCMU062 MEDCOR/MEDREF 07/30/01
MCDU062 ATTAINMENT REFERRAL 09:59:40
INIT REF CODE 8901 A 123-45-6789 REF DATE 05-25-2001

NOTIFY BA 1309 STEEL COMPANY RR OF DIABILITY ANNUANT MEDICARE
ENTITLEMENT

CLAIM NUMBER	TYPE CASE	DOB
A 123-45-6789	9	09-04-1941
USER MORRISA		

-----RESPONSES-----

CLEAR=REFLIST PA1=REFMENU PA2=RRAPID
PF1=HELP PF4=DELETE PF9=MEDCOR

3.13.65 Screen MCMU063 - State Buy In/PARS Referral Screen

Below is an example of Screen MCMU063, the State Buy-In/PARS Referral Screen. See RCM 3.3 Exhibit 1a for the messages.

MCMU063 MEDCOR/MEDREF 07/30/01
MCDU063 STATE BUY IN/PARS REFERRAL 09:56:17

INIT REF CODE 6301 A 123-45-6789 REF DATE 05-25-2001
STATE BUY IN ADJUSTMENT WITH PARS

SBI CLM NO SBI BEN NAME SBI SEX SBI DOB PARS CAUSE CD
A 123-45-6789 DERRICK L JONES M 08-03-1949

PARS CLM NO PARS BILL DOC ID PARS TYPE PARS DUE DATE PARS
AMT
A 123-45-6789 B5123456789A1 530 07-24-1998

AGCY ACCTG ACCR DEL ACCR/DEL AGCY ACCTG ACCR DEL
ACCR/DEL
CD DATE CD CD DATE CD DATE CD CD DATE
010 06-2001 1180 05-2001

USER MORRISA

-----RESPONSES-----

CLEAR=REFLIST PA1=REFMENU PA2=RRAPID
PF1=HELP PF4=DELETE PF9=MEDCOR

3.13.66 Screen MCMU064 - DOD Alert Referral Screen

Below is an example of Screen MCMU064, the DOD Alert Referral Screen. See RCM 3.3 Exhibit 1a for the messages. See RCM 3.6 for handling of the referrals.

MCMU064 MEDCOR/MEDREF 08/01/01
MCDU064 DOD ALERT REFERRAL 18:12:04
INIT-TRAC REF CODE 4002 A 123-45-6789 REF DATE 07-20-2001
DATE OF DEATH DISCREPANCY REFERRAL

***** EDB INFORMATION *****

HI CLM NO HI DOD RRB DOD PROVIDER NO
A 123-45-6789 06-20-2001 07-31-2001

***** MOLI INFORMATION *****

RR CLM NO PSEUDO NO PC TYPE BEN PYMT DOB HI DOB
A 123-45-6789
SEX DOD LAP CD/DT PRE LAP CD/DT BEN NAME

***** DATAQ INFORMATION *****

DQ CLM NO PC RRB DOB SSA DOB BENE SSA NO
RR TERM CD/DT RR VCH NO/DT SS TERM CD/DT SS VCH NO/DT

USER MORRISA

-----RESPONSES-----

CLEAR=REFLIST PA1=REFMENU PA2=RRAPID
PF1=HELP PF4=DELETE PF9=MEDCOR

3.13.67 Screen MCMU065 - SSA-EDB Alert Or Exception Screen

Below is an example of Screen MCMU065, the SSA-EDB Alert or Exception Screen. See RCM 3 - Exhibit X for the messages. See RCM 3.6 for handling of the referrals.

```

MCMU065          MEDCOR/MEDREF          08/01/01
MCDU065          HCFA-EDB ALERT OR EXCEPTION    18:11:02
INIT  REF CODE 5048  MA 123-45-6789  REF DATE 07-20-2001
      RRB URIC REJECT, RRB HI CLAIM NUMBER XREF TO SSA EDB

      ***** EDB INFORMATION *****
HI CLM NO   DOB   SEX  NAME   TYP  DISP  REC  HCFA PROC DT
MA 123-45-6789 06-24-1933 F  C I JONES  B   F3   B   07-19-2001

      ***** MOLI INFORMATION *****
RR CLM NO   PSEUDO NO           BEN NAME      TYP BEN   RS
MA 123-45-6789
SEX   HI DOB      PYMT DOB      PT A EFF   PT A TRM   SOC

EQR CD  PT B EFF  PT B TRM CD/DT  P PT B EFF/SOC  P PT B TRM CD/DT

DOD      LAP CD/DT      PRE LAP CD/DT

      USER MORRISA
-----RESPONSES-----
CLEAR=REFLIST      PA1=REFMENU      PA2=RRAPID
PF1=HELP           PF4=DELETE      PF9=MEDCOR

```

3.13.68 Screen MCMU066 - Screening Reject Referral Screen

Below is an example of Screen MCMU066, the Screening Reject Referral Screen. See RCM 3 - Exhibit X for the messages, See RCM 3.6 for handling of the referrals.

```

MCMU066          MEDCOR/MEDREF          07/30/01
MCDU066          SCREENING REJECT REFERRAL    10:00:40
INIT-OTHR  REF CODE 5070  A 123-45-6789  REF DATE 05-10-2001
      NO SSA MATCH ON IDENTITY OF BENE

RR CLM NO   HI CLM NO   RR BEN NAME      STATUS  BENE
A 123-45-6789  A 123-45-6789  BERNARD D JONES  CPS    EE
SEX  SSA CLM NO/SUF  RR PT A EFF  RR SOC  RR PT B EFF  PTD  SS SBI CD
U 123-45-6789      10-2001  YES    10-2001

TYP RR      DOB      RR NAME/ADDRESS      SS NAME/ADDRESS
DED      10-10-1936      BERNARD D JONES
SS RS      SS PT A EFF      31 BRYN MAWR RD
UNK                      ANYWHERE PA 15221

```

SS SOC SS PT B EFF
 XXXXXX
 SS PT B TRM SS PT B RT REC COUNT RIC CD EXCP CD SSA PROC DT
 TYPE
 2 F ID 05-04-2001 XREF
 SS JUR CD SS PREM DUE AMT
 NIF USER MORRISA
 -----RESPONSES-----
 CLEAR=REFLIST PA1=REFMENU PA2=RRAPID
 PF1=HELP PF4=DELETE PF9=MEDCOR

3.13.69 Screen MCMU067 - Daily Referral Screen

Below is an example of Screen MCMU067, the Daily Referral screen. See RCM 3.3 Exhibit 1a for the messages. See RCM 3.6 for handling of the referrals.

MCMU067 MEDCOR/MEDREF 07/30/01
 MCDU067 DAILY REFERRAL 09:55:08
 INIT-TRAC-OTHR REF CODE 1075 A 123-45-6789 REF DATE 05-15-2001
 NO CHICO MASTER PRESENT ON INQUIRY REPLY

ACCTG DT UNIT RUN ACT RR CLM NO RR BEN NAME RS SEX
 05-11-2001 ESA 193 03M A 701-16-9999 M

TYP BEN PYMT DOB HI DOB PSEUDO NO BEN SSA NO EE SSA NO
 DOF
 06-00-1912
 SSA CLM NO/SUF FORMER SSA/RR NO ABD FF MO DIS PT A EFF PT A TRM
 SOC

EQR GEP PT B EFF PT B TRM CD/DT PT B RT PTD EXC PREM ARR DUE
 CD/AMT

DELQ DT SBI AD SBI DD P SBI AD P SBI DD TP PR ID NAME/ADDRESS
 NEVA R JONES
 PYMT DT/BCH NO TYP BILL PAID A/D CD POSTMK REFUND |7196
 ROBINWOOD DRAW
 ANYBURY MN 55125 \

PC RP DOD PROV NO VAR DATA/EFF DT EVENT CD/DT
 1
 USER MORRISA
 -----RESPONSES-----
 CLEAR=REFLIST PA1=REFMENU PA2=RRAPID
 PF1=HELP PF4=DELETE PF9=MEDCOR

3.13.71 Screen MCMU069 - Monthly Referral Screen

See MEDCOR/REDREF for a sample of Screen MCMU069, the Monthly Referral screen. See RCM 3.3 Exhibit 1a for the messages. See RCM 3.6 for handling of the referrals.

3.13.72 Screen MCMU070 - PAM Reformat Reject Screen

See MEDCOR/REDREF for a sample of Screen MCMU070, the PAM Reformat Reject Referral screen. See RCM 3.3 Exhibit 1a for the messages.

3.13.73 Medicare Payment System (MPS)

The Medicare Payment System (MPS) is a web-based system for calculating and issuing Medicare payments and letters. Medicare payments include, but are not limited to:

- Canadian Part A benefit payments
- Premium refunds
- Erroneous payments received in the Railroad Retirement Board's Medicare lockbox

Beginning in January 2017, MPS replaces the Survivor Payments System (SURPASS) previously used to issue Medicare payments. It also replaces the Automated Award Letters to Annuitants (ALTA) previously used to issue Medicare payment letters. SURPASS and ALTA will still be in use, but not for Medicare purposes.

3.13.74 Accessing MPS

Access to MPS is through a link on Boardwalk, under Applications. On the Applications screen, click on WEB Applications, then Medicare Payment System. A welcome screen is displayed upon accessing MPS.

3.13.75 MPS Levels of Access

There are six levels of access to MPS. A description of the levels is shown below:

- EXAMINER – Those with examiner access can enter, modify, and submit Medicare payments and letters. After a payment has been started by an examiner, only (s)he can enter data for that payment.
- TRAINEE – Those with trainee access can enter, modify, and submit Medicare payments and letters. After a payment has been started by a trainee, only (s)he

can enter data for that payment. An authorizer must review all payments entered by trainees, regardless of dollar amount.

NOTE: Do not remove trainee status from any user until all cases assigned to the trainee are complete.

- **AUTHORIZER** – Those with authorizer access can enter, modify, and submit Medicare payments and letters. After a payment has been started by an authorizer, only (s)he can enter data for that payment. In authorize mode, the user can either approve another examiner, trainee, or authorizer's payment or return it for corrections. They will be unable to enter or modify data on another user's payment while authorizing it.
- **SUPERVISOR** - Those with supervisor access can enter, modify, and submit Medicare payments and letters. They can also reassign a case from one examiner/trainee/authorizer to another and delete payments when needed. Supervisors also have access to
- **FIELD OFFICE** – RRB Field Office staff have read-only access in order to review the status of payments.
- **SYSTEMS ADMINISTRATOR** – System Administrators are able to perform maintenance as needed to maintain the system.

3.13.76 MPS Award Process

MPS Medicare payments are initiated by examiner input. Data on the claim number is gathered from sources such as MIRTEL Online Inquiry (MOLI), Payment Rate and Entitlement History (PREH) and Electronic Check Processing (ECP). Based on the data provided by the examiner, MPS calculates the net amount due for the Medicare payment.

After the data entry and calculations have been completed, the examiner completes the letter and submits the award for payment. If the refund is over \$1,000, an authorizer is required to review the case and either approves it for payment or returns it to the examiner for correction. If the refund is over \$5,000, a second authorizer is required to review the case before the payment is approved. All payments entered by trainees require authorization, regardless of the dollar amount.

MPS vouchers the award based on the fund code(s) selected during the calculation process. Payments are vouchered in the first DAISY run after they have been approved for payment. Since DAISY can only voucher one award per claim number in a single run, payments involving multiple fund codes will voucher separately with each new DAISY run. The priority of payment of each fund code is determined by the payment amount. The fund code with the highest payment amount vouchers first. The fund code with the second highest fund code payment would voucher next, and so on.

A separate award form is imaged for each fund code. The award form is sent to Workdesk when the award for that fund vouchers. The letter associated with the payment is sent to Workdesk when all funds have successfully vouchered.

3.13.77 Prefilling Information From Other Systems

MPS prefills information from the MIRTEL On-line Inquiry (MOLI) and the Applications Express (APPLE). The system used to prefill information is determined by the refund type selected by the examiner when adding a new payment.

The following is a general description of the data obtained from other systems:

- MOLI – In Medicare refunds and Canadian Part A payments, MOLI is accessed to obtain contact and address information.
- APPLE – In Medicare Survivor refunds, APPLE is accessed to obtain contact and address information.

3.13.78 MPS Screens

The Medicare Payment System interface contains the following screens and tabs:

1. Login/Welcome Screen
 - a. My Dashboard
 - b. Add New
 - c. System Alerts
 - d. Admin Settings (displayed only for users with Supervisor or Admin status)
2. My Dashboard Screen
 - a. My Dashboard
 - b. In-Progress
 - c. Sent to Auth
 - d. Pending Auth
 - e. Completed
 - f. Reports
 - g. Add New

- i. Payment screen
- ii. Details screen
- iii. Summary screen
- h. Search For Payment

3.13.79 MPS Login/Welcome Screen

The Login/Welcome screen is the first screen displayed when entering the Medicare Payment System. The screen includes the following buttons:

1. My Dashboard – when clicked, transfers the user to the My Dashboard screen
2. Add New – when clicked, transfers the user to the Payment screen
3. System Alerts – when clicked, a pop-up lists any system alerts
4. Admin Settings (displayed only for users with Supervisor or Admin status) – when clicked, contains the following drop-down menu:
 - a. Assignment Management – when clicked, transfers the user to the Payment Assignment Management screen
 - b. Fund Codes – when clicked, transfers the user to the Manage Fund Codes screen
 - c. Letter Information – when clicked, transfers the user to the Manage Paragraphs screen
 - d. Standard Notes – when clicked, transfers the user to the Manage Standard Notes screen
 - e. System Alert – when clicked, transfers the user to the Manage System Alerts screen
 - f. Users Information – when clicked, transfers the user to the Manager User Roles screen

3.13.80 MPS My Dashboard Screen

The My Dashboard screen includes tabs to access, search and add new payments, as well as create reports. It also displays the number of payments made in the past 90 days within each of the following payment status categories:

- In-Progress – these are payments started by an examiner that are not completed or sent for authorization. Payments that reject for any reason also return to the

In-Progress area. When this tab is clicked, it transfers the user to the In-Progress screen.

- Sent to Auth – these are payments sent for authorization but not assigned to an authorizer. When this tab is clicked, it transfers the user to the Sent to Auth screen.
- Pending Auth – these are payments sent for authorization that are assigned to an authorizer. When this tab is clicked, it transfers the user to the Pending Auth screen.
- Completed – these are payments that are completed. When this tab is clicked, it transfers the user to the Completed screen.

In addition to the payment status tabs mentioned above, the Dashboard contains the following tabs:

- Reports – when clicked, transfers the user to the Reports screen
- Add New – when clicked, transfers the user to the Payment screen
- Search for Payments - Users can search for payments by Claim #, Social Security #, Pseudo # or Payment #. Search results can be sorted by clicking any of the headers listed in the results panel.

3.13.81 MPS Payment Screen

The Payment screen is used to initiate a new Medicare payment. The Payment screen is accessed by pressing the Add New button from the Dashboard. The user will be able to select from the following payment types:

- Medicare Beneficiary- these are payments made to a beneficiary due a Medicare refund (the system defaults to this category)
- Survivor – these are payments made to one or more survivor(s) of a beneficiary due a Medicare refund
- Canadian –these are payments made for Canadian Part A claims

After the payment type is selected, the user will enter an RRB claim number in the Search box and hit the Search button. If no results are found, an error message is displayed. If results are found, a list of all beneficiaries under that claim number is displayed.

The following fields are displayed for Medicare Beneficiary and Survivor payments once a valid claim number is found:

FIELD	DESCRIPTION
Beneficiary	Name(s) of all beneficiaries under that claim number that have a MOLI record (if entering a Medicare Beneficiary or Canadian payment) or an open SMIB APPLE application (if entering a Survivor payment)
SSN	The beneficiary's SSN (if unavailable, will read all zeros or nines)
DOB	The beneficiary's date of birth (MM/DD/YYYY)
BEN	The bene's beneficiary symbol (See FOM1_1540.10 for the list of symbols)
Payee Code	The beneficiary's payee code
# Shares	The number of shares payable to the payee indicated on that row (USER ENTERED)
Total Shares	The total number of shares for the payment (for example: a refund split between two survivors would have 2 total shares, one share each) (USER ENTERED)
Payable Shares	The total shares payable to all payees (MECHANICAL)
Period: (A) from (MM/YY)	The month and year the refund period began (USER ENTERED)
Period: (B) To (MM/YY)	The month and year the refund period ended (USER ENTERED)
Actual: (C) Premium Rate	The monthly premium rate paid from Period (A) to Period (B) (USER ENTERED)
Actual: (D) No. of Months	The number of months from Period (A) to Period (B) (MECHANICAL)

Actual: (E) Amount	The total amount paid from Period (A) to Period (B) (MECHANICAL)
Required: (F) Premium Rate	The monthly premium rate that should have been paid from Period (A) to Period (B) (USER ENTERED)
Required: (G) No. of Months	The number of months from Period (A) to Period (B) (MECHANICAL)
Required: (H) Amount	The total amount that should have been paid from Period (A) to Period (B) (MECHANICAL)
Refund: (I) Difference	The total difference between what was actually paid and what should have been paid from Period (A) to Period (B) for that row (MECHANICAL)
(J) Total	The total payment amount due for all periods entered

To add a new row for fields (A) through (I), users will hit the Add button below the (J) Total: field.

After entries are made in the above fields, users will designate how the funds are split among the 9 fund codes. To open the fund code designation box, users will click on the Add button after Selected Fund Codes.

For each fund code included in the payment, users will click the Include box next to that fund code and enter the total payment for that fund in the Payment box on that line. As each payment amount is entered, the amount in the Total at the bottom will be updated. This Total, after all fund codes have been selected and updated with payment amounts, must equal the Worksheet Total amount. The Worksheet Total amount is prefilled with the total from field (J) of the calculation section. The user will hit Ok to accept the fund code selections or Cancel to exit the fund code selection area. If Cancel is selected, a message will pop up asking "Are you sure you want to Cancel?" with the options "Ok" or "Cancel".

The following is a description of the available fund codes:

FUND CODE	DESCRIPTION
SMIA	Part B, aged
SMID	Part B, disabled

SMIL	Part B, limited payability
IRAA	IRMAA B, aged
IRAD	IRMAA B, disabled
DIRM	IRMAA D
CREF	Part C
DREF	Part D
SMIC	Canadian Part A (set by default for Canadian Claims)

Under the fund code selection area is a Remarks box. Entries made in the Remarks box will appear on the Award Form.

At the bottom of the Payment screen are three buttons:

- Save – This button must be pressed to save all entries made on the Payment screen before advancing to the next screen
- Submit – This button is inactive on the Payment screen
- Cancel – This button is used to exit the Payment screen and return to the Dashboard. If the Save button was pressed prior to hitting Cancel, the payment will show up on the Dashboard as In-Progress. If Save was not pressed prior to hitting Cancel, no entries will be saved.

After a user completes the Payment screen and successfully saves, they will click the Details button at the top of the screen to advance to the Details screen.

3.13.82 MPS Details Screen

The Details screen is used to compose the payment letter to the beneficiary/payee. The Details screen is accessed by clicking on the Details button at the top of the Payment screen after successfully entering and saving the payment information.

The top of the Details screen lists the payment type (Medicare Beneficiary, Survivor, or Canadian) and the claim number from the Payment screen. The beneficiary(s)/payee(s) selected on the Payment screen are listed under the Select a Beneficiary header. The following information is listed for each beneficiary/payee:

- Beneficiary/Payee – The beneficiary/payee's name
- SSN – The beneficiary/payee's social security number (if available)

- DOB – The beneficiary/payee's date of birth
- Payee Code – The beneficiary/payee's payee code

If only one beneficiary/payee was entered on the Payment screen, it is preselected on the Details screen. If more than one beneficiary/payee was entered, the user will select the beneficiary/payee by clicking anywhere in the row with the desired beneficiary/payee.

Below the beneficiary selection area, is the Letter area. The following information is listed:

- Paragraph – The code paragraph selected
- Title – The title of the code paragraph selected
- Sort – Used to move the selected code paragraph(s) up or down (indicated by arrows)
- Remove – Used to remove the selected code paragraph(s)

Nothing will be listed in the Letter area until a code paragraph is selected. The user will bring up the list of code paragraphs by clicking the Select Paragraphs button. The following is a list of the code paragraphs and their descriptions:

CODE PARAGRAPH		DESCRIPTION
With Date Range	Without Date Range	
955A	956A	Medicare Premium Refund; Premiums deducted from annuity
955B	956B	Medicare Premium Refund; Premiums collected after death
955C	956C	Medicare Premium Refund; RRB and SSA deducted
955D	956D	Medicare Premium Refund; Premiums collected after termination
955E	956E	Medicare Premium Refund; RRB and State deducted
955F	956F	Medicare Premium Refund; Premiums paid twice
955G	956G	Medicare Premium Refund; Change in

		premium rate
955H	956H	Medicare Premium Refund; Limited payability
955I	956I	Miscellaneous
955J	956J	Medicare Premium Refund; Medicare Advantage Part B premium (BIPA)
955K	N/A	Medicare Premium Refund to Third Party; RRB and State deducted
955L	N/A	Part B IRMAA Refund; IRMAA reduced
955M	N/A	Part B IRMAA Refund; IRMAA eliminated
9999S	N/A	Custom Paragraph; Blank for custom paragraph entry

To select a code paragraph, the user will click the box on the line with the desired code paragraph and then click the Add button. The selected code paragraph will then show up in the Letter section.

Only one code paragraph should be selected per letter, with the exception of the Custom Paragraph (9999S). The Custom Paragraph may be selected on its own or in addition to any other code paragraph. The reason for this is that the information in the code paragraphs other than the Custom Paragraph is prefilled from data entered on the Payment screen. Selecting multiple code paragraphs from 955A-956J will load the same data to each code paragraph and lead to inaccurate letters.

Four of the code paragraphs require the user to enter data after selecting that code paragraph. The data will be entered in a drop-down box(es) after selecting that code paragraph. The following are the code paragraphs that require data entry and the data requested:

1. 955J – Medicare Premium Refund; Medicare Advantage PT B premium (BIPA)
 - a. “Enter amount of monthly Part B premium reduction (Max: \$9999.99)” – User will enter the amount by which the Part B premium is reduced
2. 955L – Medicare Part B IRMAA Refund; IRMAA reduced
 - a. “Enter YEAR for which IRMAA premium was collected” – User will enter the year for which the IRMAA premium was collected
 - b. “Enter previous IRMAA premium (Max: \$9999.99)” – User will enter the previous IRMAA premium amount

- c. “Enter current (revised) IRMAA premium (Max: \$9999.99)” – User will enter the current IRMAA premium amount
 - d. “Select the first month for which IRMAA premium refund is due [Month]” – User will select the first month for which the IRMAA premium refund is due from the drop down menu
 - e. “Select the last month for which IRMAA premium refund is due [Month]” – User will select the last month for which the IRMAA premium refund is due from the drop down menu
3. 955M – Medicare Part B IRMAA Refund; IRMAA eliminated
- a. “Enter YEAR for which IRMAA premium was collected” – User will enter the year for which the IRMAA premium was collected
 - b. “Enter previous IRMAA premium (Max: \$9999.99)” – User will enter the previous IRMAA premium amount
 - c. Select the first month for which IRMAA premium refund is due [Month]” – User will select the first month for which the IRMAA premium refund is due from the drop down menu
 - d. “Select the last month for which IRMAA premium refund is due [Month]” – User will select the last month for which the IRMAA premium refund is due from the drop down menu
4. 9999S – Custom Paragraph
- a. [Blank] – User will enter any text in place of or in addition to any code paragraphs (NOTE: There is no spell-check so the user must check spelling and grammar prior to accepting the entry)

Beneath the Letter area is the Address. For Medicare Beneficiary and Survivor payments, this is read-only. Users are unable to update the address within the Medicare Payment System. The address for Medicare Beneficiary payments is prefilled from MOLI. If there is an error with the address for those cases, it will need to be updated on MOLI prior to completing the payment. The address for Survivors is prefilled from their APPLE application. If there is an error with the address for those cases, it would have to be updated on the APPLE application by a Field Office representative.

At the bottom of the Details screen are three buttons:

- Save – This button must be pressed to save all entries made on the Details screen before advancing to the next screen
- Submit – This button is inactive on the Details screen

- Cancel – This button is used to exit the Details screen and return to the Dashboard

After the user completes the Details screen and successfully saves, they will click the Summary button at the top of the screen to advance to the Summary screen.

3.13.83 MPS Summary Screen

The Summary screen displays a summary of the information entered on the Payment and Details screens, as well as a view-only preview of the award form and letter(s). The Summary screen is accessed by clicking on the Summary button at the top of the Details screen after successfully entering and saving the payment and letter information.

The top of the Summary screen lists the payment type (Medicare Beneficiary, Survivor, or Canadian) and the claim number from the Payment screen. The beneficiary(s)/payee(s) selected on the Details screen will be displayed with the following information:

- Name – The beneficiary/payee's name
- Address – The beneficiary/payee's address
- Bank Info – The beneficiary/payee's bank information, if available
- # Shares – The number of shares being paid to that beneficiary/payee
- Payment Share – The amount being paid to the beneficiary/payee

Beneath the beneficiary/payee information is the Total, indicating the total number of shares for all beneficiary(s)/payee(s) for that payment, with the total paid for all shares to the right of it.

The date range for the payment is displayed below the payment total. The Beginning Date and Ending Date for each row entered on the Payment screen will be listed.

The user can view the award form by clicking the View Award button. A preview of the award form is displayed in a new browser tab. There is a separate award form for each fund code selected but only the award form for the primary fund code is viewable on MPS. All award forms will be mechanically sent to WorkDesk once the payment successfully vouchers. Since DAISY can only voucher one payment per claim number per day, payments with multiple fund codes will voucher one fund code payment daily until all funds have been vouchered. Therefore, the award forms for those payments will be sent to WorkDesk over multiple days as they are vouchered.

The user can view the letter(s) by clicking the View Letters button. A preview of the letter (or letters if there are multiple payees) is displayed in a new browser tab. The letter(s) mechanically issue after the payment successfully vouchers.

Beneath the buttons to view the Award and Letters are two headers:

- Selected Fund Codes – Lists the fund codes selected for the payment
- Remarks – Shows the remarks entered by the user on the Payment screen

At the bottom of the Summary screen are three buttons:

- Save – This button is inactive on the Summary screen
- Submit – This button is used to submit the payment
- Cancel – This button is used to exit the Summary screen and return to the Dashboard

After a user completes the Summary screen and successfully submits the payment, the Summary screen is still displayed. Users can click the Dashboard button at the top of the screen to return to the Dashboard screen.

3.13.84 MPS In-Progress Screen

The In-Progress screen lists all payments currently in progress and any rejected payments. Users with Supervisor or Admin status will see all in-progress and rejected payments for all users. All other users will see only those assigned to them. The In-Progress screen is accessed by clicking the In-Progress tab on the menu bar at the top of the Dashboard screen. The user can search for a specific payment by the following criteria:

- Claim # (do not enter the prefix or symbol)
- Social Security #
- Pseudo #
- Payment #

The in-progress payments can be sorted by any of the criteria listed at the top of the results panel by clicking on the name of the desired criterion. The sortable criteria are as follows:

- Refund/Claim – This is the refund type. There are three different refund types:
 - Medicare B – A payment made to a Medicare beneficiary

- Medicare S – A payment made to a survivor of a Medicare beneficiary
- Medicare C – A Canadian Part A payment
- Pseudo # - The payee's pseudo number, if applicable. If there is no pseudo number, this field is blank.
- Claim # - The RRB claim number
- Payee Name – The name of the payee
- Fund Code – The primary fund code for the payment. If the payment involved more than one fund code, the primary fund code is listed in red.
- Payment – The payment total
- Payment # - The payment number
- Exam ID – The ID number of the examiner who entered the case
- Auth 1 – The ID number of the authorizer who authorized the case, if applicable. If no authorization is needed, a "0" is shown.
- Auth 2 – The ID number of the authorizer who completed the second authorization of the case, if applicable. If no second authorizer is needed, a "0" is shown.
- Complete Date – The date the payment was completed
- Rejected Date – The date the payment rejected, if applicable. If the payment did not reject, this field is blank.
- Actions – the available actions to take for that payment. There are two actions:
 - View Payment Summary (symbolized by a magnifying glass icon) – Opens the payment in a view-only capacity
 - Reopen Payment (symbolized by a round arrow icon) – Reopens the payment for modifications. This action can only be done before the payment is sent to DAISY for processing.

3.13.85 MPS Sent to Auth Screen

The Sent to Auth screen lists all payments currently sent for authorization, but not assigned to an authorizer. Users with Supervisor or Admin status will see all Sent to Auth payments for all users. All other users will see only those they sent for authorization. The Sent to Auth screen is accessed by clicking the Sent to Auth tab on

the menu bar at the top of the Dashboard screen. The user can search for a specific payment by the following criteria:

- Claim #
- Social Security #
- Pseudo #
- Payment #

The sent to auth payments can be sorted by any of the criteria listed at the top of the results panel by clicking on the name of the desired criterion. The sortable criteria are as follows:

- Refund/Claim – This is the refund type. There are three different refund types:
 - Medicare B – A payment made to a Medicare beneficiary
 - Medicare S – A payment made to a survivor of a Medicare beneficiary
 - Medicare C – A Canadian Part A payment
- Pseudo # - The payee's pseudo number, if applicable. If there is no pseudo number, this field is blank.
- Claim # - The RRB claim number
- Payee Name – The name of the payee
- Fund Code – The primary fund code for the payment. If the payment involved more than one fund code, the primary fund code will be listed in red.
- Payment – The payment total
- Payment # - The payment number
- Submitted Date – The date the payment was submitted for authorization
- Action (symbolized by a pencil icon) – Opens the payment

3.13.86 MPS Pending Auth Screen

The Pending screen lists all payments currently assigned to authorizers for authorization. Users with Supervisor or Admin status will see all Pending Auth payments for all users. All other users will see only those assigned to them. The Pending Auth screen is accessed by clicking the Pending Auth tab on the menu bar at the top of the Dashboard screen. The user can search for a specific payment by the following criteria:

- Claim #
- Social Security #
- Pseudo #
- Payment #

The pending auth payments can be sorted by any of the criteria listed at the top of the results panel by clicking on the name of the desired criterion. The sortable criteria are as follows:

- Refund/Claim – This is the refund type. There are three different refund types:
 - Medicare B – A payment made to a Medicare beneficiary
 - Medicare S – A payment made to a survivor of a Medicare beneficiary
 - Medicare C – A Canadian Part A payment
- Pseudo # - The payee's pseudo number, if applicable. If there is no pseudo number, this field is blank.
- Claim # - The RRB claim number
- Payee Name – the name of the payee
- Fund Code – The primary fund code for the payment. If the payment involved more than one fund code, the primary fund code will be listed in red.
- Payment – The payment total
- Payment # - The payment number
- Submitted Date – The date the payment was submitted for authorization
- Exam ID – The ID number of the examiner who entered the case
- Action (symbolized by a pencil icon) – Opens the payment

3.13.87 MPS Completed Screen

The Completed screen lists all payments that have been submitted for payment. Users with Supervisor or Admin status will see all Completed payments for all users made in the last 90 days. All other users will see only those they completed. The Completed screen is accessed by clicking the Completed tab on the menu bar at the top of the Dashboard screen. The user can search for a specific payment by the following criteria:

- Claim #
- Social Security #
- Pseudo #
- Payment #

The completed payments can be sorted by any of the criteria listed at the top of the results panel by clicking on the name of the desired criterion. The sortable criteria are as follows:

- Refund/Claim – This is the refund type. There are three different refund types:
 - Medicare B – A payment made to a Medicare beneficiary
 - Medicare S – A payment made to a survivor of a Medicare beneficiary
 - Medicare C – A Canadian Part A payment
- Pseudo # - The payee's pseudo number, if applicable. If there is no pseudo number, this field is blank.
- Claim # - The RRB claim number
- Payee Name – The name of the payee
- Fund Code – The primary fund code for the payment. If the payment involved more than one fund code, the fund code will be listed in red.
- Payment – The payment total
- Payment # - The payment number
- Exam ID – The ID number of the examiner who entered the case
- Auth 1 – The ID number of the authorizer who authorized the case, if applicable. If no authorization is needed, a "0" is shown.
- Auth 2 – The ID number of the authorizer who completed the second authorization of the case, if applicable. If no second authorizer is needed, a "0" is shown.
- Complete Date – The date the payment was completed
- Rejected Date – The date the payment was rejected, if applicable. If the payment was not rejected, this field is blank.

- Actions – the available actions to take for that payment. There are two actions:
 - View Payment Summary (symbolized by a magnifying glass icon) – Opens the payment in a view-only capacity
 - Reopen Payment (symbolized by a round arrow icon) – Reopens the payment for modifications. This action can only be done before the payment is sent to DAISY for processing.

3.13.88 MPS Reports

The Reports can be accessed by clicking the Report tab on the menu bar at the top of the Dashboard screen. The user is prompted to select a report from the Select Report drop-down menu. There are two sections of Reports- Examiner/Authorizer Tools and Medicare Division. The reports under Examiner/Authorizer Tools are viewable by all users, but the reports under Medicare Division are only viewable by users with supervisor or administrative access.

The following reports are available under Examiner/Authorizer Tools in the drop-down menu :

- All Awards as Examiner
- All Awards as Authorizer
- Refunds by Claim #
- Refunds B. SSN

The following reports are available under Medicare Division in the drop-down menu:

- Address Verification
- Monthly Report
- Output by Unit
- Refunds Paid on MM/YYYY
- Refunds by Status
- Refunds by Exam/Auth
- Refund Amt Totals by Unit
- Refunds by DAISY Status

To run a report, users will click the report they wish to run and enter the requested information. The following is how to run each report available in the Examiner/Authorizer Tools section:

1. **All Awards by Examiner** – This report returns all awards the requesting user entered as an examiner. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Start Date . . .	A drop-down calendar is displayed for the user to select the beginning date of the report
End Date . . .	A drop-down calendar is displayed for the user to select the end date of the report
All Refund Types	<p>The user will select one of the three options:</p> <ul style="list-style-type: none"> • All Refund Types – Includes Medicare and Canadian payments • Medicare – Includes Medicare payments only • Canadian – Includes Canadian payments only
All Statuses	<p>The user will select one of the five options:</p> <ul style="list-style-type: none"> • All Statuses – Includes In-Progress, Sent to Auth, Pending Auth and Completed payments • In-Progress – Includes In-Progress payments only • Sent to Auth – Includes Sent to Auth payments only • Pending Auth – Includes Pending Auth payments only

	<ul style="list-style-type: none"> Completed – Includes Completed payments only
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2. **All Awards as Authorizer**– This report returns all awards the requesting user worked on as an authorizer. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
State Date . . .	A drop-down calendar is displayed for the user to select the beginning date of the report
End Date . . .	A drop-down calendar is displayed for the user to select the end date of the report
All Refund Types	<p>The user will select one of the three options:</p> <ul style="list-style-type: none"> All Refund Types – Includes Medicare and Canadian payments Medicare – Includes Medicare payments only Canadian – Includes Canadian payments only
All Statuses	<p>The user will select one of the five options:</p> <ul style="list-style-type: none"> All Statuses – Includes In-Progress, Sent to Auth, Pending Auth and Completed payments In-Progress – Includes In-Progress payments only Sent to Auth – Includes Sent to Auth payments only Pending Auth – Includes Pending Auth payments only

	<ul style="list-style-type: none"> Completed – Includes Completed payments only
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3. **Refunds by Claim #** - This report returns all awards for the claim number entered. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Claim #	The user will enter the Medicare claim number for which they want the report
All Refund Types	<p>The user will select one of the three options:</p> <ul style="list-style-type: none"> All Refund Types – Includes Medicare and Canadian payments Medicare – Includes Medicare payments only Canadian – Includes Canadian payments only
All Statuses	<p>The user will select one of the five options:</p> <ul style="list-style-type: none"> All Statuses – Includes In-Progress, Sent to Auth, Pending Auth and Completed payments In-Progress – Includes In-Progress payments only Sent to Auth – Includes Sent to Auth payments only Pending Auth – Includes Pending Auth payments only Completed – Includes Completed payments only

4. **Refunds B. SSN** - This report returns all awards for the social security number entered. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Social Security #	The user will enter the social security number for which they want the report
All Refund Types	<p>The user will select one of the three options:</p> <ul style="list-style-type: none"> • All Refund Types – Includes Medicare and Canadian payments • Medicare – Includes Medicare payments only • Canadian – Includes Canadian payments only
All Statuses	<p>The user will select one of the five options:</p> <ul style="list-style-type: none"> • All Statuses – Includes In-Progress, Sent to Auth, Pending Auth and Completed payments • In-Progress – Includes In-Progress payments only • Sent to Auth – Includes Sent to Auth payments only • Pending Auth – Includes Pending Auth payments only • Completed – Includes Completed payments only

The following is how to run each report in the Medicare Division section of the drop-down menu. These reports are only accessible by users with supervisor or admin status:

1. **Address Verification** – This report returns the addresses for all completed cases within the date range specified by the user. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Calendar: MM	A drop-down menu of the months numbered 01-12 is displayed for the user to select the report month
Calendar: YYYY	A drop-down menu of the years is displayed for the user to select the report for that year
Fiscal Year	A drop-down menu of the fiscal years is displayed for the user to select the report for that fiscal year

2. **Monthly Report** – This report returns the One Payment Only Awards count for the month selected by the user. The report returns the results for each fund code category and a total for all fund codes. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Calendar: MM	A drop-down menu of the months numbered 01-12 is displayed for the user to select the report month

3. **Output by Fund** – This report returns the number of cases completed, authorized and returned for correction for each examiner/authorizer. The report returns results for a specific month and year or fiscal year. A separate report is shown for each fund code. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Calendar: MM	A drop-down menu of the months numbered 01-12 is displayed for the user to select the report month
Calendar: YYYY	A drop-down menu of the years is

	displayed for the user to select the report for that year
Fiscal Year	A drop-down menu of the fiscal years is displayed for the user to select the report for that fiscal year
All Fund Codes	<p>A drop-down menu of the fund codes is displayed for the user to select from. There are nine options:</p> <ul style="list-style-type: none"> • SMIA • SMID • SMIL • IRAA • IRAD • DIRM • CREF • DREF • SMIC

4. **Refunds Paid on MM/YYYY** – This report returns a list of the payments made for a specific month and year or fiscal year for the selected refund type, user and fund code. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Calendar: MM	A drop-down menu of the months numbered 01-12 is displayed for the user to select the report month
Calendar: YYYY	A drop-down menu of the years is displayed for the user to select the report for that year
Fiscal Year	A drop-down menu of the fiscal years is displayed for the user to select the

	report for that fiscal year
All Refund Types	<p>The user will select one of the three options:</p> <ul style="list-style-type: none"> • All Refund Types – Includes Medicare and Canadian payments • Medicare – Includes Medicare payments only • Canadian – Includes Canadian payments only
All Users	<p>A drop-down menu of all the users in the Medicare Payment System is displayed for the user to select from. The user can also select All Users to return results for all users in MPS.</p>
All Fund Codes	<p>A drop-down menu of the fund codes is displayed for the user to select from. There are nine options:</p> <ul style="list-style-type: none"> • SMIA • SMID • SMIL • IRAA • IRAD • DIRM • CREF • DREF • SMIC

5. **Refunds by Status** – This report will return a list of the refund status of payments with the selected refund type, status and fund code for the selected date range. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Start Date . . .	A drop-down calendar is displayed for the user to select the beginning date of the report
End Date . . .	A drop-down calendar is displayed for the user to select the end date of the report
All Refund Types	<p>The user will select one of the three options:</p> <ul style="list-style-type: none"> • All Refund Types – Includes Medicare and Canadian payments • Medicare – Includes Medicare payments only • Canadian – Includes Canadian payments only
All Statuses	<p>The user will select one of the five options:</p> <ul style="list-style-type: none"> • All Statuses – Includes In-Progress, Sent to Auth, Pending Auth and Completed payments • In-Progress – Includes In-Progress payments only • Sent to Auth – Includes Sent to Auth payments only • Pending Auth – Includes Pending Auth payments only • Completed – Includes Completed payments only
All Fund Codes	A drop-down menu of the fund codes is displayed for the user to select from. There are nine options:

	<ul style="list-style-type: none"> • SMIA • SMID • SMIL • IRAA • IRAD • DIRM • CREF • DREF • SMIC
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6. **Refunds by Exam/Auth** – This report lists all the payments made by examiner/authorizer for a user-specified time frame. It includes the number of refunds created, completed and authorized and the associated dollar amounts for all payments created and completed within the user-specified time frame. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Start Date . . .	A drop-down calendar is displayed for the user to select the beginning date of the report
End Date . . .	A drop-down calendar is displayed for the user to select the end date of the report
All Users	A drop-down menu of all the users in the Medicare Payment System is displayed for the user to select from. The user can also select All Users to return results for all users in MPS.

7. **Refund Amt Totals by Fund** – This report lists the number of payments and associated dollar amount for each fund code for the specified time frame. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Start Date . . .	A drop-down calendar is displayed for the user to select the beginning date of the report
End Date . . .	A drop-down calendar is displayed for the user to select the end date of the report

8. **Refunds by DAISY Status** – This report lists all DAISY payments for the specified time frame. The results are sortable by DAISY status. The user will enter information in the requested fields and hit the Run Report button to display the results.

FIELD	ENTRY
Start Date. . .	A drop-down calendar is displayed for the user to select the beginning date of the report
End Date. . .	A drop-down calendar is displayed for the user to select the end date of the report
All Payments	<p>The user will select from three options on the drop-down menu:</p> <ul style="list-style-type: none"> • All Payments • DAISY Approved Payments Only • DAISY Rejected Payments Only

3.13.89 Entering a Medicare Beneficiary or Survivor Payment on MPS

Payments made via the Medicare Payment System can only be made when a valid RRB claim number exists on MOLI or, in the case of survivor refunds, a valid SMIB application on APPLE. All payments paid via MPS are issued as One Pay Only (OPO) awards.

Once a Medicare examiner has determined that a Medicare payment should be made, the user will enter MPS through the link on Boardwalk.

Follow the instructions below for each screen to enter a payment for a Medicare Beneficiary or Survivor:

A. Welcome Screen

STEP	ACTION
1	Click the Add New button to add a new payment

B. Add New Screen

STEP	ACTION										
1	Select the Payment type:										
	<table> <tr> <th>If the payment is for...</th><th>Then choose...</th></tr> <tr> <td>A living Medicare beneficiary</td><td>Medicare Beneficiary</td></tr> <tr> <td>A deceased Medicare beneficiary with a living spouse on MOLI</td><td>Medicare Beneficiary</td></tr> <tr> <td>A deceased Medicare beneficiary with survivor(s) with SMIB APPLE application(s)</td><td>Survivor</td></tr> <tr> <td>A Canadian Part A claim (instructions for Canadian payments will be covered in the next section)</td><td>Canadian</td></tr> </table>	If the payment is for...	Then choose...	A living Medicare beneficiary	Medicare Beneficiary	A deceased Medicare beneficiary with a living spouse on MOLI	Medicare Beneficiary	A deceased Medicare beneficiary with survivor(s) with SMIB APPLE application(s)	Survivor	A Canadian Part A claim (instructions for Canadian payments will be covered in the next section)	Canadian
If the payment is for...	Then choose...										
A living Medicare beneficiary	Medicare Beneficiary										
A deceased Medicare beneficiary with a living spouse on MOLI	Medicare Beneficiary										
A deceased Medicare beneficiary with survivor(s) with SMIB APPLE application(s)	Survivor										
A Canadian Part A claim (instructions for Canadian payments will be covered in the next section)	Canadian										
2	Enter the Medicare claim number in the search box and hit the Search button										
	Once a valid claim number is found, the Add New screen becomes the Payment screen. If no valid claim is found for the number entered, an error message will be displayed.										

C. Payment Screen

STEP	ACTION				
1	Enter the number of shares payable to the payee(s):				
	<table> <tr> <th>If...</th><th>Then...</th></tr> <tr> <td>There is one payee</td><td>Enter the number 1 in the # Shares box on the line for the applicable payee</td></tr> </table>	If...	Then...	There is one payee	Enter the number 1 in the # Shares box on the line for the applicable payee
If...	Then...				
There is one payee	Enter the number 1 in the # Shares box on the line for the applicable payee				

	There is more than one payee (e.g. APPLE survivor payments)	Enter the number of shares (almost always 1) in the # Shares box on the line for each applicable payee
2	Enter the total number of shares for the payment:	
	If...	Then...
	There is one payee	Enter the number 1 in the Total Shares box
	There is more than one payee	Enter the total number of shares for all payees NOTE: The total number of shares for survivor payments is equal to the number of eligible survivors. See the section on Payments Requiring Special Handling for further instruction on how to handle cases where not all survivors file an APPLE application.
3	Enter the first month in the payment calculation period in the box under Period (A) From (MM/YY). Enter the date in MM/YY format as indicated.	
4	Enter the last month in the payment calculation period in the box under Period (B) To (MM/YY). Enter the date in MM/YY format as indicated. The number of months in the period from (A) to (B) will calculate mechanically and prefill in the boxes under Actual (D) No. of Months and Required (G) No. of Months. NOTE: If the Premium Rate amounts in boxes (C) and (F) change for the period entered from (A) to (B), a new period must be added for each change. See step 5.	
5	Add a new period, if necessary. Click the Add button beneath the (J) Total box to add a new row. Return to step 3. NOTE: Payment periods must be added in chronological order, with the exception of arrearage offsets which may be entered in any order. This is to ensure the dates load into the code paragraphs on the letters correctly. Arrearage periods are automatically excluded from the letters. A Custom Paragraph will need to be added to notify the payee about any arrearage offsets.	
6	In the box under Actual (C) Premium Rate, enter the premium rate paid for the	

	calculation period entered in boxes (A) and (B). Do not include the dollar sign. The total amount paid for the period from (A) to (B) will calculate mechanically and prefill in the box under Actual (E) Amount.	
7	<p>In the box under Required (F) Premium Rate, enter the premium rate that should have been paid for the calculation period entered in boxes (A) and (B). Do not include the dollar sign. The total amount that should have been paid for the period from (A) to (B) will calculate mechanically and prefill in the box under Required (H) Amount.</p> <p>The difference in the amounts of boxes (E) and (H) for that row will be mechanically calculated and prefilled in the box under Refund (I) Difference. If the difference for that period does not result in a refund, the amount prefilled in box (I) will have a negative sign before it.</p>	
8	<p>If there is another payment period, click the Add button under the Total (J) box to add a new calculation row. Return to step 3 for the new calculation row.</p> <p>If a calculation row was added in error, click the Delete button at the end of that row to delete it.</p>	
9	Click the Add button next to Selected Fund Codes to open the fund code selection box.	
10	Select all fund codes included in the payment total from box (J) of the calculation section and indicate the payment amount for each fund as indicated below:	
	If. . .	Then. . .
	The fund code is included in the payment	<ul style="list-style-type: none"> Click on the Include checkbox next to that fund code Enter the payment amount for that fund in the Payment box If there are multiple fund codes, include the fund code splits in the Remarks box under the Selected Fund Codes area
	The fund code is not included in the payment	Do not check the Include box next to that fund and do not enter a payment amount
The payment total from box (J) of the calculation form prefills into the space		

	<p>next to Worksheet Total in the fund code selection box. The amount in the box next to Total in the fund code selection box updates mechanically as each fund payment is entered, The amounts in the Worksheet Total and Total boxes must match in order to accept the entries.</p> <p>Click Ok to accept the fund code(s) selection and payment allocation.</p>
11	Enter any remarks regarding the payment in the Remarks box under the Selected Fund Codes area. The remarks will display on the award form.
12	Click the Save button in the bottom tool bar to accept all entries made on the Payment screen. The message "SUCCESS: true TEXT:PAYMENT SAVED" should be displayed. Click OK.

D. Details Screen

STEP	ACTION	
1	Click the Details button at the top of the page to go to the Details screen.	
2	Select the beneficiary/payee(s):	
	If. . .	Then. . .
	There is one beneficiary/payee	That person is preselected; move to step 3.
	There is more than one beneficiary/payee	Click on the beneficiary/payee to select and move to step 3.
3	Click the Select Paragraphs button to open the code paragraph selection box.	
4	Select the applicable code paragraph(s) by clicking on the checkbox next to the description:	
	If. . .	Then. . .
	There is one reason for the payment	<p>Select one of the code paragraphs from 955A-9999S.</p> <p>NOTE: Code paragraph 9999S may be selected on its own or in addition to any of the code paragraphs from 955A-956J.</p>
	There is more than one reason for the payment	<p>Select code paragraph 9999S.</p> <p>NOTE: Since the payment periods</p>

		are mechanically inserted into the letters, choosing two code paragraphs from 955A-956J would load the same dates for both paragraphs and result in inaccurate letters.
5	Click the Add button to accept the code paragraph selection. The code paragraph number and title should show up under Paragraph and Title in the Letter section.	
6	Rearrange the paragraph order:	
	If. . .	Then. . .
	There is only one code paragraph	Skip to step 7.
	There is more than one code paragraph	Use the up and down arrow icons under Sort to move the code paragraph up or down, if desired.
7	Click the X icon under Remove to remove code paragraphs, if necessary.	
8	If there is more than one beneficiary/payee, repeat from step 2 for each.	
9	Click the Save button in the bottom tool bar to accept all entries made on the Details screen. The message "SUCCESS: true TEXT:SUCCESS" should be displayed. Click OK.	

E. Summary Screen

STEP	ACTION	
1	Click the Summary button at the top of the page to go to the Summary screen.	
2	Review the data for accuracy. If necessary, return to any of the previous screens to make corrections.	
3	Click the View Award button for a preview of the award form. Review for accuracy.	
4	Click the View Letters button for a preview of the letter. Review for accuracy.	
5	Click the Submit button in the bottom tool bar to submit the payment:	
	If. . .	Then. . .
	The payment was for less than	The payment requires no

	\$1000 and the user was not a trainee	authorization and will voucher with the next DAISY run. The message "Payment Complete- Payment has been completed" should be displayed.
	The payment is for more than \$1000, but less than \$5000; or the payment was for any amount entered by a user with trainee status	The payment will require authorization. The message "Payment Submitted- Payment has been submitted for authorization" should be displayed.
	The payment is for more than \$5000	The payment will require authorization by two separate authorizers. The message "Payment Submitted- Payment has been submitted for authorization" should be displayed.
6	Click the Dashboard button at the top of the page to return to the Dashboard.	

3.13.90 Entering a Canadian Part A Payment on MPS

MPS screens for completing Canadian payments are not yet available.

3.13.91 MPS Payments Requiring Special Handling

A. Multiple Survivor Payments With Missing/Incomplete APPLE Applications

Payments made to multiple APPLE survivors are completed on MPS in one transaction. If one or more of the survivors failed to complete their APPLE application(s), their portion of the payment must be set aside in case they complete the application later. Since MPS is set up to issue all portions of a survivor payment in the same transaction, special handling is required in these situations.

The examiner must determine the payment amounts due to each survivor, including those who have not filed applications. The portion(s) due to the survivor(s) who haven't completed their application(s) should be removed from the calculations on the Payment screen as a one month offset. The remaining portion(s) will be issued to the survivor(s) with completed applications. A note must be made in the Remarks section screen indicating that there is a portion of the payment remaining.

When and if the remaining survivor(s) complete their application(s), the payment(s) would be issued as a new transaction with the previous survivor's payments removed as an offset. A note should be entered in the Remarks. See the example below.

Example:

A deceased bene is due a refund for the period 1/16-3/16 at \$121.80 per month. The total refund due is \$365.40. There are three survivors but only two completed their APPLE applications for their portion of the payment. Each survivor's portion of the payment would be \$121.80. The Payment screen should be completed as usual but the Total Shares should be entered as 2 instead of 3, and the third survivor's payment of \$121.80 should be taken off as a one month offset. This will leave the remaining \$243.60 to be split between the two survivors who completed their applications. A note should be made in the Remarks section to indicate that the offset is due to a remaining survivor.

If the third survivor completes their APPLE application after the other payment has been completed, the same process should be used to issue their portion. The refund period should be entered as usual on the Payment screen, the Total Shares entered should be 1, and the payment amount of \$243.60 for the previous two survivors should be taken off as a one month offset. This will leave the \$121.80 due to the third survivor. The Remarks section should be notated accordingly.

B. Survivor Payment Paid to a Family Member in Pay Status With a MOLI Record

MPS is set up to issue the payment to the same beneficiary to whom it is due. If that beneficiary has died and the payment is payable to a family member in current pay status, that case requires special handling. Since the family member is in pay status, they do not need to fill out an APPLE application and the payment would be issued as a Medicare Beneficiary payment instead of a Survivor payment. When selecting the beneficiary to issue shares to on the Payment screen, the surviving family member should be chosen instead of the deceased beneficiary. Since this will make it look like the refund is in their name, instead of the deceased beneficiary's, a note must be made in the Remarks section noting that the refund was due to them as a survivor of the deceased bene.

NOTE: Since these are Medicare Beneficiary (not Survivor) payments, the payee information is prefilled from MOLI. This means the payee needs to have a MOLI record. If the payee does not have a MOLI record, see Part C below.

C. Survivor Payment Paid to a Family Member in Pay Status Without a MOLI Record

Payments of this type cannot be made at this time. Procedure will be updated as soon as it is available.

D. Survivor Payment with Less than Three Months of Premiums Payable

The Medicare Unit (MU) only develops for survivors if the payment amount is equal to three months' premiums or more. If the payment amount is less than three months' premiums and there is not an eligible family member in pay status, an examiner should fill out a G-363M on RRAILS and send it to Imaging. The MU would not develop for survivors and no further action would be taken.

If survivor(s) file later for the Medicare payment, the payment would be handled like a regular survivor payment. The examiner would use the calculations from the Imaged G-363M to fill in the calculations on the Payment screen.

E. Payments that Net to Zero

Sometimes a payment will be offset to zero by other amounts owed. In this situation, an examiner should fill out a G-363M on RRAILS and send it to Imaging as a record that it was handled. No further action would be necessary.

3.13.92 Modifying or Deleting Payments on MPS

Payments entered on the Medicare Payment System can be modified or deleted before they are sent to DAISY for payment. Payments are sent to DAISY the night they are submitted as completed. Therefore, completed payments must be reopened before the end of the business day they were entered if the user wishes to modify them.

Payments can only be modified or deleted by the examiner assigned to that case or a user with supervisor or admin status. After entering the Medicare Payment System, users should follow the instructions below to modify or delete payments.

A. Modifying an In-Progress/Sent to Auth/Pending Auth Payment

STEP	ACTION	
1	Click the My Dashboard button in the middle of the screen or the Dashboard button in the top menu bar. The Dashboard displays all the user's in-progress payments.	
2	Select status of payment to be modified:	
	If the payment is. . .	Then. . .
	In-Progress	Skip to step 3
	Sent to Auth	Click the Sent to Auth button or tab at the top of the screen
	Pending Auth	Click the Pending Auth button or tab at the top of the screen
3	Find the payment that needs to be modified. To find a payment, users can do any of the following: <ul style="list-style-type: none"> • Search for the payment by claim number, social security number, pseudo number or payment number using the Search box • Click on any of the headers in the results panel to sort the results by that 	

	criterion
4	Open the selected payment by clicking on the Open Payment button (indicated by a pencil icon) under Actions. The Payment screen will be displayed upon reopening the payment.
5	Modify the payment

B. Modifying a Completed Payment

Completed payments must be reopened by a user with supervisor or admin access. Users with examiner/authorizer/trainee access will need to contact their supervisor to reopen a completed payment.

Users with supervisor or admin access will follow the instructions below to reopen a completed payment for modification:

STEP	ACTION
1	Click the My Dashboard button in the middle of the screen or the Dashboard button in the top menu bar
2	Click the Completed button or tab near the top of the screen
3	Find the payment that needs to be modified. To find a payment, a user can do any of the following: <ul style="list-style-type: none"> • Search for the payment by claim number, social security number, pseudo number or payment number using the Search box • Click on any of the headers in the results panel to sort the results by that criterion
4	Reopen the selected payment by clicking on the Reopen Payment button (indicated by a round arrow icon) under Actions.
5	A message will be displayed asking to verify the action. Click Ok. This returns the payment to the In-Progress screen
6	Click the In-Progress button or tab near the top of the screen
7	Find the payment that needs to be modified using the same methods as step 3
8	Open the selected payment by clicking on the Open Payment button (indicated by a pencil icon) under Actions. The Payment screen will be displayed upon reopening the payment.
9	Modify the payment

C. Deleting a Payment

STEP	ACTION	
1	Click the My Dashboard button in the middle of the screen or the Dashboard button in the top menu bar	
2	Click on the button or tab that corresponds to the status of the payment being deleted: In-Progress, Sent to Auth, Pending Auth or Completed.	
3	<p>Find the payment that needs to be modified. To find a case, a user can do any of the following:</p> <ul style="list-style-type: none"> • Search for the payment by claim number, social security number, pseudo number or payment number using the Search box • Click on any of the headers in the results panel to sort the results by that criterion 	
4	Delete the payment	
	If the case is. . .	Then. . .
	In-Progress	Delete the payment by clicking on the Delete Payment button, indicated by a fire icon. A message will be displayed asking to verify the action. Click OK. The payment is now deleted.
	Sent to Auth	Request deletion from your supervisor. The supervisor must assign the payment to an authorizer and instruct the authorizer to return the payment to the examiner. The authorizer will click the Reopen Payment button (indicated by a circle arrow icon) to return the payment to In-Progress status. Once the payment has been returned it will be listed as In-Progress and can be deleted as indicated above.
	Pending Auth	Request deletion from the authorizer assigned to that payment. The authorizer will click the Reopen Payment button (indicated by a circle

		arrow icon) to return the payment to In-Progress status. Once the payment has been returned it will be listed as In-Progress and can be deleted as indicated above.
	Completed	Request deletion from your supervisor. The supervisor will click the Reopen Payment button (indicated by a circle arrow icon) to return the payment to In-Progress status. The user can then go back to step 2 to complete the deletion.

3.13.93 Assigning Authorizers/Reassigning Payments on MPS

Examiners assign cases to themselves automatically when they start a new payment. Once that payment is assigned to an examiner, no other examiner can complete that case unless it is reassigned. A user with supervisor or admin status can modify payments, but not submit them. Supervisors/Admins can assign authorizers to cases and change the examiner or authorizer already assigned to a case. Below are instructions on how cases are assigned and reassigned.

A. Assigning an Authorizer to a Payment

Once a payment has been Sent to Auth, it will be eligible for assignment to an authorizer. Payments that are Sent to Auth must be assigned to an authorizer for authorization before the payment is complete.

The supervisor/admin user will complete the following steps to assign an authorizer to a payment:

STEP	ACTION	
1	Enter the Medicare Payment System through the link on Boardwalk	
2	Click the Admin Settings button at the top of the Welcome page	
3	Select Assignment Management from the drop-down menu	
4	Find the payment(s) that need to be authorized by using one of the following methods:	
	To Find. . .	Then. . .
	A specific claim or payment number	Enter the claim or payment number in the Claim/Payment # box and hit

		the Search button
	All payments with Sent to Auth status	<p>Click the Status header at the top of the results panel. Results will be displayed in A-Z order. Clicking a second time will display the results in Z-A order. A third click will display the user's own cases at the top.</p> <p>Scroll to the payments with the Sent to Auth status.</p>
5	Select an Authorizer	
	If. . .	Then. . .
	Only one authorizer is needed for the payment	<p>Click on the drop-down menu under Authorizer #1 and select an authorizer. The message "[Name of Authorizer #1] has been assigned as AUTHORIZER1 on Payment # [number]" should be displayed.</p> <p>Note: Authorizer #1 must be a different user from the Examiner.</p>
	If two authorizers are needed	<p>Select authorizer #1 as indicated above, then click on the drop-down menu under Authorizer #2 and select another authorizer. The message "[Name of Authorizer #2] has been assigned as AUTHORIZER2 on Payment # [number]" should be displayed.</p> <p>NOTE: Authorizer #2 must be a different user from the Examiner and Authorizer #1.</p>
	Once an authorizer has been assigned to a payment, that payment will move from the Sent to Auth screen to the Pending Auth screen.	

B. Assigning a different Examiner/Authorizer to a Payment

If the original examiner is unable to complete their assigned payment, it can be reassigned to a new examiner.

The supervisor/admin user will complete the following steps to reassign an examiner or authorizer to a payment:

STEP	ACTION	
1	Enter the Medicare Payment System through the link on Boardwalk	
2	Click the Admin Settings button at the top of the Welcome page	
3	Select Assignment Management from the drop-down menu	
4	Find the payment(s) that need to be reassigned by using one of the following methods:	
	To Find. . .	Then. . .
	A specific claim or payment number	Enter the claim or payment number in the Claim/Payment # box and hit the Search button
	All results by a specific examiner or authorizer	Click the Examiner or Authorizer (#1 or #2) header at the top of the results panel. Results will be displayed in A-Z order. Clicking a second time will display the results in Z-A order. A third click will display the user's own payments at the top.
5	Click the drop-down name menu under Examiner or Authorizer (#1 or #2) and select the new Examiner or Authorizer. The message "[New Examiner/Authorizer Name] has been assigned as EXAMINER/AUTHORIZER on Payment #[number]" should be displayed.	

3.13.94 Authorizing Payments on MPS

All payments assigned to an authorizer for authorization will show up on the Pending Auth page for that user. To authorize a payment, an authorizer will complete the following steps:

STEP	ACTION
1	Enter the Medicare Payment System through the link on Boardwalk
2	Click the My Dashboard button
3	Click the Pending Auth button or tab

4	Find the payment that needs to be authorized. To find a payment, a user can do any of the following: <ul style="list-style-type: none"> Search for the payment by claim number, social security number, pseudo number or payment number using the Search box Click on any of the headers in the results panel to sort the results by that criterion 														
5	Click the Open Payment button under Action (indicated by a pencil icon) to open the payment for review (opens to the Payment screen)														
6	Verify that all entries on the Payment screen are correct:														
	<table> <tr> <th>If. . .</th><th>Then. . .</th></tr> <tr> <td>All entries are correct</td><td>Go to step 9</td></tr> <tr> <td>The incorrect beneficiary/payee or number of shares is entered</td><td>Check box number 1 under the Change Needed? heading</td></tr> <tr> <td>The incorrect number of Total Shares is entered</td><td>Check box number 2 to the right of the Total Shares box</td></tr> <tr> <td>There is a calculation error</td><td>Check box number 3 under the Add button in the calculation area</td></tr> <tr> <td>There is an error related to the fund code selection or allocation of funds</td><td>Check box number 4 next to the Selected Fund Codes area</td></tr> <tr> <td>There is an error in the Remarks</td><td>Check box number 5 next to the Remarks section</td></tr> </table>	If. . .	Then. . .	All entries are correct	Go to step 9	The incorrect beneficiary/payee or number of shares is entered	Check box number 1 under the Change Needed? heading	The incorrect number of Total Shares is entered	Check box number 2 to the right of the Total Shares box	There is a calculation error	Check box number 3 under the Add button in the calculation area	There is an error related to the fund code selection or allocation of funds	Check box number 4 next to the Selected Fund Codes area	There is an error in the Remarks	Check box number 5 next to the Remarks section
If. . .	Then. . .														
All entries are correct	Go to step 9														
The incorrect beneficiary/payee or number of shares is entered	Check box number 1 under the Change Needed? heading														
The incorrect number of Total Shares is entered	Check box number 2 to the right of the Total Shares box														
There is a calculation error	Check box number 3 under the Add button in the calculation area														
There is an error related to the fund code selection or allocation of funds	Check box number 4 next to the Selected Fund Codes area														
There is an error in the Remarks	Check box number 5 next to the Remarks section														
7	Complete the following steps to enter notes to the examiner regarding any errors: <ul style="list-style-type: none"> Click the Notes button on the right side of the screen to open the Notes menu Click +Note to open the notes selection box Check the box next to the appropriate error and/or enter a custom note in the text box (the check box next to Custom Note must be checked in order to type in the text box) Click the Add button to save the notes 														

	NOTE: Notes entered in the Notes section on the right side of the screen are only visible in MPS and will not appear on the award form	
8	Click the Save button in the bottom tool bar to accept all entries made on the Payment screen. The message "SUCCESS: true TEXT:PAYMENT SAVED" should be displayed. Click OK.	
9	Click the Details button at the top of the page to go to the Details page	
10	Verify that all entries on the Details screen are correct:	
	If. . .	Then. . .
	All entries are correct	Go to step 13
	The letter is incorrect	Check the box next to the Letter header
11	<p>Complete the following steps to enter notes to the examiner regarding any errors:</p> <ul style="list-style-type: none"> Click the Notes button on the right side of the screen to open the Notes menu Click +Note to open the notes selection box Check the box next to the appropriate error and/or enter a custom note in the text box (the check box next to Custom Note must be checked in order to type in the text box) Click the Add button to save the notes <p>NOTE: Notes entered in the Notes section on the right side of the screen are only visible in MPS and will not appear on the award form</p>	
12	Click the Save button in the bottom tool bar to accept all entries made on the Details screen. The message "SUCCESS: true TEXT:SUCCESS" should be displayed. Click OK.	
13	Click the Summary button at the top of the page to go to the Summary page	
14	<p>Verify that all information on the Summary screen is correct:</p> <ul style="list-style-type: none"> Click the View Letters button to see the letter Click the View Award button to see the award 	

15	Submit payment or return for corrections:	
	If. . .	Then. . .
	All entries are correct and no error boxes are checked	<p>Click the Approve button in the bottom tool bar to approve the payment.</p> <p>The message “Payment Complete-Payment has been completed” should display if no further authorization is required. Click Ok. The payment will voucher with the next DAISY run.</p> <p>If a second authorization is required, the message “Payment Submitted-Payment has been submitted for 2nd authorization” should display. The second authorizer will repeat the authorization process.</p>
	There are error boxes checked on the Payment or Details	Click the Return button in the bottom tool bar to return the payment to the examiner for correction. The payment will return to the examiner’s In-Progress screen.
	NOTE: The Return button only appears at the bottom of the Summary screen if one or more error boxes were checked on the Payment and/or Details screens.	
16	Click Cancel or the Dashboard button to return to the Dashboard	

3.13.95 Vouchering Awards on MPS

When an award has been authorized for payment, MPS assigns a voucher date and number and formats it into an award activity record that is passed to DAISY/CHICO.

The voucher date assigned is generally the date of the DAISY run in which the award will be processed. Awards are assigned voucher numbers based on the fund code.

The valid voucher numbers, by fund code, are:

FUND CODE	VOUCHER NUMBER
SMIA	216

SMID	217
SMIL	219
IRAA	222
IRAD	223
DIRM	224
CREF	213
DREF	214
SMIC	218

3.13.96 Voucher Rejects on MPS

If an award rejects in DAISY/CHICO, the payment can be reopened by a supervisor. Once it has been reopened, it will return to the originating user's In-Progress queue on MPS. The examiner can then correct the reject and resubmit for payment. The payment will also be listed as rejected in the Reports section of MPS. Users with supervisor or admin status can view the rejected payments by clicking on Refunds by DAISY Status in the Reports section.

If the rejected payment cannot be reopened, a new award must be established to pay the rejected amount. If a payment to multiple survivors is being paid and the entire award rejects, it can be reopened and the errors corrected. If the award is a partial reject, some survivors vouchered while others rejected, a new payment will need to be created for the rejected amount.

If the rejected award does not require revouchering, it should be deleted.

Appendices

Appendix A - MEDCOR Screen MCMM001 - Entries That Can Be Made

MEDCOR MENU SCREEN - SCREEN MCMM001

FIELD NAMES AND ENTRIES THAT CAN BE MADE

MEDCOR SCREEN	ENTRY
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FIELD NAME	
<u>UNIT</u>	<p><u>Entry is mandatory.</u> The entry in this field is carried over to all the MEDCOR main and subordinate activity screens and cannot be changed on the MEDCOR activity screens.</p> <p>Enter the appropriate unit as shown below:</p> <p><u>MS</u> examiners should enter HB1, HB2, HB3, HB4, HB5, HB6, HB6, HB7, HB8, HB9</p> <p><u>DSUBD</u>: Disability initial examiners should enter DPI, and disability post examiners should enter DPP.</p> <p><u>RBD and SBD</u>: Retirement examiners should enter BRB, survivor examiners should enter BSB, and other examiners in Operations should enter DOC.</p> <p><u>Field Offices</u> should enter BFS.</p> <p>RRB Helpline: HB5</p> <p>Internet: HB7</p> <p><u>Others</u> who have access to MOLI should enter SEE.</p>
<u>CLAIM NUMBER</u>	<p><u>Entry is not necessary when accessing Screen MCMU017 or MCMI018.</u> If a RRB claim number is entered, if an activity was added to MEDCOR, the claim number will be displayed as the first RRB claim number on Screen MCMU017 or MCMI018. If no claim number is entered, the first claim number on the pending or completed list will appear on Screen MCMU017 or MCMI018. If prefilled via the HotKey, entry can be spaced out.</p> <p><u>Entry is mandatory when accessing a MEDCOR main activity screen.</u> The entry in this field is carried over to all the MEDCOR main and subordinate activity screens and cannot be changed on the MEDCOR activity screens. If an incorrect entry was made and the activity was not added to MEDCOR, do not add the activity. Hit the clear key until you return to Screen MCMM001 and start over. If the activity was added to MEDCOR and not processed into MIRTEL, delete it and start over from Screen MCMM001. If the activity was added to MEDCOR and processed into MIRTEL, establish a MIRTEL record under the correct RRB claim number and consolidate the incorrect RRB claim number under the correct RRB claim number.</p> <p>In an entry is made, the RRB symbol, prefix and claim number</p>

	<p>should be entered. If 6 digit RRB claim number, precede with 3 zeros. The RRB symbol and prefix should be entered in the appropriate space, if necessary, space to the correct field. For example, the "M" in MA-123-45-6789 should be entered in the second space of the CLAIM NUMBER field.</p> <p>Blank blank, blank M, blank P, blank J, blank C, blank W, WC, blank X, blank K, KC, blank T and TC are valid RRB symbols.</p> <p>A, D or H are valid RRB prefixes. If the RRB symbol is equal to blank blank, blank C, blank M, blank J or blank X, then the RRB prefix must equal A.</p> <p>The RRB claim number should be numeric. A 9 digits RRB claim number cannot start with 729 or 000 and the 2 middle positions cannot be 00. A 6 digit RRB claim number with a prefix of A must be greater than 0 and less than 991274. A 6 digit RRB claim number with a prefix of D must be greater than 0 and less than 415936. A RRB claim number with a prefix of H must be greater than 0 and less than 049160.</p>
<u>BEN SSA NUMBER</u>	<p><u>Make no entry when accessing Screen MCMU017 or MCMI018.</u> If prefilled via the HotKey, space out the entry.</p> <p><u>The following applies when accessing a MEDCOR main activity screen:</u></p> <p><u>For employees:</u></p> <p>Make no entry.</p> <p><u>For non-employees:</u></p> <ul style="list-style-type: none"> • If ACTIVITY INPUT field on Screen MCMM001 is 11, 20, 21, 22, 32 or 34, enter beneficiary's social security account number (SSAN) if the beneficiary does not have a pseudo number. If beneficiary has a pseudo number and this field was prefilled via the HotKey, space out the entry. If no SSAN and no pseudo number, enter 999-99-9999. • If ACTIVITY INPUT field on Screen MCMM001 is 12, 13, 31 or 33, entry is mandatory. Enter beneficiary's SSAN. If no SSAN, enter 999-99-9999.

	<p>The SSAN cannot be the RRB claim number or the employee's SSAN. The SSAN should be numeric and cannot start with 729 or 000 and the 2 middle positions cannot be 00.</p> <p>The entry in this field is carried over to some of the MEDCOR main activity screens and cannot be changed on the MEDCOR main activity screens. If an incorrect entry was made and the activity was not added to MEDCOR, do not add the activity. Hit the clear key until you return to Screen MCMM001 and start over. If the activity was added to MEDCOR and not processed into MIRTEL, delete it and start over from Screen MCMM001. If the activity was added to MEDCOR and processed into MIRTEL, drop the MIRTEL record with the incorrect beneficiary's SSAN and establish a MIRTEL record with the correct beneficiary's SSAN. If a MIRTEL record exists but an incorrect beneficiary's SSAN is entered on Screen MCMM001, you will receive a reject message.</p>
<u>PSEUDO NUMBER</u>	<p><u>Make no entry when accessing Screen MCMU017 or MCMI018.</u> If prefilled via the HotKey, space out the entry.</p> <p><u>The following applies when accessing a MEDCOR main activity screen:</u></p> <p><u>For employees:</u></p> <p>Make no entry.</p> <p><u>For non-employees:</u></p> <ul style="list-style-type: none"> • If ACTIVITY INPUT field on Screen MCMM001 is 11, 20, 21, 22, 32, 34 or 62, enter the beneficiary's pseudo number if the beneficiary has a pseudo number and make no entry in BEN SSA NUMBER field on Screen MCMM001. • If ACTIVITY INPUT field on Screen is 12, 13, 31 or 33, enter the pseudo number if initially assigning a pseudo number or if a pseudo number was previously assigned. When the ACTIVITY INPUT field is 12 on Screen MCMU011, entry in the PSEUDO NUMBER field is limited to the Medicare Section (MS) personnel only. <p>The entry in this field is carried over to the MEDCOR main activity screens and cannot be changed on the MEDCOR main activity screens. If an incorrect entry was made and the activity was not added to MEDCOR, do not add the activity. Hit the clear key until you return to Screen MCMM001 and start over. If the</p>

	<p>activity was added to MEDCOR and not processed into MIRTEL, delete it and start over from Screen MCOMM001. If the activity was added to MEDCOR and processed into MIRTEL, establish a MIRTEL record under the correct pseudo number and consolidate the incorrect pseudo number under the correct pseudo number.</p> <p>The pseudo number cannot be the RRB claim number or the employee's SSAN. If the pseudo number is not a 6 digit number and the SSAN is not 999's, the pseudo number must be the beneficiary's SSAN. The pseudo number should be numeric and cannot start with 729 and the 2 middle positions cannot be 00. If 6 digit pseudo number, precede with three zeros and the 3 middle positions must be 995, 996, 997 or 998.</p>
<u>ACTIVITY INPUT</u>	<p><u>Make no entry when accessing Screen MCMU017 or MCMI018.</u></p> <p><u>Entry is mandatory when accessing a MEDCOR main activity screen.</u> If a subordinate screen is selected from one of the MEDCOR main activity screens, the entries in the ACTIVITY INPUT field on Screen MCOMM001 is carried over to the top of the subordinate screens and cannot be changed.</p> <p>Enter the number of the activity to be created. The following are valid activity numbers, who has access to the activities and information about the MIRTEL/MOLI to allow the activity to be accessed:</p> <p><u>ACT</u> <u>OTHER INFO</u></p> <p><u>11</u> <u>Miscellaneous Input</u></p> <p>MS examiners: all activities</p> <p>DSUBD examiners: 50, 51, 52, 60 and 61</p> <p>RBD/SBD examiners: 50, 51, 52, 60 and 61</p> <p>Field Offices: 62</p> <p>Others who have access to MOLI: 98 and 99</p> <p>If an 11 is entered, a MIRTEL/MOLI record should exist. When an 11 is entered, the user will be able to create 1 of the various miscellaneous input activities (former G-811).</p> <p><u>12</u> <u>Establish/Screen SS</u></p>

MS and RBD/SBD examiners

If a 12 is entered, a MIRTEL/MOLI record should not exist.

13 Establish Only

MS examiners

If a 13 is entered, a MIRTEL/MOLI record should not exist.

20 Internal Change

MS and RBD/SBD examiners

If a 20 is entered, a MIRTEL/MOLI record should exist; the MIRTEL/MOLI record status cannot be 01, 02, 03, 04, 05 or 98; the MIRTEL/MOLI Part B option cannot be 9; and the screening request code on MIRTEL/MOLI cannot be 2, 4, B or D.

21 Rescreen SS

MS examiners

If a 21 is entered, a MIRTEL/MOLI record should exist; the MIRTEL/MOLI record status cannot be 90, 98 or 99; and the MIRTEL/MOLI Part B option cannot be 9.

22 Internal Change/URIC

MS examiners

If a 22 is entered, a MIRTEL/MOLI record should exist; the MIRTEL/MOLI record status cannot be 01, 02, 03, 04, 05 or 98; the MIRTEL/MOLI Part B option cannot be 9; and the screening request code on MIRTEL/MOLI cannot be 2, 4, B or D.

31 Establish/Cross Refer SS

MS examiners

If a 31 is entered, a MIRTEL/MOLI record should not exist.

32 Correct/Cross Refer SS

	<p>MS examiners</p> <p>If a 32 is entered, a MIRTEL/MOLI record should exist; the MIRTEL/MOLI record status cannot be 90, 98 or 99; and the MIRTEL/MOLI Part B option cannot be 9.</p>
<u>33</u>	<p><u>Establish/Cross Refer RR</u></p> <p>MS examiners</p> <p>If a 33 is entered, a MIRTEL/MOLI record should not exist.</p>
<u>34</u>	<p><u>Correct/Cross Refer RR</u></p> <p>MS examiners</p> <p>If a 34 is entered, a MIRTEL/MOLI record should exist; the MIRTEL/MOLI record status cannot be 90, 98 or 99; and the MIRTEL/MOLI Part B option cannot be 9.</p>
<u>62</u>	<p><u>Generate Duplicate Medicare Card</u></p> <p>MS examiners and Field Offices</p> <p>If 62 is entered, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90, 98, or 99; the MIRTEL/MOLI Part B option must not be 9; and there must be an address on MIRTEL/MOLI or DATAQ.</p>

Appendix B - MEDCOR Screen MCMU011 - Entries That Can Be Made

MEDCOR MISCELLANEOUS INPUT SCREEN - SCREEN MCMU011

FIELD NAMES AND ENTRIES THAT CAN BE MADE

MEDCOR SCREEN FIELD NAME	ENTRY
<u>ACTIVITY</u>	<p>Entry is mandatory.</p> <p>Enter the number of the activity to be created. The following are valid activity numbers, who has access to the activities and information about the MIRTEL/MOLI to allow the activity to be accessed:</p>

ACT OTHER INFO05 Drop Record - MPS examiners06 Drop Record and RIC - MPS examiners

If 06 is entered, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90, 98 or 99; the MIRTEL/MOLI Part B option must not be 9; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

21 Rescreen - MPS examiners

If 21 is entered, the MIRTEL/MOLI record status cannot be 90, 98 or 99; the MIRTEL/MOLI Part B option cannot be 9; and there must be an address on MIRTEL/MOLI.

22 RIC - MPS examiners

If 22 is entered, the MIRTEL/MOLI record status cannot be 01, 02, 03, 04, 04 or 98; the MIRTEL/MOLI Part B option cannot be 9; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

23 Withdrawal - MPS examiners

If 23 is entered, the MIRTEL/MOLI record status must be 21, 22, 23, 24 or 31; the MIRTEL/MOLI Part B option must be 1 or 5; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

24 Withdrawal After SBI - MPS examiners

If 24 is entered, the MIRTEL/MOLI record status must be 21, 22, 23, 24 or 31; the MIRTEL/MOLI Part B option must be 1; there must be a State Buy-In deletion date on MIRTEL/MOLI; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

25 Option Change - MPS examiners

If 25 is entered and the EVENT CODE is 1, the MIRTEL/MOLI record status must be 11, 12 or 13; the MIRTEL/MOLI Part B option must be 2, 3, 4, or 6; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

If 25 is entered and the EVENT CODE is 2, the MIRTEL/MOLI record status must be 21, 22, 23, 24 or 31; the MIRTEL/MOLI Part B option must be 1; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

If 25 is entered and the EVENT CODE is 5, the MIRTEL/MOLI record status must be 11, 12 or 13; the MIRTEL/MOLI Part B option must be 2 or 3; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

If 25 is entered and the EVENT CODE is 8, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90, 98 or 99; the MIRTEL/MOLI Part B option must not be 8 or 9; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

26 Reverse Term for Non-Payment - MPS examiners

If 26 is entered, the MIRTEL/MOLI record status must be 11, 12 or 13; the MIRTEL/MOLI Part B option must be 4 or 6; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

27 GEP Enrollment - MPS examiners

If 27 is entered and the EVENT CODE is 1, the MIRTEL/MOLI record status must be 11, 12 or 13; the MIRTEL/MOLI Part B option must be 2, 3 or 4; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

If 27 is entered and the EVENT CODE is 2, the MIRTEL/MOLI record status must be 11, 12, 13, 21,

22, 23, 24 or 31; the MIRTEL/MOLI Part B option must be 1, 2, 3, 4 or 5; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

30 Transfer Util SSA-RRB - MPS examiners

If 30 is entered, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90, 98 or 99; the MIRTEL/MOLI Part B option must not be 9; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

32 Clear Juris and Trans UTIL SSA-RRB - MPS examiners

If 32 is entered, the MIRTEL/MOLI record status must not be 90, 98 or 99; the MIRTEL/MOLI Part B option must not be 9; and there must be an address on MIRTEL/MOLI or DATAQ.

34 Clear Juris and Trans UTIL RRB-RRB - MPS examiners

If 34 is entered, the MIRTEL/MOLI record status must not be 90, 98 or 99; the MIRTEL/MOLI Part B option must not be 9; and there must be an address on MIRTEL/MOLI or DATAQ.

35 Kill Credit RRB-RRB - MPS examiners

If 35 is entered, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90, 98 or 99; the MIRTEL/MOLI Part B option must not be 9; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

36 Kill Credit SSA-RRB - MPS examiners

If 36 is entered, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90, 98 or 99; the MIRTEL/MOLI Part B option must not be 9; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

50 Death - MPS examiners, DPS examiners and ORSP examiners

If 50 is entered, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90 or 98; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

51 Cessation of DIB - MPS examiners and DPS examiners

If 51 is entered, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90, 98 or 99; there must be an address on MIRTEL/MOLI or DATAQ; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

52 Loss of QRRB Status - MPS examiners, DPS examiners and ORSP examiners

If 52 is entered, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90, 98 or 99; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

60 Manual Award Stop Billing - MPS examiners, DPS examiners and ORSP examiners

If 60 is entered, the MIRTEL/MOLI record status must be 22, 23 or 24; the MIRTEL/MOLI Part B option must not be 9; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

61 Prevent Year End Billing - MPS examiners, DPS examiners and ORSP examiners

If 61 is entered, the MIRTEL/MOLI record status must be 23 or 24; the MIRTEL/MOLI Part B option must not be 9; and the screening request code on MIRTEL/MOLI cannot be 1, 2, 4, A, B or D.

62 Release ID Card - MPS examiners and Field Offices

If 62 is entered, the MIRTEL/MOLI record status must not be 01, 02, 03, 04, 05, 90, 98 or 99; the MIRTEL/MOLI Part B option must not be 9; and there must be an address on MIRTEL/MOLI or DATAQ.

98 Combined CHICO/MIRTEL Inquiry - MPS examiners

	and anyone who has access to MOLI																				
	<u>99</u> <u>Inquiry</u> - MPS examiners and anyone who has access to MOLI																				
<u>TYPE BENEFICIARY</u>	No entry allowed, the displayed data cannot be changed, unless the ACTIVITY is 25.																				
<u>DATE OF BIRTH</u>	No entry allowed, the displayed data cannot be changed.																				
<u>DATE OF BIRTH</u>	No entry allowed, the displayed data cannot be changed.																				
<u>SEX CODE</u>	No entry allowed unless the field is blank, the displayed data cannot be changed. If the SEX CODE field is blank, enter a "M" or "F".																				
<u>PSEUDO NUMBER</u>	No entry allowed, the displayed data cannot be changed.																				
<u>EVENT CODE</u>	<p>If the entry in the ACTIVITY field is a 05, 22, 26, 30, 32, 34, 35, 36, 52, 60, 61, 62, 98 or 99 make no entry.</p> <p>If the entry in the ACTIVITY field is 06, an entry can be made or the EVENT CODE field can be blank.</p> <p>If the entry in the ACTIVITY field is a 23, 24, 25, 27, 50 or 51, a valid entry must be made.</p> <p>The following are valid event codes that go with the applicable ACTIVITY code:</p> <table> <thead> <tr> <th><u>ACTIVITY</u></th><th><u>EVENT CODE</u></th></tr> </thead> <tbody> <tr> <td>06</td><td>9</td></tr> <tr> <td>23</td><td>3</td></tr> <tr> <td>24</td><td>4</td></tr> <tr> <td>25</td><td>1 YES</td></tr> <tr> <td></td><td>2 NO</td></tr> <tr> <td></td><td>5 GOOD CAUSE,</td></tr> <tr> <td></td><td>8 DUAL ANNUITANT</td></tr> <tr> <td>27</td><td>1 YES</td></tr> <tr> <td></td><td>2 NO</td></tr> </tbody> </table>	<u>ACTIVITY</u>	<u>EVENT CODE</u>	06	9	23	3	24	4	25	1 YES		2 NO		5 GOOD CAUSE,		8 DUAL ANNUITANT	27	1 YES		2 NO
<u>ACTIVITY</u>	<u>EVENT CODE</u>																				
06	9																				
23	3																				
24	4																				
25	1 YES																				
	2 NO																				
	5 GOOD CAUSE,																				
	8 DUAL ANNUITANT																				
27	1 YES																				
	2 NO																				

	50	6																		
	51	7																		
<u>EVENT DATE</u>	<p>If the entry in the ACTIVITY field is a 05, 22, 26, 30, 32, 34, 35, 36, 52, 60, 61, 62, 98 or 99 make no entry.</p> <p>If the entry in the ACTIVITY field is 06 with a 9 in EVENT CODE field, an entry must be made.</p> <p>If the entry in the ACTIVITY field is a 23, 24, 25, 27, 50 or 51, a valid entry must be made.</p> <p>The following are valid event codes that go with the applicable ACTIVITY code:</p> <table><tr><td><u>ACTIVITY</u></td><td><u>EVENT CODE</u></td><td><u>DATE</u></td></tr><tr><td>06</td><td>9</td><td></td></tr><tr><td>23</td><td>3</td><td>The date must be equal to or greater than the MIRTEL/MOLI Part B date; less than or equal to the current date and greater than the current date minus 2 years.</td></tr><tr><td>24</td><td>4</td><td>The date must be equal to or greater than the MIRTEL/MOLI Part B date; equal to or greater than the MIRTEL/MOLI State Buy-In deletion; and less than or equal to the MIRTEL/MOLI State Buy-In Deletion Accounting date plus 7 months.</td></tr><tr><td rowspan="2">25</td><td>1 YES</td><td>The date must be within the IEP period.</td></tr><tr><td>2 NO</td><td>The date must be within the IEP period.</td></tr></table>			<u>ACTIVITY</u>	<u>EVENT CODE</u>	<u>DATE</u>	06	9		23	3	The date must be equal to or greater than the MIRTEL/MOLI Part B date; less than or equal to the current date and greater than the current date minus 2 years.	24	4	The date must be equal to or greater than the MIRTEL/MOLI Part B date; equal to or greater than the MIRTEL/MOLI State Buy-In deletion; and less than or equal to the MIRTEL/MOLI State Buy-In Deletion Accounting date plus 7 months.	25	1 YES	The date must be within the IEP period.	2 NO	The date must be within the IEP period.
<u>ACTIVITY</u>	<u>EVENT CODE</u>	<u>DATE</u>																		
06	9																			
23	3	The date must be equal to or greater than the MIRTEL/MOLI Part B date; less than or equal to the current date and greater than the current date minus 2 years.																		
24	4	The date must be equal to or greater than the MIRTEL/MOLI Part B date; equal to or greater than the MIRTEL/MOLI State Buy-In deletion; and less than or equal to the MIRTEL/MOLI State Buy-In Deletion Accounting date plus 7 months.																		
25	1 YES	The date must be within the IEP period.																		
	2 NO	The date must be within the IEP period.																		

Appendix C - MEDCOR Main Activity Screens - Entries That Can Be Made

FIELD NAMES AND ENTRIES THAT CAN BE MADE

MEDCOR SCREEN

FIELD NAME ENTRYBENEFICIARY NAME

Display only on Screen MCMU020.

Entry not necessary on Screens MCMU012, MCMU013, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034.

If entry, the 1st name should be alpha in the 1st position, the 2nd through 12th position can be blank or alpha and no alpha after a blank space. The middle initial should be blank or alpha. The last name should be alpha in 1st position, the 2nd through 12th can be blank or alpha and no alpha after a blank space.

This field is not moved to the activity record.

RECORD STATUS: Entry is mandatory on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034.

If the RRB symbol is C, entry should be 02, 12, 22, 90, 98 or 99. If MIRTEL/MOLI record status is 11, 21 or 31 and the entry in RECORD STATUS is 12 or 22, Screen MCMU016 should also be completed.

Enter the appropriate record status code as shown below:

- 01 Annuity Application Filed - Jurisdiction Pending - enter only on Screens MCMU012 and MCMU021, if MIRTEL/MOLI's record status is 01, 02, 03, 04 or 05.
- 02 No Annuity Application Filed - Jurisdiction Pending - enter only on Screens MCMU012 and MCMU021, if MIRTEL/MOLI's record status is 01, 02, 03, 04 or 05.
- 03 Annuity in Suspense (Year-end Billing) - Jurisdiction Pending - enter only on Screens MCMU012 and MCMU021, if MIRTEL/MOLI's record status is 01, 02, 03, 04 or 05.
- 04 Annuity in Suspense (Quarterly Billing) - Jurisdiction Pending - enter only on Screens MCMU012 and MCMU021, if MIRTEL/MOLI's record status is 01, 02, 03, 04 or 05.
- 05 Attainment - Jurisdiction Pending - enter only on Screens MCMU012 and MCMU021, if MIRTEL/MOLI's record status is 01, 02, 03, 04 or 05.
- 11 Annuity Application Filed - Jurisdiction Cleared - enter only on Screens MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

In entry in PART B OPTION, the Part B option should be 2, 3, 4, 6, 8 or 9.

- 12 No Annuity Application Filed - Jurisdiction Cleared - enter only on Screens MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If entry in PART B OPTION, the Part B option should be 2, 3, 4, 6, 8 or 9.

- 13 Annuity in Suspense - Jurisdiction Cleared - No Billing Required - enter only on Screens MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If entry in PART B OPTION, the Part B option should be 2, 3, 4, 6, 8 or 9.

- 21 Annuity Application Filed - Jurisdiction Cleared - To Be Adjusted - enter only on Screens MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If entry in PART B OPTION, the Part B option should be 1, 5, A, B, C, or Z.

- 22 Medicare Only Application Filed or Annuity in CPS Without Sufficient Funds to Make Deductions - Jurisdiction Cleared - Direct Billing Required - enter only on Screens MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If entry in PART B OPTION, the Part B option should be 1, 5, A, B, C, or Z.

- 23 Annuity in Suspense - Jurisdiction Cleared - Year-end Billing Required - enter only on Screens MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If entry in PART B OPTION, the Part B option should be 1, 5, A, B, C, or Z.

- 24 Annuity in Suspense - Jurisdiction Cleared - Quarterly Billing Required - enter only on Screens MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If entry in PART B OPTION, the Part B option should be 1, 5, A, B, C, or Z.

- 31 Annuity in Force With Premium Deductions - Enter record status 21 if MIRTEL/MOLI record status is 31 and it is not changing. If MIRTEL/MOLI record status is 31 and it is being changed to 22, 23 or 24, entry should also be made in the PAID THRU DATE field.

- 90 Cessation of Disability - enter only on Screen MCMU022. If entry is 90, entry should also be made in the PART A TERM DATE field.

- 98 Loss of QRRB Status - enter only on Screen MCMU013

- 99 Death - enter only on Screens MCMU013, MCMU022, MCMU031 and MCMU032. If entry is 99, entry should also be made in the DATE OF DEATH field.

TYPE BENEFICIARY: Display only on Screen MCMU020, if blank or incorrect use Screen MCMU022.

Entry is mandatory on Screens MCMU012, MCMU013, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034. The entry in TYPE BENEFICIARY is linked with the RRB beneficiary symbol as indicated below:

<u>IF RRB SYMBOL</u>	<u>TYPE BENEFICIARY SHOULD BE</u>
bb	01, 11, 21
bM, bX	02, 12, 22
bW, bT, bK, bJ	03, 13, 23
WC, TC, KC	04, 14, 24
bP	05, 15, 25
bC, bX, bM	06, 16, 26

For all Screens, if the 1st position of entry in TYPE BENEFICIARY is 0 or 2, the calculated age must be equal to or greater the age 64 and 6 months.

For all Screens, if the 1st position of entry in TYPE BENEFICIARY is 1, the calculated age must be less than age 65.

For Screen MCMU032, the entry in TYPE BENEFICIARY does not have to match MIRTEL/MOLI's type beneficiary, it should be consistent with the entry in the HI DATE OF BIRTH field.

On Screens MCMU021, MCMU022 and MCMU034, the entry should be the same as on MIRTEL/MOLI unless MIRTEL/MOLI's record status is not 90 and the beneficiary is going from disabled to disabled now age 65, (the 1st position is changing from a 1 to a 2); or MIRTEL/MOLI record status is 90 and an age 65 enrollment is being processed (the 1st position can be changed from a 1 to a 0). In both situation, the name and date of birth on the activity must match what is on MIRTEL/MOLI.

Enter the appropriate type beneficiary code as shown below:

- 01 Employee, age 65
- 11 Employee, disabled
- 21 Employee, previously disabled now age 65
- 02 Spouse, age 65
- 12 Spouse, disabled
- 22 Spouse, previously disabled now age 65
- 03 Widow(er), age 65
- 13 Widow(er), disabled
- 23 Widow(er), previously disabled now age 65
- 04 Survivor child, age 65
- 14 Survivor child, disabled
- 24 Survivor child, previously disabled now age 65
- 05 Parent, age 65
- 15 Parent, disabled
- 25 Parent, previously disabled now age 65
- 06 IPI, age 65
- 16 IPI, disabled
- 26 IPI, previously disabled now age 65

SEX CODE: Display only on Screen MCMU020. If blank or incorrect, use Screen MCMU022.

Entry is mandatory on Screens MCMU012, MCMU013, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034. Enter the appropriate sex code, M for Male or F for Female. If an entry is made and the sex code is different from what is shown on MIRTEL/MOLI, the NAME and/or HI DATE OF BIRTH should match.

PYMT DATE OF BIRTH

Display only on Screen MCMU020. If blank or incorrect, use Screen MCMU022.

Entry is mandatory on Screens MCMU012, MCMU013, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034. Enter the enrollee's date of birth used to pay benefits. Entry should be numeric, format of month (01 - 12), day (01 - 31), century (18, 19 or 20) and year (00 - 99) and be greater than 12-1-1849.

If MIRTEL/MOLI has 00 in the day field, MEDCOR will display 15. If both month and day are 00, 00's will be displayed.

HI DATE OF BIRTH: Display only on Screen MCMU020. If blank or incorrect, use Screen MCMU022.

Entry is mandatory on Screens MCMU012, MCMU013, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034. Enter the enrollee's date of birth used to establish Medicare entitlement. Entry should be numeric, format of month (01 - 12), day (01 - 31), century (18, 19 or 20) and year (00 - 99) and be greater than 12-1-1849.

The entry in HI DATE OF BIRTH is used for all comparisons made during the edit process.

If the HI date of birth on MIRTEL/MOLI is changing, other than the day of birth from 00, name on Screen MCMU016 should match what is on MIRTEL/MOLI.

If MIRTEL/MOLI has 00 in the day field, MEDCOR will display 15. If both month and day are 00, 00's will be displayed.

PSEUDO NUMBER: Display only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034.

BEN SSA NUMBER: Display only on Screens MCMU012, MCMU013, MCMU021, MCMU031, and MCMU033.

EE SSA NUMBER: Entry is mandatory on Screens MCMU012, MCMU013, MCMU021, MCMU031 and MCMU033.

If RRB claim number is nine digits, MEDCOR will prefill on the activity screens. Otherwise, enter employee's SSAN or 999-99-9999's. If the RRB claim number is nine digits, the EE SSA NUMBER should be the same as the RRB claim number. The SSAN should be numeric, 1st 3 positions cannot equal 000 or 729 and the middle 2 positions cannot equal 00.

FORMER SS CL NO: Entry is optional on Screens MCMU012 and MCMU013.

Entry is mandatory on Screens MCMU021, MCMU031 and MCMU032.

The FORMER SS CL NO should be numeric, 1st 3 positions cannot be 000 or 729 and the middle 2 positions cannot be 00.

The FORMER SS CL NO suffix, can be 2 alpha characters or 1 alpha and 1 numeric characters.

The following are valid suffixes:

Ab

Bb, B1, B2, B3, B4, B5, B6, B7, B8, B9, BA, BD, BG, BH, BJ, BK, BL, BN, BP, BQ, BR, BT, BW, BY,

C1, C2, C3, C4, C5, C6, C7, C8, C9, CA, CB, CC, CD, CE, CF, CG, CH, CI, CJ, CK,

Db, D1, D2, D3, D4, D5, D6, D7, D8, D9, DA, DC, DD, DG, DH, DJ, DK, DL, DM, DN, DP, DQ, DR, DS, DT, DV, DW, DX, DW, DY, DZ,

Eb, E1, E2, E3, E4, E5, E6, E7, E8, E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM,

F1, F2, F3, F4, F5, F6, F7, F8,

J1, J2, J3, J4,

K1, K2, K3, K4, K5, K6, K7, K8, K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM,

Wb, W1, W2, W3, W4, W5, W6, W7, W8, W9, WB, WC, WF, WG, WJ, WR, WT,

Mb, M1,

Tb, T2, T3, T4, T5, T6, T7, T8, T9, TA, TB, TC, TD, TE, TF, TG, TH, TJ, TK, TL, TM, TN, TP, TQ, TR, TS, TT, TU, TV, TW, TX, TY, TZ

If an entry is made in FORMER SS CL NO, the following applies:

- If the former SSA suffix is Ab, HA, J1, J2, J3, J4, Mb, M1, Tb or TA; and the RRB ben symbol is blank, the FORMER SS CL NO should be the employee SSAN.
- If the former SSA suffix is not Ab, HA, J1, J2, J3, J4, Mb, M1, Tb or TA; and the RRB ben symbol is blank, the FORMER SS CL NO should not be the employee SSAN.
- If the former SSA suffix is Ab, HA, J1, J2, J3, J4, Mb, M1, Tb or TA; and the RRB ben symbol is not blank, the FORMER SS CL NO should be the beneficiary's SSAN.
- If the former SSA suffix is not Ab, HA, J1, J2, J3, J4, Mb, M1, Tb or TA; and the RRB ben symbol is not blank, the FORMER SS CL NO should not be the beneficiary's SSAN.
- If the former SSA suffix is Bb, B3, B4, B8, BA, BD, BG, BH, BJ, HB, TD, TG, TH, TJ or TK; and the RRB ben symbol is bM, the FORMER SS CL NO should be the employee's SSAN.

- If the RRB ben symbol is bC or WC and the FORMER SS CL NO is the employee's SSAN, the first position of former suffix should be C.
- If the beneficiary's sex is female, the FORMER SS CL NO cannot be the following:
 B1, B4, BG, BH, BJ, BR, BT, BW, BY,
 D1, D3, D5, DC, DH, DJ, DK, DM, DP, DQ, DR, DS, DT, DX, DZ,
 E4, E5, E6, E9, EF, EG, EH, EJ, EK, EM,
 F1, F3, F5, F7,
 TF,
 W1, W3, W5, WB, WG, WR, WT
- If the beneficiary's sex is male, the FORMER SS CL NO cannot be the following:
 B, B2, B3, B5, B6, B7, B8, B9, BA, BD, BK, BL, BN, BP, BQ,
 D, D2, D4, D6, D7, D8, D9, DA, DD, DF, DL, DN, DV, DW, DY,
 E, E1, E2, E3, E7, E8, EA, EB, EC, ED,
 F2, F4, F6, F8,
 W2, W4, W6, W7, W8, W9, WF, WJ

FORMER RR CL NO: Entry is mandatory on Screens MCMU033 and MCMU034.

If entry in FORMER RR CL NO, if 6 digit former RRB claim number, precede with 3 zeros. The former RRB symbol and former prefix should be entered in the appropriate space, if necessary, space to the correct field. For example, the "M" in MA-123-45-6789 should be entered in the second space of the FORMER RR CL NO field.

Blank, blank M, blank P, blank J, blank C, blank W, WC, blank X, KC, blank T and TC are valid former RRB symbols.

A, D or H are valid former RRB prefixes.

The former RRB claim number should be numeric. A 9 digits former RRB claim number cannot start with 729 or 000 and the 2 middle positions cannot be 00. A 6 digit former RRB claim number with a prefix of A must be greater than 0 and less than 991274 or greater than 994999. A 6 digit former RRB claim number with a prefix of D must be greater than 0 and less than 415936 or greater than 994999. A former RRB claim number with a prefix of H must be greater than 0 and less than 049160 or greater than 994999.

If the former RRB ben symbol is blank, bC, bM, BJ or bX the former RRB prefix must be A or H.

The former RRB claim number cannot be the RRB claim number.

ANN BEGIN DATE: For Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, if the record status is 02, 12 or 22, make no entry.

For Screen MCMU012, for a disabled or disabled now age type beneficiary other than a child, enter the ABD. For disabled or disabled now age children, if an entry is made in 1ST FULL MO DIS, enter the ABD. If the TYPE BENEFICIARY is age 65 and the RECORD STATUS is 01, 03, 04, 05, 11, 13, 21, 23 or 24, the ABD can be entered. If the entry in PART B OPTION is Z, make no entry.

For Screens MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, if the type beneficiary is disabled or disabled now age 65, if an entry is made in 1ST FULL MO DIS, enter the ABD. If the TYPE BENEFICIARY is age 65 and the RECORD STATUS is 01, 03, 04, 05, 11, 13, 21, 23 or 24, the ABD can be entered. If the entry in PART B OPTION is Z, make no entry.

Entry should be numeric, format of month (01 - 12), century (19 or 20) and year (00 - 99) and be greater than 12-1934 and less than current date plus 3 months.

1ST FULL MO DIS: For Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, if the type beneficiary is age 65, make no entry.

For Screen MCMU012, for a disabled or disabled now age type beneficiary other than a child, enter the 1ST FULL MO DIS. For disabled or disabled now age children, if an entry is made in ANN BEGIN DATE, enter the 1ST FULL MO DIS. If the entry in PART B OPTION is Z, make no entry.

For Screens MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, if the type beneficiary is disabled or disabled now age 65, if an entry is made in ANN BEGIN DATE, enter the 1ST FULL MO DIS. If the entry in PART B OPTION is Z, make no entry.

Entry should be numeric, format of month (01 - 12), century (18, 19 or 20) and year (00 - 99) and be greater than 12-1934 and less than current date plus 3 months.

If type beneficiary is a disabled child, the entry should be less or equal to the current date minus 18 months. For other disabled type beneficiaries, the entry should be less than or equal to the current date minus 23 months.

PART A EFF DATE: For Screens MCMU012, MCMU013, MCMU031 and MCMU033, entry is mandatory.

For Screens MCMU021, MCMU022, MCMU032 and MCMU034, entry can be made.

Entry should be numeric, format of month (01 - 12), century (19 or 20) and year (00 - 99). If entry in PART A EFF DATE, an entry must also be made in the ID ISSUE CODE.

AGED PART A EFFECTIVE DATE:

Entry must be equal to or greater than 07-1966; and equal to or greater than age 65; and cannot be greater than the current date plus 6 months.

If the entry in PART B FILING DATE is an IEP DOF, the entry in PART A EFF DATE should be equal to the latest of the following: 07-1966 or the month the person attained age 65.

If the entry in PART B FILING DATE is an GEP DOF, DEEMED GEP DOF or there is no entry in PART B FILING DATE, the entry in PART A EFF DATE should be equal to or greater than the latest of the following: 07-1966 or the month the person attained age 65.

If the entry in PART B FILING DATE is not an IEP, GEP or DEEMED GEP, the entry in PART A EFF DATE must be equal to the latest of the following: 07-1966; or the month the person attained age 65; or if the DOF is less than 09-83 or RRB ben symbol is blank X, 12 months prior to the DOF; or if the DOF is greater than 08-83 and RRB ben symbol is not equal to blank X, 6 months prior to the DOF.

DISABILITY PART A EFFECTIVE DATE:

Entry must be equal to or greater than 07-1973; less than the month the beneficiary attained age 65; and cannot be greater than the current date plus 6 months.

If the entry in PART B OPTION is Z, the entry must be equal to or greater than the latest of: 07-1973 or the year and month in which age 20 is attained.

For disabled children:

- If there is an entry in ANN BEGIN DATE and 1ST FULL MO DIS, the entry must be equal to the latest of the following: 07-1973; or the year and month in which age 20 is attained; or ABD plus 24 months; or FFMD plus 24 months
- If there is no entry in the ANN BEGIN DATE and 1ST FULL MO DIS, the entry must be equal to or greater than the latest of the following: 07-1973 or the year and month in which age 20 is attained.

For other disabled type beneficiaries:

- If there is an entry in ANN BEGIN DATE and 1ST FULL MO DIS, the entry must be equal to the latest of the following: 07-1973; or ABD plus 24 months; or FFMD plus

29 months if FFMD is after 07-1972 or FFMD plus 30 months if FFMD is before 08-1972.

- If there is no entry in the ANN BEGIN DATE and 1ST FULL MO DIS, the entry must be equal to or greater than 07-1973.

PART A TERM DATE: For Screens MCMU013, MCMU020 and MCMU022, if the entry in RECORD STATUS is 90 or if MIRTEL/MOLI's record status is 90, entry is mandatory.

Entry should be numeric, format of month (01 - 12), century (19 or 20) and year (00 - 99) and be equal to or greater than the Part A effective date and less than current date plus 2 months.

XXXXXX's can be entered on Screen MCMU020 if the Part A termination date on MIRTEL/MOLI is greater than the current date. XXXXXX's can be entered on Screen MCMU022 if the Part A termination date on MIRTEL/MOLI is equal to or less than the current date. If XXXXXX's are entered in PART A TERM DATE, MIRTEL/MOLI's record status must be 90; the entry in the RECORD STATUS must be 11, 12, 13, 21, 22, 23 or 24; and the entry in the ID ISSUE CODE must be 2.

If a date is entered in PART A TERM DATE, the entry in the RECORD STATUS must be 90. If entry in the PART A TERM DATE, the entry in the PART B OPTION must be what is on MIRTEL/MOLI.

No entry allowed on Screen MCMU013.

PART B FILING DATE

For Screens MCMU012, MCMU013, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034: If the entry in PART B OPTION is A, B, C, Z, 4, 6, 8 or 9, make no entry. If the entry in PART B OPTION is 3, 1 or 5, an entry can be made.

Entry should be numeric, format of month (01 - 12), century (19 or 20) and year (00 - 99); if aged, be greater than 08-1965; if disabled, be greater than 03-1973; and not greater than the current date plus 5 months unless it is equal to 01, 02 or 03 of the current year plus one.

VALID AGED IEP DATE OF FILING:

If age 65 after 02-1966, the DOF must be after age 64 plus 8 months and before age 65 plus 4 months.

If age 65 before 03-1966, the DOF must be after 08-1966 and before 10-1966.

VALID AGED GEP DATE OF FILING:

If age 65 before 03-1966 and DOF is after 09-1966; or age 65 after 02-1966 and before 12-1967 and the DOF is after age 65 plus 3 months, the DOF must be equal to 10-

1967, 11-1967, 12-1967, 01-1968, 02-1968, 03-1968, 04-1981, 05-1981, 06-1981, 07-1981, 08-1981, 09-1981, or 01, 02, 03 of a year greater than 1968 through the current year.

If age 65 after 11-1967 and DOF is after age 65 plus 3 months, the DOF must be equal to: 04-1981, 05-1981, 06-1981, 07-1981, 08-1981, 09-1981, or 01, 02, 03 of a year greater than 1968 through the current year.

VALID AGED DEEMED GEP DATE OF FILING:

For Screen MCMU012 only, if age 65 and DOF is after age 65 plus 3 months, the DOF must be 01, 02, 03 of the current year plus 1.

VALID DISABILITY IEP DATE OF FILING:

DOF must be after Part A effective date less 4 months and before Part A effective date plus 4 months and before age 64 plus 9 months.

VALID DISABLED NOW AGE 65 IEP DATE OF FILING:

DOF must be after age 64 plus 8 months and before age 65 plus 4 months.

VALID DISABILITY GEP DATE OF FILING:

DOF must be after Part A effective date plus 3 months and before age 64 plus 9 months and be equal to 04-1981, 05-1981, 06-1981, 07-1981, 08-1981, 09-1981, or 01, 02, 03 of a year greater than 1973 through the current year.

VALID DISABLED NOW AGE 65 GEP DATE OF FILING:

DOF must be after age 65 plus 3 months and be equal to 04-1981, 05-1981, 06-1981, 07-1981, 08-1981, 09-1981, or 01, 02, 03 of any year through the current.

EQ RELIEF ENROLL For Screens MCMU012 (MPS only), MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, if entry in PART B OPTION is A, B, C or z, entry is mandatory. Enter 1, 2, 3 or 4 as shown below:

<u>ENTER EQ RELIEF ENROLL</u>	<u>IF PART B OPTION</u>
1	A
2	B
3	C - 3rd or later enrollment - OMN

4	Z - disability 24 month not consecutive - ZZZ
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The data in the EQ RELIEF ENROLL field is not moved to the activity record.

GEP CODE: Display only on Screen MCMU020.

For Screen MCMU012, an entry may be made when the record status is 01, 02, 03 or 04. Valid entries are 4 or 5.

If 4 entered, yes election in current GEP, the PART B OPTION should be 1 or A, the PART B FILING DATE should be January, February or March of the current year, the PART B EFF DATE should be July of the current year and the ID ISSUE CODE should be 2 or 5.

If 5 entered, deemed GEP, the PART B OPTION should be 1, the PART B FILING DATE should be January, February or March of the current year plus 1, the PART B EFF DATE should be July of the current year plus 1 and the ID ISSUE CODE should be 2 or 5.

The data in GEP CODE is not moved to the activity record.

PART B OPTION: Entry is mandatory on Screens MCMU012, MCMU013, MCMU031 and MCMU033.

Entry is optional on Screens MCMU020, MCMU021, MCMU022, MCMU032 and MCMU034.

Valid entries are:

- 2 No Response - enter only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If 2 entered, make no entries in the EQ RELIEF ENROLL, PART B EFF DATE and PART B PREM RATE fields. On Screen MCMU012, do not enter the GEP CODE.

- 3 Refusal - enter only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If 3 entered, make no entries in the EQ RELIEF ENROLL, PART B EFF DATE and PART B PREM RATE fields. On Screen MCMU012, do not enter the GEP CODE.

- 1 1st Enrollment - enter only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If 1 entered, make entries in the PART B EFF DATE and PART B PREM RATE fields.

- A 1st Enrollment/Good Cause - enter only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If A entered, make entries in the EQ RELIEF ENROLL, PART B EFF DATE and PART B PREM RATE fields.

- 4 1st Termination - enter only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If 4 entered, make entries in the PART B EFF DATE, PART B PREM RATE, PART B TERM DATE and PART B TERM CODE fields. For Screen MCMU021, MIRTEL/MOLI must has a Part B termination date.

- 5 2nd Enrollment - enter only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If 5 entered, make entries in the PART B EFF DATE and PART B PREM RATE fields.

- B 2nd Enrollment/Good Cause - enter only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If B entered, make entries in the EQ RELIEF ENROLL, PART B EFF DATE and PART B PREM RATE fields.

- 6 2nd Termination - enter only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If 6 entered, make entries in the PART B EFF DATE, PART B PREM RATE, PART B TERM DATE and PART B TERM CODE fields. For Screen MCMU021, MIRTEL/MOLI must has a Part B termination date.

- 8 State Buy-in - enter only on Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034

If 8 entered, make entries in the PART B EFF DATE, PART B PREM RATE and SBI ACC DATE fields.

- 9 Dual Annuitant - enter only on Screen MCMU013

- C 3rd or Subsequent Enrollment - enter only on Screens MCMU013

If C entered, make entries in the EQ RELIEF ENROLL, PART B EFF DATE and PART B PREM RATE fields.

Z Enrollment based on disability/months not consecutive - enter only on Screens MCMU012

If Z entered, make entries in the EQ RELIEF ENROLL, PART B EFF DATE and PART B PREM RATE fields.

PART B EFF DATE: For Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU033 and MCMU034: If entry in PART B OPTION is 2, 3 or 9, make no entry. If entry in PART B OPTION is 1, A, 4, 5, B, 6, 8, C or Z, entry is mandatory.

Entry should be numeric and format of month (01 -12), century (19 or 20) and year (00 - 99).

AGED PART B EFFECTIVE DATE

The entry must be greater than 06-1966 and less than the current date plus 6 months, unless the entry is equal to 07 of the current year plus 1 year.

If the entry in PART B OPTION is 4, 8 or A the entry must be equal to or greater than the month and year the beneficiary attained age 65.

If the entry in PART B OPTION is 6, B or C, the entry must be equal to or greater than the month and year the beneficiary attained age 65 plus 6 months.

If the entry in PART B OPTION is 5:

- If the entry in PART B FILING DATE is 10-1967, 11-1967, 12-1967, 01-1968, 02-1968 or 03-1968, the entry must be 07-1968.
- If the entry in PART B FILING DATE is 04-1981, 05-1981, 06-1981, 07-1981, 08-1981 or 09-1981, the entry must be one of the following based on the entry in PART B FILING DATE:

<u>DOF</u>	<u>ENTER</u>
04-1981	07-1981
05-1981	08-1981
06-1981	09-1981
07-1981	10-1981

08-1981	11-1981
09-1981	12-1981

- If the entry in PART B FILING DATE is 01, 02 or 03 of a year after 1967, the entry must be July of the filing year.
- If there is no entry in PART B FILING DATE, the entry must be one of the following:
 - July of any year after 1967 greater than the date age 65 attained plus 6 months; or
 - 08-1981, 09-1981, 10-1981, 11-1981 or 12-1981, if the Part B effective date is greater than the date age 65 attained plus 6 months.

If the entry in PART B OPTION is 1 and the entry in PART B FILING DATE is during the IEP:

- If age 65 after 06-1966:

The entry must be one of the following based on the entry in the PART B FILING DATE:

DOF	ENTER
LESS THAN AGE 65	DATE AGE 65
DATE AGE 65	DATE AGE 65 PLUS 1 MONTH
DATE AGE 65 PLUS 1 MONTH	DATE AGE 65 PLUS 3 MONTHS
DATE AGE 65 PLUS 2 MONTHS	DATE AGE 65 PLUS 5 MONTHS
DATE AGE 65 PLUS 3 MONTHS	DATE AGE 65 PLUS 6 MONTHS

- If age 65 before 03-1966 and the DOF is after 08-1965 and before 06-1966; or age 65 after 02-1966 but before 07-1966 and the DOF is after age 64 plus 8 months and before age 65 plus 4 months, the entry must be 07-1966.
- If age 65 before 03-1966 and the DOF is after 05-1966 and before 10-1966, the entry must be one of the following based on the entry in the PART B FILING DATE:

DOF	ENTER
06-1966	12-1966
07-1966	01-1967
08-1966	02-1967
09-1966	03-1967

If the entry in PART B OPTION is 1 and the entry in PART B FILING DATE is during a GEP:

- If the entry in PART B FILING DATE is 10-1967, 11-1967, 12-1967, 01-1968, 02-1968 or 03-1968, the entry must be 07-1968.
- If the entry in PART B FILING DATE is: 04-1981, 05-1981, 06-1981, 07-1981, 08-1981 or 09-1981, the entry must be equal to one of the following based on the entry in the PART B FILING DATE:

DOF	ENTER
04-1981	07-1981
05-1981	08-1981
06-1981	09-1981
07-1981	10-1981
08-1981	11-1981
09-1981	12-1981

- If the entry in PART B FILING DATE is 01, 02 or 03 of a year after 1967, the entry must be July of the filing year.

If the entry in PART B OPTION is 1 and the entry in PART B FILING DATE is during a deemed GEP, the entry must be July of the current year plus one.

If the entry in PART B OPTION is 1 and there is no entry in PART B FILING DATE, the entry must be one of the following:

- If age 65 after 06-1966, the entry must be one of the following:

DATE AGE 65, or

DATE AGE 65 PLUS 1 MONTH, or

DATE AGE 65 PLUS 3 MONTHS, or

DATE AGE 65 PLUS 5 MONTHS, or

DATE AGE 65 PLUS 6 MONTHS, or

July of any year after 1967, or

08-1981, 09-1981, 10-1981, 11-1981, 12-1981, or

If SBI involvement, the entry must be equal to or greater than the month and year the beneficiary attained age 65

- If age 65 before 03-1966, the entry must be one of the following:

07-1966, or

12-1966, 01-1967, 02-1967, 03-1967, or

July of any year after 1967, or

08-1981, 09-1981, 10-1981, 11-1981, 12-1981, or

If SBI involvement, the entry must be equal to or greater than the month and year the beneficiary attained age 65d

- If age 65 after 02-1966 and before 07-1966, the Part B effective date must be one of the following:

07-1966, or

July of any year after 1967, or

08-1981, 09-1981, 10-1981, 11-1981, 12-1981, or

If SBI involvement, the entry must be equal to or greater than the month and year the beneficiary attained age 65

DISABILITY PART B EFFECTIVE DATE

The entry must be greater than 06-1973; and less than the current date plus 6 months; and less than age 65.

If the entry in PART B OPTION is 4, 8 or A the entry must be equal to or greater than the Part A effective date.

If the entry in PART B OPTION is 6, B or C, the entry must be equal to or greater than the Part A effective date plus 6 months.

If the entry in PART B OPTION is 5:

- If the entry in PART B FILING DATE is 04-1981, 05-1981, 06-1981, 07-1981, 08-1981 or 09-1981, the entry must be one of the following based on the entry in PART B FILING DATE:

DOF	ENTER
04-1981	07-1981
05-1981	08-1981
06-1981	09-1981
07-1981	10-1981
08-1981	11-1981
09-1981	12-1981

- If the entry in PART B FILING DATE is 01, 02 or 03 of a year after 1973, the entry must be July of the filing year.
- If there is no entry in PART B FILING DATE, the entry must be one of the following:
 July of any year after 1967 greater than the Part A effective date plus 6 months; or
 08-1981, 09-1981, 10-1981, 11-1981 or 12-1981, if the Part B effective date is greater than the Part A effective date plus 6 months.

If the entry in PART B OPTION is 1 and the entry in PART B FILING DATE is during the IEP, the entry must be one of the following based on the entry in the PART B FILING DATE:

DOF	ENTER
LESS THAN PART A DT	EQUAL PART A DT
PART A DT	PART A DT PLUS 1 MONTH
PART A DT PLUS 1 MONTH	PART A DT PLUS 3 MONTHS
PART A DT PLUS 2 MONTHS	PART A DT PLUS 5 MONTHS
PART A DT PLUS 3 MONTHS	PART A DT PLUS 6 MONTHS

If the entry in PART B OPTION is 1 and the entry in PART B FILING DATE is during a GEP:

- If the entry in PART B FILING DATE is: 04-1981, 05-1981, 06-1981, 07-1981, 08-1981 or 09-1981, the entry must be one of the following based on the entry in the PART B FILING DATE:

DOF	ENTER
04-1981	07-1981
05-1981	08-1981
06-1981	09-1981
07-1981	10-1981
08-1981	11-1981
09-1981	12-1981

- If the entry in PART B FILING DATE is 01, 02 or 03 of a year after 1973, the entry must be July of the filing year.

If the entry in PART B OPTION is 1 and there is no entry in PART B FILING DATE, the entry must be one of the following:

PART A DT, or

PART A DT PLUS 1 MONTH, or

PART A DT PLUS 3 MONTHS, or

PART A DT PLUS 5 MONTHS, or

PART A DT PLUS 6 MONTHS, or

July of any year greater than the Part A eff dt, or

08-1981, 09-1981, 10-1981, 11-1981, 12-1981, or

If SBI involvement, the entry must be equal to or greater than the Part A effective date

DISABILITY NOW AGE 65 PART B EFFECTIVE DATE: The entry must be greater than 06-1973; and less than the current date plus 6 months; and less than age 65.

If the entry in PART B OPTION is 4, 8 or A the entry must be equal to or greater than the Part A effective date.

If the entry in PART B OPTION is 6, B or C, the entry must be equal to or greater than the Part A effective date plus 6 months.

If the entry in PART B OPTION is 5:

- If the entry in PART B FILING DATE is 04-1981, 05-1981, 06-1981, 07-1981, 08-1981 or 09-1981, the entry must be one of the following based on the entry in PART B FILING DATE:

DOF	ENTER
04-1981	07-1981
05-1981	08-1981
06-1981	09-1981
07-1981	10-1981
08-1981	11-1981
09-1981	12-1981

- If the entry in PART B FILING DATE is 01, 02 or 03 of a year after Part A effective date, the entry must be July of the filing year.

- If there is no entry in PART B FILING DATE, the entry must be one of the following:

July of any year greater than the Part A effective date plus 6 months; or

08-1981, 09-1981, 10-1981, 11-1981 or 12-1981, if the Part B effective date is greater than the Part A effective date plus 6 months.

If the entry in PART B OPTION is 1 and the entry in PART B FILING DATE is during the disability IEP, the entry must be one of the following based on the entry in the PART B FILING DATE:

DOF	ENTER
LESS THAN PART A DT	EQUAL PART A DT
PART A DT	PART A DT PLUS 1 MONTH
PART A DT PLUS 1 MONTH	PART A DT PLUS 3 MONTHS
PART A DT PLUS 2 MONTHS	PART A DT PLUS 5 MONTHS
PART A DT PLUS 3 MONTHS	PART A DT PLUS 6 MONTHS

If the entry in PART B OPTION is 1 and the entry in PART B FILING DATE is during the aged IEP, the entry must be one of the following based on the entry in the PART B FILING DATE:

DOF	ENTER
LESS THAN AGE 65	DATE AGE 65
DATE AGE 65	DATE AGE 65 PLUS 1 MONTH
DATE AGE 65 PLUS 1 MONTH	DATE AGE 65 PLUS 3 MONTHS
DATE AGE 65 PLUS 2 MONTHS	DATE AGE 65 PLUS 5 MONTHS
DATE AGE 65 PLUS 3 MONTHS	DATE AGE 65 PLUS 6 MONTHS

If the entry in PART B OPTION is 1 and the entry in PART B FILING DATE is during a GEP:

- If the entry in PART B FILING DATE is: 04-1981, 05-1981, 06-1981, 07-1981, 08-1981 or 09-1981, the entry must be one of the following based on the entry in the PART B FILING DATE:

DOF	ENTER
04-1981	07-1981
05-1981	08-1981
06-1981	09-1981
07-1981	10-1981
08-1981	11-1981
09-1981	12-1981

- If the entry in PART B FILING DATE is 01, 02 or 03 of a year after 1973, the entry must be July of the filing year.

If the entry in PART B OPTION is 1 and there is no entry in PART B FILING DATE, the entry must be one of the following:

PART A DT, or

PART A DT PLUS 1 MONTH, or

PART A DT PLUS 3 MONTHS, or

PART A DT PLUS 5 MONTHS, or

PART A DT PLUS 6 MONTHS, or

DATE AGE 65, or

DATE AGE 65 PLUS 1 MONTH, or

DATE AGE 65 PLUS 3 MONTHS, or

DATE AGE 65 PLUS 5 MONTHS, or

DATE AGE 65 PLUS 6 MONTHS, or

July of any year greater than the Part A eff dt, or

08-1981, 09-1981, 10-1981, 11-1981, 12-1981, or

If SBI involvement, the entry must be equal to or greater than the Part A effective date

PART B PREM RATE or Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU031, MCMU032, MCMU033 and MCMU034, when the entry in PART B OPTION is 1, 4, 5, 6, 8, A, B or C, an entry is mandatory. Enter only a table rate (not a variable rate) in PART B PREM RATE.

For Screen MCMU022, when the entry in PART B OPTION is 1, 4, 5, 6, 8, A, B or C, an entry is mandatory. Enter the PART B PREM RATE, either a table or variable rate.

If the PART B OPTION is 8, the PART B PREM RATE should be the basic rate.

If Screen MCMU014 is completed, the PART B PREM RATE should be consistent with the CURR RESIDENCY CO, CURR VAR RATE CD and CURR PEN PERCENT. The entry in PART B PREMIUM RATE must be numeric and last position must be a 0. If the entry in the CURR VAR RATE CD is a N, the entry in PART B PREMIUM RATE must be the table rate indicated at the percent entered in CURR PEN PERCENT. If the entry in the CURR VAR RATE CD is a V, the entry in PART B PREMIUM RATE must be less than the table rate indicated at the percent entered in CURR PEN PERCENT.

PART B TERM DATE or Screens MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, if the PART B OPTION is 4 or 6; or the RECORD STATUS is 90; or MIRTEL/MOLI's record status is 90, an entry is mandatory.

Entry should be numeric, format of month (01 -12), century (19 or 20) and year (00 - 99) and be greater than 6-1966 and equal to or greater than the PART B EFF DATE.

On Screen MCMU020, XXXXXX's can be entered if the Part B termination date on MIRTEL/MOLI is in the future. On Screen MCMU022, XXXXXX's can be enter if the Part B termination date on MIRTEL/MOLI is equal to current date or past. If XXXXXX's are entered in PART B TERM DATE, the PART B OPTION should be 1, 5, A or B.

If Part B terminated for non-payment, the PART B TERM DATE should be greater than the PART B EFF DATE plus 3 months. If the Part B termination resulted from a withdrawal, if the PART B TERM DATE is greater than 8-1987, the PART B TERM DATE should be greater than the PART B EFF DATE plus 1 month, otherwise the PART B TERM DATE is always the last month of a calendar quarter. If Part B terminated because the enrollee is no longer disabled, the PART B TERM DATE should be greater than the current date.

PART B TERM CODE or Screens MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, if entry in the PART B TERM DATE and it is not XXXXXX's, entry is mandatory.

Enter 1, 2 or 3 as shown below:

1 - If Part B terminated for non-payment.

2 - Enrollee withdrew from Part B coverage.

3 - Medicare coverage terminated because the enrollee is no longer disabled.

The data in PART B TERM CODE is not moved to the activity record.

PAID THRU DATE For Screens MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, entry is optional.

Entry should be numeric, format of month (01 - 12), century (19 or 20) and year (00 - 99); be greater than 06-1966; cannot be less than the Part B effective date; and cannot be greater than the current table rate in the MIRTEL system.

XXXXXX's can be entered in PAID THRU DATE on Screen MCMU020 to remove the paid through date on MIRTEL.

If MOLI's record status is 31 and the entry in RECORD STATUS is 22, 23 or 24, an entry must be made in the PAID THRU DATE.

If the entry in PART B OPTION is 2, 3 or 8, make no entry.

If there is an entry in the SBI ACC DATE, the PAID THRU DATE cannot be less than the entry in the SBI ACC DATE.

If there is an entry in the DATE OF DEATH or the PART B TERM DATE, the PAID THRU DATE cannot be greater than the entry in those fields.

EXCESS PREMIUM: For Screens MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, entry is optional.

If entry and not XXXXXX's, the entry must be numeric (999.99); less than the Part B premium; and the entry in RECORD STATUS must be 22, 23 or 24.

XXXXXX's are allowed on Screens MCMU020 and MCMU022 if MIRTEL/MOLI has an excess amount and MIRTEL/MOLI's Part B option is not 2, 3, 8 or 9.

DELINQUENCY DATE or Screens MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, if the RECORD STATUS is 22, 23 or MEDCOR will calculate the delinquency date. If the RECORD STATUS is not 22, 23 or 24, MEDCOR will remove the delinquency date.

ARREARAGE DUE CODE

Display only on Screens MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034.

The data in the ARREARAGE DUE CODE field is not moved to the activity record.

SBI ACC DATE: For Screens MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, entry is optional.

Entry should be numeric, format of month (01 - 12), century (19 or 20) and year (00 - 99) and be equal to or less than current date plus 2 months.

If entry in SBI ACC DATE, the entry in PART B OPTION can be blank, 1, A or 8.

If aged, the entry in SBI ACC DATE should be equal to or greater than the date the beneficiary attains age 65. If disabled or disabled now age 65, the entry in SBI ACC DATE should be equal to or greater than the Part A effective date.

If MIRTEL/MOLI Part B option is 1 and the entry in PART B OPTION is 1, an entry must be made in the SBI ACC DATE and the SBI DEL DATE.

If the entry in PART B OPTION is a 1 and the SBI ACC DATE and SBI DEL DATE have entries, the entry in SBI ACC DATE must be equal to or less than the entry in the SBI DEL DATE.

If the entry in PART B OPTION is 8 and the SBI ACC DATE and SBI DEL DATE have entries, the entry in SBI ACC DATE must be equal to or greater than the entry in the SBI DEL DATE and the SBI DEL DATE must be equal to or greater than MIRTEL/MOLI's SBI accretion date.

SBI DEL DATE: For Screens MCMU013, MCMU020, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034, entry is optional.

Entry should be numeric, format of month (01 - 12), century (19 or 20) and year (00 - 99) and be equal to or less than current date plus 2 months.

If entry in SBI DEL DATE, the entry in PART B OPTION can be blank, 1, A or 8.

If MIRTEL/MOLI Part B option is 1 and the entry in PART B OPTION is 1, an entry must be made in the SBI ACC DATE and the SBI DEL DATE.

If MIRTEL/MOLI Part B option is 8 and MIRTEL/MOLI record status is less than 98, if the PART B OPTION is 1 or A, an entry must be in the SBI DEL DATE.

If the entry in PART B OPTION is 8 and the SBI ACC DATE and SBI DEL DATE have entries, the entry in SBI ACC DATE must be equal to or greater than the entry in the

SBI DEL DATE and the SBI DEL DATE must be equal to or greater than MIRTEL/MOLI's SBI accretion date.

PREV SBI ACC DATE

Display only on Screen MCMU020.

The data in the PREV SBI ACC DATE field is not moved to the activity record.

PREV SBI DEL DATE

Display only on Screen MCMU020

The data in the PREV SBI ACC DATE FIELD is not move to the activity record.

3RD PTY/PROT CODE

For Screens MCMU013, MCMU020, MCMU022, MCMU032, and MCMU034, entry is optional.

Valid entries are 01, 51, 52, 53, 54, 55, 56, 57, 58, 60, 61, 62, 63, 64, 66, 67, 69, 70, 98, 99.

If entry in 3RD PTY/PROT CODE is not 99, the entry in RECORD STATUS must be 22, 23, or 24. If entry in 3RD PTY/PROT CODE is 99, the entry in RECORD STATUS must be 21, 22, 23 or 24.

PAYEE CODE For Screens MCMU012, MCMU013, MCMU020, MCMU021, MCMU022, MCMU031, MCMU032, MCMU033 and MCMU034:

If the ben symbol is C; if the second position of the TYPE BENEFICIARY is 6; or if the record status is 02, 12, 22, 90, 98 or 99, make no entry in the PAYEE CODE field.

If the ben symbol is not C; if the second position of the TYPE BENEFICIARY is not 6; or if the record status is 01, 03, 04, 05, 11, 13, 21, 23 or 24, make entry. Valid entries are 1, 2, 3, 4, 5, 6, 7, 8 or 9.

If the ben symbol is blank blank, the PAYEE CODE must be 1. If the ben symbol is blank J, the PAYEE CODE must be a 2. If the ben symbol is blank M or blank X, the PAYEE CODE must not be a 1. Otherwise the PAYEE CODE may be 1 through 9.

ID ISSUE CODE For Screens MCMU012, MCMU013, MCMU031 and MCMU033, entry is mandatory.

For Screens MCMU012, MCMU020, MCMU021, MCMU022, MCMU032 and MCMU034, entry is optional.

Valid entries are:

1 G-41 Required

If 1 entered, the Screen must be MCMU012; the Part B effective date must be equal to or greater than 30 days; and the record status must be 01, 02, 03, 04 with a Part B option of 1 or A or the record status must be 05 with a Part B option of 1.

2 G-43 (Medicare Card) Required

If a 2 is entered, the record status cannot be 90, 98, or 99 and the Part B option cannot be 9.

3 G-41 Released

If a 3 is entered, the record status must be 01, 02, 03, or 04 and the Part B option must be 1 or A.

4 G-43 (Medicare Card) Part A Released

If a 4 is entered, the Part B option code must be 2, 3, 4, or 6. For Screen MCMU13, the Part B option code can also be 9.

5 G-43 (Medicare Card) Part A & B Released

If a 5 is entered, the Part B option must be 1, 5, 8, A, B or C.

If there is an entry in the PART A EFF DATE and/or PART B EFF DATE, the ID ISSUE CODE must have an entry.

DATE OF DEATH For Screens MCMU013, MCMU022 and MCMU031, entry is mandatory when the record status is 99.

Entry should be numeric, format of month (01 -12), day (01-31), century (19 or 20) and year (00 - 99); be greater than 06-1966; if aged, be greater than 06-01-1966; if disabled, be greater than 06-01-1973; be equal to or greater than the Part A effective date; and be equal to or less than the current date.

XXXXXXXX's are allowed on Screen MCMU022.

For Screen MCMU022, if entry and not XXXXXXXX's, the entry in RECORD STATUS must be 99. If XXXXXXXX's, if MIRTEL/MOLI's Part B option is 1 or 5, the entry in RECORD STATUS must be 21, 22, 23 or 24. If XXXXXXXX's, if MIRTEL/MOLI's Part B option is 2, 3, 4, 6, 8 or 9, the entry in RECORD STATUS must 11, 12 or 13.

Appendix D - MEDCOR Screen MCMU014

MEDCOR VARIABLE PART B SCREEN - SCREEN MCMU014

FIELD NAMES AND ENTRIES THAT CAN BE MADE

MEDCOR SCREEN FIELD NAME	ENTRY
<u>PART B PREMIUM RATE</u>	If Screen MCMU014 is added to Screen MCMU022, a valid entry must be made in the PART B PREMIUM RATE field and it must be consistent with the entries in the CURR RESIDENCY CD, CURR VAR RATE CD and CURR PEN PERCENT fields on Screen MCMU014. The entry in the PART B OPTION must also be 1, A, 4, 5, B, 6, C or 8. The entry in PART B PREMIUM RATE must be numeric and last position must be a 0. If the entry in the CURR VAR RATE CD is a N, the entry in PART B PREMIUM RATE must be the table rate indicated at the percent entered in CURR PEN PERCENT. If the entry in the CURR VAR RATE CD is a V, the entry in PART B PREMIUM RATE must be less than the table rate indicated at the percent entered in CURR PEN PERCENT.
<u>CURR RESIDENCY CD</u>	<p>If Screen MCMU014 is added to Screen MCMU022, a valid entry must be made in the CURR RESIDENCY CD field.</p> <p>Valid entries are:</p> <ul style="list-style-type: none"> • S - Standard Table • P - Puerto Rico Table • C - Commonwealth/Territory Table
<u>CURR VAR RATE CD</u>	<p>If Screen 14 is added to Screen MCMU022, a valid entry must be made in the CURR VAR RATE CD field.</p> <p>Valid entries are:</p> <ul style="list-style-type: none"> • V - Variable Rate • N - No Variable Rate

<u>CURR PEN PERCENT</u>	If Screen 14 is added to Screen MCMU022, a valid entry must be made in the CURR PEN PERCENT field. A valid entry must be numeric; the last position of entry must be 0; and the entry must be 000, 010, 020, 030, etc., through the maximum percent on the current premium rate table.
<u>CURR CAT EFF DATE</u>	If Screen 14 is added to Screen MCMU022, a valid entry must be made in the CURR CAT EFF DATE field. A valid entry should be numeric, format of month (01 - 12), century (19 or 20) and year (00 - 99) and be greater than 12-1988 and equal to or greater than the PART B EFF DATE. If the entry in CURR VAR RATE CD is V, the CURR CAT EFF DATE should be January of the current year.
<u>CURR VAR BASE RATE</u>	<p>If Screen 14 is added to Screen MCMU022 and if the CURR VAR RATE CD is V, a valid entry must be made in CURR VAR BASE RATE field.</p> <p>A valid entry must be numeric; and be equal to or greater 24.80; and be less than the current basic rate table of the year of the CURR CAT EFF DATE field and the last position must always be 0.</p>
<u>PREV PT B PREM RATE</u>	Previous Part B premium rate, display only.
<u>PREV RESIDENCY CD</u>	Previous residency code, display only.
<u>PREV VAR RATE CD</u>	Previous variable rate code, display only.
<u>PREV PEN PERCENT</u>	Previous penalty percent, display only.
<u>PREV CAT EFF DATE</u>	Previous catastrophic effective date, display only.
<u>PREV CAT ACCTG DATE</u>	Previous catastrophic effective date accounting date, display only.
<u>PREV VAR BASE RTE</u>	Previous variable base rate, display only.
<u>2ND PT B PREM RATE</u>	Second previous Part B premium rate, display only.
<u>2ND RESIDENCY CD</u>	Second previous residency code, display only.
<u>2ND VAR RATE CD</u>	Second previous variable rate code, display only.
<u>2ND PEN PERCENT</u>	Second previous penalty percent, display only.

<u>2ND CAT EFF DATE</u>	Second previous catastrophic effective date, display only.
<u>2ND CAT ACCTG DATE</u>	Second previous catastrophic effective date accounting date, display only.
<u>2ND VAR BASE RATE</u>	Second previous variable base rate, display only.
<u>3RD PT B PREM RATE</u>	Third previous Part B premium rate, display only.
<u>3RD RESIDENCE CD</u>	Third previous residency code, display only.
<u>3RD VAR RATE CD</u>	Third previous variable rate code, display only.
<u>3RD PEN PERCENT</u>	Third previous penalty percent, display only.
<u>3RD CAT EFF DATE</u>	Third previous catastrophic effective date, display only
<u>3RD CAT ACCTG DATE</u>	Third previous catastrophic effective date accounting date, display only.
<u>3RD VAR BASE RATE</u>	Third previous variable base rate, display only.

Appendix E - MEDCOR Screen MCMU015

MEDCOR PREVIOUS INFORMATION SCREEN - SCREEN MCMU015

FIELD NAMES AND ENTRIES THAT CAN BE MADE

MEDCOR SCREEN FIELD NAME	ENTRY
<u>PREV BEN SYM</u>	Previous beneficiary symbol, display only
<u>PREV RECORD STATUS</u>	Previous record status, display only
<u>PREV TYPE BEN</u>	Previous type beneficiary, display only
<u>PREV ABD</u>	Previous annuity beginning date, display only
<u>PREV 1ST FULL MO DIS</u>	Previous first full month of disability, display only
<u>PREV PART A TERM DATE</u>	Previous Part A termination date, display only
<u>PREV PART B OPT FILE DATE</u>	Previous Part B filing date, display only
<u>PREV PART B OPTION</u>	Previous Part B option, display only

<u>PREV PART B EFF DATE</u>	Previous Part B effective date, display only
<u>PREV PART B TERM DATE</u>	Previous Part B termination date, display only
<u>PREV PART B TERM CODE</u>	Previous Part B termination code, display only
<u>PREV PART B PREM RATE</u>	Previous Part B premium rate, display only
<u>ESR INDICATOR</u>	End Stage Renal Disease Indicator, future use
<u>REFERRAL CODE</u>	Referral Code, display only
<u>REFERRAL DATE</u>	Referral Date, display only
<u>PREV REFERRAL CODE</u>	Previous referral code, display only
<u>PREV REFERRAL DATE</u>	Previous referral date, display only
<u>SECTION/UNIT</u>	Section/Unit, display only
<u>ARREARAGE DUE AMOUNT</u>	Arrearage due amount, display only
<u>ARREARAGE DUE CODE</u>	Arrearage due code, display only
<u>YEAR END CODE</u>	Year end billing code, display only
<u>STOP BILL CODE</u>	Stop billing code, display only
<u>TYPE APPLICATION</u>	Type of application filed, display only

Appendix F - MEDCOR Screen MCMU016

MEDCOR ADDRESS SCREEN - SCREEN MCMU016

FIELD NAMES AND ENTRIES THAT CAN BE MADE

MEDCOR SCREEN FIELD NAME	ENTRY
<u>REP PAYEE CODE</u>	<p>If the beneficiary has a representative payee, make an entry. Valid entries are:</p> <p>1 - Court Appointed</p> <p>2 - Board Appointed</p>

	3 - Parent
<u>NAME</u>	Enter the beneficiary's name. If entry in REP PAYEE CODE, enter the beneficiary's representative name and the start of the 2nd or 3rd line of address should start with "For."
<u>NAME/ADDRESS</u>	<p>The group mark indicating the start of address must be at start of the 2nd, 3rd or 4th line. Only one group mark in address.</p> <p>Fields before group mark are the name segment and must be alpha. Fields after group mark are the address segment and could be alpha, numeric or "%" or "/".</p>
<u>NAME/ADDRESS</u> <u>ADDRESS</u> <u>ADDRESS</u> <u>ADDRESS</u>	

Appendix G - MEDCOR Error Messages

PROGRAM NAME IS MCDM001

01-M001	ENTER UNIT CODE.
02-M001	NO ACF2 CLEARANCE FOR MEDCOR.
03-M001	NO ACF2 CLEARANCE FOR ACT 12.
03A-M001	NO ACF2 CLEARANCE FOR ENTERING PSEUDO NO ON ACT 12.
04-M001	NO ACF2 CLEARANCE FOR ACT 13.
05-M001	NO ACF2 CLEARANCE FOR ACT 20.
06-M001	NO ACF2 CLEARANCE FOR ACT 21.
07-M001	NO ACF2 CLEARANCE FOR ACT 22.
08-M001	NO ACF2 CLEARANCE FOR ACT 31.
09-M001	NO ACF2 CLEARANCE FOR ACT 32.

10-M001	NO ACF2 CLEARANCE FOR ACT 33.
11-M001	NO ACF2 CLEARANCE FOR ACT 34.
12-M001	INVALID UNIT.
13-M001	INVALID UNIT.
14-M001	INVALID UNIT.
15-M001	INVALID UNIT.
16-M001	INVALID UNIT.
17-M001	INVALID UNIT.
18-M001	EMPLOYEE RECORD INDICATED, NO ENTRY IN BEN SSA NUMBER.
19-M001	EMPLOYEE RECORD INDICATED, NO ENTRY IN PSEUDO NUMBER.
20-M001	ENTRY NEEDED IN BEN SSA NUMBER AND/OR PSEUDO NUMBER.
20A-M001	ONLY ONE ENTRY ALLOWED, EITHER BEN SSA NUMBER OR PSEUDO NO, NOT BOTH.
21-M001	ENTRY NEEDED IN BEN SSA NUMBER.
22-M001	INVALID OR INCORRECT ACTIVITY CODE.
23-M001	MEDCOR RECORD EXISTS, DUPLICATE ACTIVITY NOT ALLOWED.
24-M001	INCORRECT ACTIVITY CODE - NO MOLI RECORD EXISTS.
25-M001	INVALID RECORD STATUS 01, 02, 03, 04 OR 05 FOR ACTIVITY.
26-M001	INVALID RECORD STATUS 90 OR 99 FOR ACTIVITY.
27-M001	INVALID SMI OPTION CODE 9 FOR ACTIVITY.
28-M001	INVALID RECORD STATUS 98 FOR ACTIVITY.
29-M001	INVALID RECORD STATUS 99 FOR ACTIVITY.
30-M001	INCORRECT ACTIVITY CODE - MOLI RECORD EXISTS.

PROCESS NAME IS MCDM001-RP-OTHER

01-O001	INVALID KEY.
02-O001	ENTER UNIT CODE.
03-O001	INVALID UNIT.
04-O001	SSA NUMBER MUST BE LEFT BLANK.
05-O001	PSEUDO NUMBER MUST BE LEFT BLANK.
06-O001	ACTIVITY INPUT MUST BE LEFT BLANK.

PROCESS NAME IS MCDU011-PM

PROCESS NAME IS MCDU011-RP-PF2

PF2-2	TO ADD, PRESS PF2 AGAIN.
PF2-02A	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-02B	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-03C	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF2-3	NOT ABLE TO ADD; ACT-11 SW NOT EQ Y OR N.
PF2-4	NOT ABLE TO ADD - DONT KNOW WHAT SCREEN TO RETURN TO.
PF2-5	INVALID OR INCORRECT ACTIVITY.
PF2-6	NO ACF2 SECURITY CLEARANCE FOR THIS ACTIVITY.
PF2-7	NO ACF2 SECURITY CLEARANCE FOR THIS ACTIVITY.
PF2-8	NO ACF2 SECURITY CLEARANCE FOR THIS ACTIVITY.
PF2-9	NO ACF2 SECURITY CLEARANCE FOR THIS ACTIVITY.
PF2-10	SEX CODE MUST BE -F- OR -M-.
PF2-11	INVALID DATE OF BIRTH - UNABLE TO PROCESS MISCELLANEOUS

	INPUT ACTIVITY.
PF2-12	TYPE BENEFICIARY CHANGE NOT ALLOWED.
PF2-13	INVALID DATE OF DEATH.
PF2-14	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-15	ACTIVITY INVALID OR INCORRECT FOR MOLI PART B OPTION.
PF2-16	ACTIVITY INVALID OR INCORRECT FOR MOLI RECOD STATUS.
PF2-17	ACTIVITY INVALID OR INCORRECT FOR MOLI PART B OPTION.
PF2-18	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-19	ACTIVITY INVALID OR INCORRECT FOR MOLI PART B OPTION.
PF2-20	INVALID OR INCORRECT EVENT CODE.
PF2-21	INVALID OR INCORRECT EVENT DATE.
PF2-22	UNABLE TO PROCESS MISCELLANEOUS ACTIVITY, NO PART B EFF DATE ON MOLI.
PF2-23	INVALID OR INCORRECT EVENT DATE.
PF2-24	INVALID OR INCORRECT EVENT DATE.
PF2-25	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-26	ACTIVITY INVALID OR INCORRECT FOR MOLI PART B OPTION.
PF2-27	ACTIVITY INVALID OR INCORRECT, MOLI HAS NO SBI INFORMATION.
PF2-28	INVALID OR INCORRECT EVENT CODE.
PF2-29	INVALID OR INCORRECT EVENT DATE.
PF2-30	UNABLE TO PROCESS MISCELLANEOUS ACTIVITY, NO PART B EFF DATE ON MOLI.
PF2-30A	UNABLE TO PROCESS MISCELLANEOUS ACTIVITY, NO SBI ACCOUNTING DATE ON MOLI.
PF2-31	INVALID OR INCORRECT EVENT DATE.

PF2-32	ACTIVITY INVALID OR INCORRECT EVENT DATE.
PF2-32B	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-33	ACTIVITY INVALID FOR MOLI PART B OPTION.
PF2-34	INVALID OR INCORRECT CHANGE IN TYPE BENEFICIARY.
PF2-35	INVALID OR INCORRECT EVENT DATE.
PF2-36	INVALID OR INCORRECT EVENT DATE.
PF2-37	INVALID OR INCORRECT CHANGE IN TYPE BENEFICIARY.
PF2-38	INVALID OR INCORRECT EVENT DATE.
PF2-39	INVALID OR INCORRECT EVENT DATE.
PF2-40	INVALID OR INCORRECT CHANGE IN TYPE BENEFICIARY.
PF2-41	INVALID OR INCORRECT EVENT DATE.
PF2-42	INVALID OR INCORRECT EVENT DATE.
PF2-43	ACTIVITY INVALID OR INCORRECT FOR MOLI DATA.
PF2-44	INVALID OR INCORRECT EVENT DATE.
PF2-45	INVALID OR INCORRECT EVENT DATE.
PF2-46	ACTIVITY 25 INVALID FOR EVENT CODE 1.
PF2-47	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-48	ACTIVITY INVALID FOR MOLI PART B OPTION.
PF2-49	INVALID OR INCORRECT CHANGE IN TYPE BENEFICIARY.
PF2-50	INVALID OR INCORRECT EVENT DATE.
PF2-51	INVALID OR INCORRECT EVENT DATE.
PF2-52	INVALID OR INCORRECT CHANGE IN TYPE BENEFICIARY.
PF2-53	INVALID OR INCORRECT EVENT DATE.
PF2-54	INVALID OR INCORRECT EVENT DATE.

PF2-55	INVALID OR INCORRECT CHANGE IN TYPE BENEFICIARY.
PF2-56	INVALID OR INCORRECT EVENT DATE.
PF2-57	INVALID OR INCORRECT EVENT DATE.
PF2-58	ACTIVITY 25 INVALID FOR EVENT CODE 2.
PF2-59	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-60	ACTIVITY INVALID FOR MOLI PART B OPTION.
PF2-61	INVALID OR INCORRECT CHANGE IN TYPE BENEFICIARY.
PF2-62	INVALID OR INCORRECT EVENT DATE.
PF2-63	INVALID OR INCORRECT EVENT DATE.
PF2-64	INVALID OR INCORRECT CHANGE IN TYPE BENEFICIARY.
PF2-65	INVALID OR INCORRECT EVENT DATE.
PF2-66	INVALID OR INCORRECT EVENT DATE.
PF2-67	INVALID OR INCORRECT CHANGE IN TYPE BENEFICIARY.
PF2-68	INVALID OR INCORRECT EVENT DATE.
PF2-69	INVALID OR INCORRECT EVENT DATE.
PF2-70	ACTIVITY 25 INVALID FOR EVENT CODE 5.
PF2-71	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-72	ACTIVITY INVALID FOR MOLI PART B OPTION.
PF2-73	INVALID OR INCORRECT EVENT DATE.
PF2-74	INVALID OR INCORRECT EVENT DATE.
PF2-75	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-76	ACTIVITY INVALID FOR MOLI PART B OPTION.
PF2-76A	INVALID ACTIVITY, MOLI TERM DATE MORE THAN 2 YEARS OLD.
PF2-77	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.

PF2-78	ACTIVITY INVALID FOR MOLI PART B OPTION.
PF2-79	INVALID OR INCORRECT EVENT DATE.
PF2-80	INVALID OR INCORRECT EVENT DATE.
PF2-81	INVALID OR INCORRECT EVENT DATE.
PF2-82	DOB PRIOR TO 1908, SYSTEM UNABLE TO CALCULATE PART B PREMIUM RATE.
PF2-83	EVENT DATE AFTER NOVEMBER 20TH OF CURRENT YEAR.
PF2-84	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-85	ACTIVITY INVALID FOR MOLI PART B OPTION.
PF2-86	UNABLE TO PROCESS MISCELLANEOUS ACTIVITY, NO PART B EFF DATE ON MOLI.
PF2-87	INVALID OR INCORRECT EVENT DATE.
PF2-88	INVALID OR INCORRECT EVENT DATE.
PF2-89	INVALID OR INCORRECT EVENT DATE.
PF2-90	INVALID OR INCORRECT EVENT DATE.
PF2-91	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-92	INVALID OR INCORRECT EVENT DATE.
PF2-93	INVALID OR INCORRECT EVENT DATE.
PF2-94	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-95	INVALID OR INCORRECT EVENT DATE.
PF2-96	INVALID OR INCORRECT EVENT DATE.
PF2-97	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS.
PF2-98	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS OR MOLI PART B OPTION.
PF2-99	ACTIVITY INVALID OR INCORRECT FOR MOLI RECORD STATUS OR MOLI PART B OPTION.

PF2-100	INVALID OR INCORRECT ACTIVITY FOR MOLI RECORD STATUS, MOLI PART B OPTION, OR MOLI ID ISSUE CODE.
PF2-101	MOLI RECORD STATUS BLANK.
PF2-102	INVALID OR INCORRECT ACTIVITY FOR MOLI RECORD STATUS OR MOLI PART B OPTION.
PF2-103	INVALID OR INCORRECT ACTIVITY FOR MOLI RECORD STATUS OR MOLI PART B OPTION.
PF2-104	INVALID OR INCORRECT EVENT CODE.
PF2-106	EVENT CODE AND EVENT DATE MUST BE SPACES FOR THIS ACTIVITY.
PF2-107	EVENT CODE AND EVENT DATE MUST BE SPACES FOR THIS ACTIVITY.
PF2-107A	EVENT DATE MUST BE SPACES WHEN EVENT CODE DOES NOT EQUAL 9.
PF2-107B	INVALID EVENT CODE FOR ACTIVITY.
PF2-108	EVENT CODE INVALID FOR ACTIVITY.
PF2-109	A VALID EVENT CODE AND EVENT DATE REQUIRED FOR THIS ACTIVITY.
PF2-110	A VALID EVENT CODE AND EVENT DATE REQUIRED FOR THIS ACTIVITY.
PF2-111	FORMER SS CL NO MUST BE BLANK.
PF2-112	FORMER SS CL NO MUST HAVE A VALID ENTRY.
PF2-113	FORMER RR CL NO MUST BE BLANK.
PF2-114	FORMER RR CL NO MUST HAVE A VALID ENTRY.
PF2-115	INVALID OR INCORRECT EVENT DATE.
PF2-117	INVALID OR INCORRECT ACTIVITY FOR MOLI SCREENING REQUEST CODE.

PROCESS NAME IS MCDU011-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-11-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU011-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT
ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU011-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 WILL SOMEDAY DISPLAY THE LAST MEDREF SCREEN.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU012-PM

PM-03	PART B PREM RATE IS PROTECTED - CHANGE ALLOWED ON VARIABLE SCREEN ONLY.
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PROCESS NAME IS MCDU012-RP-PF2

THE ADDRESS MUST BE ADDED BEFORE THE ACTIVITY CAN BE ADDED.

TO ADD - PRESS PF2 AGAIN.

01-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
02-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.
PF2-04	NOT ABLE TO ADD - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-05	NOT ABLE TO ADD - MCWU001-MC-ACT-12-ADD-SW IS NOT Y OR N.
PF2-06	INVALID OR INCORRECT GEP CODE.
PF2-07	INVALID PART B FILE DATE FOR THIS GEP CODE.
PF2-08	INVALID PART B EFF DATE FOR THIS GEP CODE.
PF2-09	INVALID PART B FILE DATE FOR THIS GEP CODE.
PF2-10	INVALID PART B EFF DATE FOR THIS GEP CODE.
PF2-11	INVALID RECORD STATUS FOR THIS GEP CODE.

PROCESS NAME IS MCDU012-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-12-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU012-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT
ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU012-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 WILL SOMEDAY DISPLAY THE LAST MEDREF SCREEN.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU013-PM

PM-03	PART B PREM RATE IS PROTECTED - CHANGE ALLOWED ON VARIABLE SCREEN ONLY.
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PROCESS NAME IS MCDU013-RP-PF2

THE ADDRESS MUST BE ADDED BEFORE THE ACTIVITY CAN BE ADDED.

TO ADD - PRESS PF2 AGAIN.

01-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
02-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.
PF2-04	NOT ABLE TO ADD - PROBLEM WITH VARIABLE PART B.
PF2-05	NOT ABLE TO ADD - PROBLEM WITH PREVIOUS INFORMATION.
PF2-06	NOT ABLE TO ADD - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-07	NOT ABLE TO ADD - MCWU001-MC-ACT-13-ADD-SW IS NOT Y OR N.

PROCESS NAME IS MCDU013-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
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PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-13-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU013-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT
ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU013-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 FUTURE USE - WILL DISPLAY THE LAST REFFERAL SCREEN.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU014-RP-PF2

PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.
PF2-01A	ONLY ACTIVITY 22 MAY HAVE VARIABLE SCREEN ADDED.

TO ADD - PRESS PF2 AGAIN.

PF2-02A	NOT ABLE TO RETURN - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-03	NOT ABLE TO ADD - MCWU001-MC-VAR-PART-B-ADD-SW IS NOT Y OR N.

PF2-04	INVALID OR INCORRECT CURR RESIDENCY CD.
PF2-05	FOR RATE CODE = V, ALL FIELDS MUST HAVE VALID ENTRIES.
PF2-06	INVALID OR INCORRECT CURR VAR RATE CD.
PF2-07	INVALID OR INCORRECT CURR PEN PERCENT.
PF2-08	INVALID OR INCORRECT CURR PEN PERCENT.
PF2-09	INVALID OR INCORRECT CURR VAR BASE RATE.
PF2-10	INVALID OR INCORRECT CURR VAR BASE RATE.
PF2-11	INVALID OR INCORRECT CURR VAR BASE RATE.
PF2-12	INVALID OR INCORRECT CURR VAR BASE RATE.
PF2-13	INVALID OR INCORRECT CURR CAT EFF DATE.
PF2-14	INVALID OR INCORRECT CURR CAT EFF DATE.
PF2-15	INVALID OR INCORRECT CURR CAT EFF DATE.
PF2-16	CURR CAT EFF DATE BEFORE PART B EFF DATE.
PF2-17	INVALID OR INCORRECT CURR CAT EFF DATE.
PF2-18	VALID ENTRY OR SPACES NEEDED IN ALL OF THESE FIELDS.
PF2-19	CURR CAT EFF DATE MONTH MUST BE 01.

PROCESS NAME IS MCDU014-RP-PF4

PF4-01	NOT ABLE TO DELETE - USER NOT AUTHORIZED.
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TO DELETE - PRESS PF4 AGAIN.

PF4-03	NOT ABLE TO DETERMINE WHAT SCREEN TO RETURN TO.
PF4-04	NOT ABLE TO DELETE - MCWU001-MC-VAR-PART-B-DEL-SW NOT Y OR N.

PROCESS NAME IS MCDU014-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT
ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU014-RP-OTHER

CLEAR NOT ALLOWED, SCREEN PREVIOUSLY ADDED - PRESS PF2 TO ADD OR
PF4 TO DELETE.

OTH-02 UNABLE TO DETERMINE WHICH SCREEN TO RETURN TO.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU015-RP-PF2

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU015-RP-PF4

AN INVALID KEY WAS PRESSED.

NOT ABLE TO DELETE - USER NOT AUTHORIZED.

TO DELETE - PRESS PF4 AGAIN.

NOT ABLE TO DELETE - MCWU001-MC-PREV-INFO-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU015-RP-PF5

AN INVALID KEY WAS PRESSED.

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT
ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU015-RP-OTHER

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU016-PM

NO DATAQ ADDRESS FOUND.

NO DATAQ ADDRESS FOR PERSONR RECORD.

ADDRESS PREFILLED FROM DATAQ.

PROCESS NAME IS MCDU016-RP-PF2

PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.
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TO ADD - PRESS PF2 AGAIN.

NOT ABLE TO ADD - MCWU001-MC-ADDRESS-ADD-SW IS NOT Y OR N.

PF2-04	NAME HAS NON ALPHABETIC CHARACTERS.
PF2-05	INVALID OR INCORRECT REP PAYEE CODE.
PF2-06	WORD "FOR" MUST BE ON NAME LINE.
PF2-07	INVALID OR INCORRECT REP PAYEE CODE.
PF2-08	GROUP MARK () SHOULD BE ON ADDRESS LINE.
PF2-09	INVALID CHARACTER ON NAME LINE.
PF2-10	INVALID CHARACTER ON ADDRESS LINE 3.
PF2-11	INVALID CHARACTER ON ADDRESS LINE 4.
PF2-12	INVALID CHARACTER ON ADDRESS LINE 5.
PF2-13	INVALID CHARACTER ON ADDRESS LINE 6.
PF2-14	INVALID CHARACTER ON ADDRESS LINE 4.
PF2-15	INVALID CHARACTER ON ADDRESS LINE 5.
PF2-16	INVALID CHARACTER ON ADDRESS LINE 6.
PF2-17	INVALID CHARACTER ON ADDRESS LINE 5.
PF2-18	INVALID CHARACTER ON ADDRESS LINE 6.
PF2-19	INVALID CHARACTER ON ADDRESS LINE 5.

PF2-20	INVALID CHARACTER ON ADDRESS LINE 6.
PF2-21	GROUP MARK () MUST BE ON FIRST ADDRESS LINE.
PF2-22	AN ENTRY MUST BE MADE ON THE NAME LINE.
PF2-23	AN ENTRY MUST BE MADE ON THE NAME/ADDRESS LINE.

PROCESS NAME IS MCDU016-RP-PF4

NOT ABLE TO DELETE - USER NOT AUTHORIZED.

NOT ABLE TO DELETE - THIS ACTIVITY MUST HAVE AN ADDRESS.

TO DELETE - PRESS PF4 AGAIN.

NOT ABLE TO DELETE - MCWU001-MC-ADDRESS-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU016-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU016-RP-OTHER

ADDRESS SCREEN ADDED, CLEAR NOT ALLOWED - PRESS PF2 TO ADD OR PF4 TO DELETE.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU017-PM

NO EQUAL OR HIGHER PENDING ACTIVITIES FOUND IN THE DATABASE *.

NO EQUAL OR HIGHER PENDING ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDU017-RP-ENTER

INVALID KEY WAS PRESSED.

NOT ABLE TO PROCESS - MORE THAN ONE P HAS BEEN ENTERED.

NOT ABLE TO PROCESS - NO P HAS BEEN ENTERED.

NOT ABLE TO PROCESS - PENDING ACTIVITY NOT FOUND IN THE DATABASE.

NOT ABLE TO PROCESS - PENDING ACTIVITY NOT FOUND IN THE DATABASE.

PROCESS NAME IS MCDU017-RP-PF4

NOT ABLE TO DELETE - SOMETHING OTHER THAN D HAS BEEN ENTERED.

NOT ABLE TO DELETE - USER DOES NOT HAVE AUTHORITY.

NOT ABLE TO DELETE - PENDING ACT NOT FOUND IN THE DATABASE.

NOT ABLE TO DELETE - PENDING ACT NOT FOUND IN THE DATABASE.

NOT ABLE TO DELETE - NO D HAS BEEN ENTERED.

DELETE COMPLETED.

PROCESS NAME IS MCDU017-RP-PF7

NO LOWER PENDING ACTIVITIES FOUND IN THE DATABASE.

NO LOWER PENDING ACTIVITIES FOUND IN THE DATABASE. NO LOWER
PENDING ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDU017-RP-PF8

NO HIGHER PENDING ACTIVITIES FOUND IN THE DATABASE.

NO HIGHER PENDING ACTIVITIES FOUND IN THE DATABASE.

NO HIGHER PENDING ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDU017-RP-PF19

NO PENDING ACTIVITIES FOUND IN THE DATABASE.

NO PENDING ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDU017-RP-PF20

NO PENDING ACTIVITIES FOUND IN THE DATABASE.

NO PENDING ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDU017-RP-OTHER

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDI018-PM

NO EQUAL OR HIGHER COMPLETED ACTIVITIES FOUND IN THE DATABASE.

NO EQUAL OR HIGHER COMPLETED ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDI018-RP-PF7

NO LOWER COMPLETED ACTIVITIES FOUND IN THE DATABASE.

NO LOWER COMPLETED ACTIVITIES FOUND IN THE DATABASE.

NO LOWER COMPLETED ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDI018-RP-PF8

NO HIGHER COMPLETED ACTIVITIES FOUND IN THE DATABASE.

NO HIGHER COMPLETED ACTIVITIES FOUND IN THE DATABASE.

NO HIGHER COMPLETED ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDI018-RP-PF19

NO COMPLETED ACTIVITIES FOUND IN THE DATABASE.

NO COMPLETED ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDI018-RP-PF20

NO COMPLETED ACTIVITIES FOUND IN THE DATABASE.

NO COMPLETED ACTIVITIES FOUND IN THE DATABASE.

PROCESS NAME IS MCDI018-RP-OTHER

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU020-PM

PM-03	PART B PREM RATE IS PROTECTED - CHANGE ALLOWED ON VARIABLE SCREEN ONLY.
PM-04	UNABLE TO PROCESS ACTIVITY 20, INVALID SEX CODE.

PROCESS NAME IS MCDU020-RP-PF2

TO ADD - PRESS PF2 AGAIN.

01-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
02-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.
PF2-02	NOT ABLE TO ADD - PROBLEM WITH VARIABLE PART B.
PF2-03	NOT ABLE TO ADD - PROBLEM WITH PREVIOUS INFORMATION.
PF2-04	NOT ABLE TO ADD - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-05	NOT ABLE TO ADD - MCWU001-MC-ACT-20-ADD-SW IS NOT Y OR N.
PF2-06	PART B EFF DATE MUST EQUAL SPACES OR PART B EFF DATE ON MOLI.
PF2-07	WITH RECORD STATUS 90, PART A TERM DATE OR PART A TERM DATE AND PART B TERM DATE SHOULD HAVE ENTRIES.
PF2-08	WITH RECORD STATUS 99 OR MOLI RECORD STATUS 99, DATE OF DEATH SHOULD HAVE ENTRY.
PF2-09	SCREEN 20 INVALID. USE SCREEN 22 TO ADD THE ADDRESS SCREEN.
PF2-10	INVALID OR INCORRECT RECORD STATUS.
PF2-11	ENTRY MUST BE MADE IN PART A TERM DATE, MOLI HAS PART A TERM DATE.
PF2-12	INVALID OR INCORRECT PREV SBI ACC DATE.
PF2-13	INVALID OR INCORRECT PREV SBI ACC DATE.
PF2-14	INVALID OR INCORRECT PREV SBI ACC DATE.
PF2-15	INVALID OR INCORRECT PREV SBI ACC DATE.
PF2-16	INVALID OR INCORRECT PREV SBI DEL DATE.
PF2-17	INVALID OR INCORRECT PREV SBI DEL DATE.

PF2-18	INVALID OR INCORRECT PREV SBI DEL DATE.
PF2-19	INVALID OR INCORRECT PREV SBI DEL DATE.
PF2-20	INVALID OR INCORRECT DATABASE RECORD STATUS.
PF2-21	ACTIVITY INVALID AGAINST DUAL ANNUITANT.
PF2-22	SBI ACTIVITY CONVEYING DEATH - MIRTEL NOT UPDATED.
PF2-23	MIRTEL SHOWS CHICO IN FORCE WITH DED - ACTIVITY SHOWS NO ANNUITY.
PF2-24	MIRTEL SHOWS CHICO IN FORCE WITH DED - ACTIVITY HAS NO PD THRU DT.
PF2-25	SMI TERM DATA INVALID FOR THIS MIRTEL.
PF2-26	UNABLE TO CHANGE ENTITLEMENT DATA OR DOB WITH THIS ACTIVITY.
PF2-27	UNABLE TO CHANGE ENTITLEMENT DATA OR DOB WITH THIS ACTIVITY.
PF2-28	UNABLE TO CHANGE ENTITLEMENT DATA OR DOB WITH THIS ACTIVITY.
PF2-29	UNABLE TO CHANGE ENTITLEMENT DATA OR DOB WITH THIS ACTIVITY.
PF2-30	SBI INFORMATION MISSING OR INVALID FOR THIS MIRTEL.
PF2-31	SBI INFORMATION MISSING OR INVALID FOR THIS MIRTEL.
PF2-32	OPTION CODES INCOMPATIBLE WITH RECORD STATUS.
PF2-33	SMI OPTION INVALID FOR THIS MIRTEL.
PF2-34	SMI OPTION INVALID FOR THIS MIRTEL.
PF2-35	SMI OPTION INVALID FOR THIS MIRTEL.
PF2-36	SMI OPTION INVALID FOR THIS MIRTEL.
PF2-37	SMI OPTION INVALID FOR THIS MIRTEL.

PROCESS NAME IS MCDU020-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-20-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU020-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER. REFRESH COMPLETED.

PROCESS NAME IS MCDU020-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 WILL SOMEDAY DISPLAY THE LAST MEDREF SCREEN. AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU021-PM

PM-03	EE SSA NUMBER BLANK, MUST BE COMPLETED.
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PROCESS NAME IS MCDU021-RP-PF2

PF2-02	ADDRESS NOT ON MOLI, ADDRESS MUST BE ADDED FOR THIS ACTIVITY.
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TO ADD - PRESS PF2 AGAIN.

01-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
02-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.
PF2-04	NOT ABLE TO ADD - PROBLEM WITH ADDRESS.
PF2-05	NOT ABLE TO ADD - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-06	NOT ABLE TO ADD - MCWU001-MC-ACT-21-ADD-SW IS NOT Y OR N.

PROCESS NAME IS MCDU021-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-21-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU021-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT
ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER. REFRESH
COMPLETED.

PROCESS NAME IS MCDU021-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 WILL SOMEDAY DISPLAY THE LAST MEDREF SCREEN. AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU022-PM

PM-03	PART B PREM RATE IS PROTECTED - CHANGE ALLOWED ON VARIABLE SCREEN ONLY.
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PROCESS NAME IS MCDU022-RP-PF2

PF2-01	ADDRESS NOT ON MOLI, ADDRESS MUST BE ADDED FOR THIS ACTIVITY.
PF2-02	TO ADD - PRESS PF2 AGAIN.
PF2-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-04	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-05	NOT ABLE TO ADD - USER NOT AUTHORIZED.
PF2-06	NOT ABLE TO ADD - PROBLEM WITH VARIABLE PART B.
PF2-07	NOT ABLE TO ADD - PROBLEM WITH PREVIOUS INFORMATION.
PF2-08	NOT ABLE TO ADD - PROBLEM WITH ADDRESS.
PF2-09	NOT ABLE TO ADD - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-10	NOT ABLE TO ADD - MCWU001-MC-ACT-22-ADD-SW IS NOT Y OR N.
PF2-11	INVALID OR INCORRECT RECORD STATUS FOR THIS MOLI.
PF2-12	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-13	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-14	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-15	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-16	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.

PF2-17	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-18	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-19	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-20	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-21	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-22	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-23	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-24	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-25	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-26	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-27	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-28	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
PF2-29	ACTIVITY INVALID FOR INACTIVE MOLI.
PF2-30	ACTIVITY INVALID FOR INACTIVE MOLI.
PF2-31	ACTIVITY INVALID FOR INACTIVE MOLI.
PF2-32	ACTIVITY INVALID FOR INACTIVE MOLI.
PF2-33	ACTIVITY INVALID FOR INACTIVE MOLI.
PF2-34	TOB INVALID FOR THIS MOLI.
PF2-35	TOB INVALID FOR THIS MOLI.
PF2-36	TOB INVALID FOR THIS MOLI.
PF2-37	SBI INFORMATION MISSING OR INVALID FOR THIS MOLI.
PF2-38	SBI INFORMATION MISSING OR INVALID FOR THIS MOLI.
PF2-39	SBI INFORMATION MISSING OR INVALID FOR THIS MOLI.
PF2-40	SBI INFORMATION MISSING OR INVALID FOR THIS MOLI.

PF2-41	SBI INFORMATION MISSING OR INVALID FOR THIS MOLI.
PF2-42	SBI INFORMATION MISSING OR INVALID FOR THIS MOLI.
PF2-43	ACTIVITY INVALID AGAINST DUAL ANNUITANT.
PF2-44	ACTIVITY INVALID AGAINST DUAL ANNUITANT.
PF2-45	ACTIVITY INVALID AGAINST DUAL ANNUITANT.
PF2-46	ACTIVITY INVALID AGAINST DUAL ANNUITANT.
PF2-47	SMI TERM DATA INVALID FOR THIS MOLI.
PF2-48	SMI TERM DATA INVALID FOR THIS MOLI.
PF2-49	SMI TERM DATA INVALID FOR THIS MOLI.
PF2-50	SMI TERM DATA INVALID FOR THIS MOLI.
PF2-51	ENROLLMENT DATA MISSING OR INVALID FOR THIS MOLI.
PF2-52	ENROLLMENT DATA MISSING OR INVALID FOR THIS MOLI.
PF2-53	ENROLLMENT DATA MISSING OR INVALID FOR THIS MOLI.
PF2-54	ENROLLMENT DATA MISSING OR INVALID FOR THIS MOLI.
PF2-55	ENROLLMENT DATA MISSING OR INVALID FOR THIS MOLI.
PF2-56	WITH XX-XX-XXXX IN DOD, THESE FIELDS MUST BE BLANK.
PF2-57	ACTIVITY INVALID FOR INACTIVE MOLI.
PF2-58	MOLI HAS NO ADDRESS - MUST SUPPLY.
PF2-59	NO HI EFF DATE EXISTS FOR THIS CLAIM NUMBER.
PF2-60	INVALID OR INCORRECT HIB TERM DATE.
PF2-61	INVALID OR INCORRECT HIB TERM DATE.
PF2-62	INVALID OR INCORRECT SMI OPTION.
PF2-63	INVALID OR INCORRECT RECORD STATUS.
PF2-64	INVALID OR INCORRECT RECORD STATUS OR DATE OF DEATH.

PF2-65	INVALID OR INCORRECT DATE OF DEATH OR RECORD STATUS.
PF2-66	VALID ENTRY NEEDED IN DATE OF DEATH, DATE OF DEATH ON MOLI.

PROCESS NAME IS MCDU022-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-22-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU022-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER. REFRESH COMPLETED.

PROCESS NAME IS MCDU022-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 WILL SOMEDAY DISPLAY THE LAST MEDREF SCREEN.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU031-PM

PM-03	PART B PREM RATE IS PROTECTED - CHANGE ALLOWED ON VARIABLE SCREEN ONLY.
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PROCESS NAME IS MCDU031-RP-PF2

PF2-02	THE ADDRESS MUST BE ADDED BEFORE THE ACTIVITY CAN BE ADDED.
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TO ADD - PRESS PF2 AGAIN.

01-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
02-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.
PF2-04	NOT ABLE TO ADD - PROBLEM WITH VARIABLE PART B.
PF2-05	NOT ABLE TO ADD - PROBLEM WITH PREVIOUS INFORMATION.
PF2-06	NOT ABLE TO ADD - DON NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-07	NOT ABLE TO ADD - MCWU001-MC-ACT-31-ADD-SW IS NOT Y OR N.

PROCESS NAME IS MCDU031-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-31-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU031-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT
ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU031-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 WILL SOMEDAY DISPLAY THE LAST MEDREF SCREEN.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU032-PM

PM-03	PART B PREM RATE IS PROTECTED - CHANGE ALLOWED ON VARIABLE SCREEN ONLY.
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PROCESS NAME IS MCDU032-RP-PF2

PF2-02	ADDRESS NOT ON MOLI, ADDRESS MUST BE ADDED FOR THIS ACTIVITY.
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TO ADD - PRESS PF2 AGAIN.

01-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
02-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.
PF2-04	NOT ABLE TO ADD - PROBLEM WITH VARIABLE PART B.
PF2-05	NOT ABLE TO ADD - PROBLEM WITH PREVIOUS INFORMATION.

PF2-06	NOT ABLE TO ADD - PROBLEM WITH ADDRESS.
PF2-07	NOT ABLE TO ADD - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-08	NOT ABLE TO ADD - MCWU001-MC-ACT-32-ADD-SW IS NOT Y OR N.

PROCESS NAME IS MCDU032-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-32-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU032-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT

ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU032-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 WILL SOMEDAY DISPLAY THE LAST MEDREF SCREEN.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU033-PM

PM-03	PART B PREM RATE IS PROTECTED - CHANGE ALLOWED ON VARIABLE SCREEN ONLY.
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PROCESS NAME IS MCDU033-RP-PF2

PF2-02	THE ADDRESS MUST BE ADDED BEFORE THE ACTIVITY CAN BE ADDED.
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TO ADD - PRESS PF2 AGAIN.

01-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
02-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.
PF2-03	NOT ABLE TO ADD - PROBLEM WITH VARIABLE PART B.
PF2-04	NOT ABLE TO ADD - PROBLEM WITH PREVIOUS INFORMATION.
PF2-05	NOT ABLE TO ADD - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-06	NOT ABLE TO ADD - MCWU001-MC-ACT-33-ADD-SW IS NOT Y OR N.

PROCESS NAME IS MCDU033-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-33-DEL-SW IS NOT Y OR N.
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PROCESS NAME IS MCDU033-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT

ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU033-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 WILL SOMEDAY DISPLAY THE LAST MEDREF SCREEN.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU034-PM

PM-03	PART B PREM RATE IS PROTECTED - CHANGE ALLOWED ON VARIABLE SCREEN ONLY.
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PROCESS NAME IS MCDU034-RP-PF2

PF2-02	ADDRESS NOT ON MOLI, ADDRESS MUST BE ADDED FOR THIS ACTIVITY.
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TO ADD - PRESS PF2 AGAIN.

01-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
02-PM	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF2-01	NOT ABLE TO ADD - USER NOT AUTHORIZED.

PF2-04	NOT ABLE TO ADD - PROBLEM WITH VARIABLE PART B.
PF2-05	NOT ABLE TO ADD - PROBLEM WITH PREVIOUS INFORMATION.
PF2-06	NOT ABLE TO ADD - PROBLEM WITH ADDRESS.
PF2-07	NOT ABLE TO ADD - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF2-08	NOT ABLE TO ADD - MCWU001-MC-ACT-34-ADD-SW IS NOT Y OR N.

PROCESS NAME IS MCDU034-RP-PF4

PF4-01	TO DELETE - PRESS PF4 AGAIN.
PF4-02	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-03	PENDING ACTIVITY NOT FOUND IN THE DATABASE.
PF4-04	NOT ABLE TO ADD USER NOT AUTHORIZED.
PF4-05	NOT ABLE TO DELETE - DO NOT KNOW WHAT SCREEN TO RETURN TO.
PF4-06	NOT ABLE TO DELETE - MCWU001-MC-ACT-34-DEL-SW IS NOT Y OR N.

PROCESS NAME IS MCDU034-RP-PF5

REFRESH NOT ALLOWED FOR PENDING ACTIVITY, PRESS CLEAR TO EXIT ACT
ACTIVITY SELECT ACTIVITY FROM PENDING MENU AND REENTER.

REFRESH COMPLETED.

PROCESS NAME IS MCDU034-RP-OTHER

DO NOT KNOW WHAT SCREEN TO RETURN TO.

PF9 WILL SOMEDAY DISPLAY THE LAST MEDREF SCREEN.

AN INVALID KEY WAS PRESSED.

PROCESS NAME IS MCDU101-RP-TIMEDATEPROCESS NAME IS MCDU102-RP-EDITS

01-102	SEX CODE MUST BE -F- OR -M-.
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PROCESS NAME IS MCDU103-RP-EDITS

01-103	MUST HAVE VALID FORMER SSA NUMBER AND SUFFIX.
02-103	INVALID OR INCORRECT SSA CLAIM NUMBER.
03-103	INVALID OR INCORRECT SSA CLAIM NUMBER.
04-103	INVALID OR INCORRECT SSA SUFFIX/SYMBOL.
05-103	INVALID OR INCORRECT SSA SUFFIX/SYMBOL.
07-103	FORMER SSA NUMBER NOT EQUAL TO EE SSA NUMBER.
08-103	INVALID OR INCORRECT SSA NUMBER.
09-103	INVALID OR INCORRECT SSA SUFFIX/SYMBOL.

PROCESS NAME IS MCDU104-RP-EDITS

01-104	INVALID OR INCORRECT PART B OPTION.
02-104	INVALID OR INCORRECT PART B OPTION.
03-104	INVALID OR INCORRECT PART B OPTION.
04-104	INVALID OR INCORRECT PART B OPTION.
05-104	INVALID OR INCORRECT PART B OPTION.
06-104	INVALID OR INCORRECT PART B OPTION.
08-104	INVALID OR INCORRECT PART B OPTION.

09-104	PART B EFF DATE AND THE PART B PREM RATE MUST HAVE ENTRIES.
10-104	PART B EFF DATE AND THE PART B PREM RATE MUST HAVE ENTRIES.
11-104	PART B EFF DATE AND THE PART B PREM RATE MUST HAVE ENTRIES.
12-104	PART B EFF DATE AND THE PART B PREM RATE MUST HAVE ENTRIES.
13-104	EQ RELIEF ENROLL MUST HAVE VALID ENTRY.
14-104	INVALID OR INCORRECT PART B OPTION.
15-104	WITH THIS PART B OPTION, THESE FIELDS MUST HAVE VALID DATA.
16-104	PART B EFF DATE & PREM AMOUNT MUST HAVE VALID ENTRIES.
17-104	WITH THIS PART B OPTION CODE, THESE FIELDS MUST BE BLANK.
18-104	WITH THIS PART B OPTION CODE, THESE FIELDS MUST BE BLANK.
19-104	WITH THIS PART B OPTION CODE, THESE FIELDS MUST HAVE ENTRIES..
20-104	WITH THIS PART B OPT CODE, THESE FIELDS MUST HAVE ENTRIES.
21-104	THE ID ISSUE CODE MUST BE 4.
22-104	FOR PART B OPTION C, THE SCREEN MUST BE 13 .
23-104	INVALID PART B OPTION OR EQ RELIEF ENROLL.
24-104	INVALID PART B OPTION CODE OR EQ RELIEF ENROLL.
25-104	INVALID PART B OPTION CODE OR EQ RELIEF ENROLL.
26-104	INVALID PART B OPTION CODE OR EQ RELIEF ENROLL.
27-104	THESE FIELDS MUST BE BLANK.
28-104	PART B EFF DATE NOT GREATER THAN MOLI PART B TERM DATE.
29-104	PART B EFF DATE NOT GREATER THAN MOLI PREV PART B TERM DATE.

30-104	INVALID OR INCORRECT PART B OPTION OR RECORD STATUS.
31-104	INVALID OR INCORRECT PART B OPTION OR RECORD STATUS.
32-104	INVALID OR INCORRECT PART B OPTION.
33-104	INVALID OR INCORRECT PART B OPTION.
34-104	INVALID OR INCORRECT PART B OPTION.
35-104	INVALID OR INCORRECT PART B OPTION.
36-104	INVALID OR INCORRECT PART B OPTION.
37-104	INVALID OR INCORRECT PART B OPTION.
37-104	INVALID OR INCORRECT PART B OPTION.
38-104	INVALID OR INCORRECT EQUI RELIEF ENROLL.
39-104	INVALID OR INCORRECT EQ RELIEF ENROLL FOR PART B OPTION.
40-104	INVALID OR INCORRECT EQUI RELIEF ENROLL.
41-104	INVALID OR INCORRECT PAYEE CODE.
42-104	INVALID OR INCORRECT PAYEE CODE.
43-104	PAYEE CODE SHOULD BE 1 .
44-104	PAYEE CODE SHOULD BE 2 .
45-104	INVALID OR INCORRECT PAYEE CODE.
46-104	PAYEE CODE SHOULD BE BLANK.
47-104	PAYEE CODE SHOULD BE BLANK.
48-104	INVALID OR INCORRECT PAYEE CODE.
49-104	INVALID OR INCORRECT PAYEE CODE.

PROCESS NAME IS MCDU105-RP-EDITS

01-105	PAID THRU DATE MUST BE NUMERIC.
01A-105	INVALID OR INCORRECT PAID THRU DATE.
02-105	INVALID OR INCORRECT PAID THRU DATE.
03-105	INVALID OR INCORRECT PAID THRU DATE.
04-105	INVALID OR INCORRECT PAID THRU DATE.
05-105	INVALID OR INCORRECT PAID THRU DATE.
06-105	INVALID OR INCORRECT PAID THRU DATE.
07-105	PAID THRU DATE MUST BE EQUAL OR GREATER THAN DELETION DATE.
08-105	INVALID OR INCORRECT PAID THRU DATE.
09-105	INVALID OR INCORRECT PAID THRU DATE.
10-105	INVALID OR INCORRECT PAID THRU DATE.
11-105	PAID THRU DATE INCORRECT.
12-105	EXCESS PREMIUM MUST BE NUMERIC.
12A-105	INVALID OR INCORRECT EXCESS PREMIUM.
13-105	INVALID OR INCORRECT EXCESS PREMIUM AMOUNT.
14-105	INVALID OR INCORRECT EXCESS PREMIUM AMOUNT.
15-105	INVALID EXCESS PREMIUM AMOUNT FOR THIS ACTIVITY.
16-105	INVALID SMI OPT CODE FOR THIS ACTIVITY.
16A-105	XXX.XX NOT ALLOWED, NO EXCESS PREMIUM AMOUNT ON MOLI.
17-105	WHEN ENTERING AN EXCESS PREMIUM AMOUNT, RECORD STATUS MUST BE 22, 23 OR 24.
17A-105	DELINQUENCY DATE REMOVED BY SYSTEM.
17B-105	DELINQUENCY DATE CORRECTED BY SYSTEM. PLEASE VERIFY.
17C-105	DELINQUENCY DATE CORRECTED BY SYSTEM. PLEASE VERIFY.

18-105	DELINQUENCY DATE MUST BE NUMERIC.
19-105	INVALID OR INCORRECT DELINQUENCY DATE.
20-105	INVALID OR INCORRECT DELINQUENCY DATE.
21-105	NO DELINQUENCY DATE ALLOWED FOR THIS RECORD STATUS.

PROCESS NAME IS MCDU106-RP-EDITS

01-106	INVALID OR INCORRECT RRB DATE OF BIRTH.
02-106	INVALID OR INCORRECT RRB DATE OF BIRTH.
03-106	INVALID OR INCORRECT RRB DATE OF BIRTH.
04-106	INVALID OR INCORRECT RRB DATE OF BIRTH.
05-106	INVALID OR INCORRECT RRB DATE OF BIRTH.
06-106	HI DATE OF BIRTH MUST BE NUMERIC.
07-106	INVALID OR INCORRECT HI DATE OF BIRTH.
08-106	INVALID OR INCORRECT HI DATE OF BIRTH.
09-106	INVALID OR INCORRECT HI DATE OF BIRTH.
10-106	INVALID OR INCORRECT RRB DATE OF BIRTH.
11-106	INVALID OR INCORRECT ANN BEGIN DATE.
12-106	INVALID OR INCORRECT ANN BEGIN DATE.
13-106	INVALID OR INCORRECT 1ST FULL MO DIS.
14-106	INVALID OR INCORRECT 1ST FULL MO DIS.
15-106	INVALID OR INCORRECT PART A EFF DATE.
16-106	INVALID OR INCORRECT PART A EFF DATE.
17-106	INVALID OR INCORRECT PART B EFF DATE.

18-106	INVALID OR INCORRECT PART B EFF DATE.
19-106	INVALID OR INCORRECT PART B FILING DATE.
20-106	INVALID TYPE BENEFICARY.
21-106	PART B FILING DATE MUST BE SPACES WITH THIS PART B OPTION.
22-106	INVALID OR INCORRECT PART B FILING DATE.
24-106	INVALID OR INCORRECT PART B FILING DATE.
25-106	INVALID OR INCORRECT PART B FILING DATE FOR PART B OPTION.
26-106	INVALID OR INCORRECT PART B FILING DATE FOR PART B OPTION.
27-106	INVALID OR INCORRECT PART B FILING DATE FOR PART B OPTION.
28-106	INVALID OR INCORRECT PART B FILING DATE FOR PART B OPTION.
29-106	INVALID OR INCORRECT PART B FILING DATE.
30-106	INVALID OR INCORRECT PART B FILING DATE FOR PART B OPTION.
31-106	INVALID OR INCORRECT PART B FILING DATE FOR PART B OPTION.
32-106	PART A EFF DATE MUST HAVE VALID ENTRY.
33-106	ID ISSUE CODE NEEDS ENTRY WHEN PART A EFF DATE OR PART B EFF DATE COMPLETED.
34-106	PART A EFF DATE CANNOT BE BEFORE 07-1966 OR AGE 65.
34A-106	PART A EFF DATE IN FUTURE AND GREATER THAN AGE 65.
35-106	PART A EFF DATE CANNOT BE MORE THAN 6 MONTHS FROM CURRENT DATE.
36-106	INVALID OR INCORRECT PART A EFF DATE.
37-106	PART A EFF DATE PRIOR TO 07-1966 OR AGE 65.
38-106	INVALID OR INCORRECT PART A EFF DATE.
39-106	PART A EFF DATE CANNOT BE BEFORE 07-1973.
40-106	PART A EFF DATE CANNOT BE MORE THAN 6 MONTHS FROM

	CURRENT DATE.
41-106	PART A EFF DATE MUST BE LESS THAN AGE 65.
42-106	PART A EFF DATE CANNOT BE BEFORE 07-1973 OR AGE 20.
43-106	INVALID OR INCORRECT PART A EFF DATE.
44-106	PART A EFF DATE CANNOT BE BEFORE 07-1973 OR AGE 20.
45-106	INVALID OR INCORRECT PART A EFF DATE.
46-106	PART A EFF DATE CANNOT BE BEFORE 07-1973.
60-106	SEX CODE MUST BE "F" OR "M".

PROCESS NAME IS MCDU107-RP-EDITS

01-107	BEN SSA NUMBER MUST BE LEFT BLANK.
03-107	ENTRY REQUIRED FOR BEN SSA NUMBER, NO ENTRY IN PSEUDO NUMBER.
04-107	BEN SSA NUMBER MUST BE DIFFERENT THAN EE SSA NUMBER.
05-107	BEN SSA NUMBER MUST BE DIFFERENT FROM CLAIM NUMBER.
06-107	BEN SSA NUMBER MUST BE NUMERIC.
07-107	INVALID OR INCORRECT BEN SSA NUMBER.
08-107	INVALID OR INCORRECT BEN SSA NUMBER.
09-107	INVALID OR INCORRECT BEN SSA NUMBER.

PROCESS NAME IS MCDU108-RP-EDITS

01-108	PSEUDO NUMBER MUST BE BLANK.
02-108	PSEUDO NUMBER MUST BE NUMERIC.

03A-108	PSEUDO NUMBER MUST BE DIFFERENT FROM CLAIM NUMBER OR EE SSA NUMBER.
03B-108	PSEUDO NUMBER MUST BE THE SAME AS BEN SSA NUMBER.
04-108	VALID ENTRY REQUIRED FOR PSEUDO NUMBER, BEN SSA NUMBER IS BLANK.
05-108	INVALID OR INCORRECT PSEUDO NUMBER.
06-108	INVALID OR INCORRECT PSEUDO NUMBER.
07-108	INVALID OR INCORRECT PSEUDO NUMBER.
08-108	PSEUDO NUMBER MUST BE DIFFERENT THAN RRB CLAIM NUMBER.

PROCESS NAME IS MCDU109-RP-EDITS

01-109	INVALID OR INCORRECT TYPE BENEFICIARY.
02-109	INVALID OR INCORRECT TYPE BENEFICIARY - NOT AGE 64 YEARS 6 MONTHS.
03-109	INVALID OR INCORRECT TYPE BENEFICIARY.
04-109	INVALID OR INCORRECT TYPE BENEFICIARY CHANGE.
07-109	INVALID OR INCORRECT TYPE BENEFICIARY.
08-109	INVALID OR INCORRECT TYPE BENEFICIARY.
09-109	INVALID OR INCORRECT TYPE BENEFICIARY.
10-109	INVALID OR INCORRECT TYPE BENEFICIARY.
11-109	INVALID OR INCORRECT TYPE BENEFICIARY.
12-109	INVALID OR INCORRECT TYPE BENEFICIARY.

PROCESS NAME IS MCDU110-RP-EDITS

01-110	INVALID OR INCORRECT 3RD PTY/PROT CODE.
02-110	USER NOT AUTHORIZED TO CHANGE 3RD PTY/PROT CODE.
03-110	INVALID OR INCORRECT 3RD PTY/PROT CODE.

PROCESS NAME IS MCDU111-RP-EDITS

01-111	PART B EFF DATE INVALID WITH PART B OPTION.
02-111	PART B EFF DATE CANNOT BE BEFORE 07-1966 OR AGE 65.
03-111	PART B EFF DATE TOO FAR IN FUTURE.
04-111	PART B EFF DATE NOT EQUAL TO MOLI PART B EFF DATE.
05-111	PART B EFF DATE BEFORE AGE 65 - TYPE BENEFICIARY AGE 65.
06-111	PART B EFF DATE IS BASED ON IEP PART B FILING DATE - PART B OPTION IS A SECOND OR LATER ENROLLMENT.
07-111	PART B EFF DATE INVALID WITHOUT (VALID AGED GEP) PART B FILING DATE.
08-111	BASED ON PART B FILING DATE, PART B EFF DATE SHOULD BE 07-1981
09-111	BASED ON SPECIAL 1981 (GEP) FILING DATE, PART B EFF DATE WOULD BE THREE MONTHS AFTER PART B FILING DATE.
10-111	BASED ON (GEP) PART B FILING DATE - PART B EFF DATE SHOULD BE JULY OF THE PART B FILING DATE.
11-111	PART B EFF DATE INVALID WITHOUT GOOD CAUSE PART B OPTION AND ENTRY IN EQ RELIEF ENROLL.
12-111	PART B EFF DATE NOT IN AGREEMENT WITH PART B FILING DATE.
13-111	BASED ON PART B FILING DATE - PART B EFF DATE SHOULD BE 07-1966.
14-111	BASED ON FIRST IEP - PART B EFF DATE SHOULD BE SIX MONTHS AFTER PART B FILING DATE.

15-111	BASED ON PART B FILING DATE - PART B EFF DATE SHOULD BE 07-1968.
16-111	BASED ON SPECIAL 1981 (GEP) FILING DATE, PART B EFF DATE SHOULD BE THREE MONTHS AFTER PART B FILING DATE.
17-111	BASED ON (GEP) PART B FILING DATE - PART B FILING DATE SHOULD BE JULY OF THE FILING YEAR.
18-111	BASED ON (DEEMED GEP) PART B FILING DATE - PART B EFF DATE EFF DATE SHOULD BE JULY OF NEXT YEAR.
19-111	PART B EFF DATE INVALID WITHOUT GOOD CAUSE PART B OPTION AND ENTRY IN EQ RELIEF ENROLL.
20-111	PART B EFF DATE INVALID WITHOUT GOOD CAUSE PART B OPTION AND ENTRY IN EQ RELIEF ENROLL.
21-111	INVALID OR INCORRECT PART B EFF DATE.
22-111	PART B EFF DATE CANNOT BE BEFORE 07-1973.
23-111	PART B EFF DATE TOO FAR IN THE FUTURE.
24-111	PART B EFF DATE INVALID WITH PART B OPTION.
25-111	PART B EFF DATE NOT EQUAL TO MOLI PART B EFF DATE.
26-111	PART B EFF DATE NOT LESS THAN AGE 65 - TYPE BENEFICIARY DISABLED.
27-111	PART B EFF DATE BEFORE PART A EFF DATE - TYPE BENEFICIARY NOT DISABLED.
28-111	PART B EFF DATE IS BASED ON (IEP) PART B FILING DATE - PART B OPTION IS A SECOND OR LATER ENROLLMENT.
29-111	INVALID (DISABILITY GEP) PART B FILING DATE.
30-111	BASED ON SPECIAL 1981 (GEP) PART B FILING DATE, PART B EFF DATE SHOULD BE THREE MONTHS AFTER PART B FILING DATE.
31-111	BASED ON (GEP) PART B FILING DATE - PART B EFF DATE SHOULD BE JULY OF THE PART B FILING YEAR.
32-111	PART B EFF DATE INVALID WITHOUT GOOD CAUSE PART B OPTION AND ENTRY IN EQ RELIEF ENROLL.

33-111	PART B EFF DATE NOT IN AGREEMENT WITH (DISABILITY IEP) PART B FILING DATE.
34-111	BASED ON SPECIAL 1981 (GEP) PART B FILING DATE, PART B EFF DATE SHOULD BE THREE MONTHS AFTER PART B FILING DATE.
35-111	BASED ON (GEP) PART B FILING DATE - PART B EFF DATE SHOULD BE JULY OF THE PART B FILING DATE YEAR.
36-111	PART B EFF DATE INVALID WITHOUT GOOD CAUSE PART B OPTION AND ENTRY IN EQ RELIEF ENROLL.
37-111	INVALID OR INCORRECT PART B EFF DATE.
38-111	PART B EFF DATE TOO FAR IN FUTURE.
39-111	PART B EFF DATE INVALID WITH PART B OPTION.
40-111	PART B EFF DATE NOT EQUAL TO MOLI PART B EFF DATE.
41-111	PART B EFF DATE BEFORE PART A EFF DATE - TYPE BENEFICIARY DISABLED NOW AGE 65.
42-111	PART B EFF DATE IS BASED ON (IEP) PART B FILING DATE - PART B OPTION IS A SECOND OR LATER ENROLLMENT.
43-111	PART B EFF DATE INVALID WITHOUT (VALID AGED GEP) PART B FILING DATE.
44-111	PART B EFF DATE NOT IN AGREEMENT WITH (DISABILITY GEP) PART B FILING DATE.
45-111	BASED ON SPECIAL 1981 (GEP) PART B FILING DATE, PART B EFF DATE SHOULD BE THREE MONTHS AFTER PART B FILING DATE.
46-111	BASED ON (GEP) PART B FILING DATE - PART B EFF DATE SHOULD BE JULY OF THE PART B FILING DATE.
47-111	PART B EFF DATE INVALID WITHOUT GOOD CAUSE PART B OPTION AND ENTRY IN EQ RELIEF ENROLL.
48-111	PART B EFF DATE NOT IN AGREEMENT WITH (DISABILITY IEP) PART B FILING DATE.
49-111	PART B EFF DATE NOT IN AGREEMENT WITH (AGED IEP) PART B FILING DATE.

50-111	PART B EFF DATE NOT IN AGREEMENT WITH (DISABILITY OR AGED IEP) PART B FILING DATE.
51-111	PART B EFF DATE NOT IN AGREEMENT WITH (DISABILITY OR AGED IEP) PART B FILING DATE.
52-111	PART B EFF DATE NOT IN AGREEMENT WITH (DISABILITY GEP) PART B FILING DATE.
53-111	BASED ON SPECIAL 1981 (GEP) PART B FILING DATE - PART B EFF DATE SHOULD BE THREE MONTHS AFTER PART B FILING DATE.
54-111	BASED ON (GEP) PART B FILING DATE - PART B EFF DATE SHOULD BE JULY OF THE PART B FILING DATE YEAR.
55-111	PART B EFF DATE NOT IN AGREEMENT WITH (AGED GEP) PART B FILING DATE.
56-111	BASED ON SPECIAL 1981 (GEP) PART B FILING DATE, PART B EFF DATE SHOULD BE THREE MONTHS AFTER PART B FILING DATE.
57-111	BASED ON (GEP) PART B FILING DATE - PART B EFF DATE SHOULD BE JULY OF THE PART B FILING YEAR.
58-111	PART B EFF DATE INVALID WITHOUT GOOD CAUSE PART B OPTION AND ENTRY IN EQ RELIEF ENROLL.

PROCESS NAME IS MCDU112-RP-EDITS

01-112	INVALID OR INCORRECT RECORD STATUS FOR ACTIVITY 12.
02-112	INVALID OR INCORRECT RECORD STATUS FOR ACTIVITY 13.
03-112	INVALID OR INCORRECT RECORD STATUS FOR ACTIVITY 22.
04-112	INVALID OR INCORRECT RECORD STATUS FOR THIS ACTIVITY.
05-112	INVALID OR INCORRECT RECORD STATUS FOR THIS ACTIVITY.
06-112	INVALID OR INCORRECT RECORD STATUS FOR ACTIVITY 20.
07-112	INVALID OR INCORRECT RECORD STATUS FOR ACTIVITY 21.

08-112	INVALID OR INCORRECT RECORD STATUS.
09-112	ANN BEGIN DATE MUST BE BLANK FOR THIS RECORD STATUS.
10-112	INCORRECT SMI OPTION CODE FOR THIS RECORD STATUS.
11-112	INCORRECT SMI OPTION CODE FOR THIS RECORD STATUS.
14-112	ADDRESS SCREEN REQUIRED FOR CHANGE IN RECORD STATUS.

PROCESS NAME IS MCDU113-RP-EDITS

01-113	ANN BEGIN DATE MUST BE SPACES WITH THIS RECORD STATUS.
02-113	ANN BEG DATE MUST BE NUMERIC.
03-113	INVALID OR INCORRECT ANN BEG DATE.
04-113	INVALID OR INCORRECT ANN BEG DATE.
06-113	INVALID OR INCORRECT ANN BEG DATE.
07-113	INVALID OR INCORRECT 1ST FULL MO DIS.
08-113	INVALID OR INCORRECT DIS FREEZE DATE.
09-113	INVALID OR INCORRECT DIS FREEZE DATE.
10-113	INVALID OR INCORRECT DIS FREEZE DATE.
11-113	INVALID OR INCORRECT DIS FREEZE DATE.
12-113	INVALID OR INCORRECT DIS FREEZE DATE.
13-113	INVALID OR INCORRECT DIS FREEZE DATE.
14-113	NEED A VALID ENTRY IN BOTH FIELDS.
15-113	NEED A VALID ENTRY OR SPACES IN BOTH FIELDS.
16-113	NEED A VALID ENTRY OR SPACES IN BOTH FIELDS.
17-113	INVALID OR INCORRECT ID ISSUE CODE.

18-113	INVALID OR INCORRECT ID ISSUE CODE.
19-113	INVALID OR INCORRECT ID ISSUE CODE.
20-113	MUST HAVE AN ENTRY FOR ID ISSUE CODE.
21-113	INVALID OR INCORRECT ID ISSUE CODE.
22-113	INVALID OR INCORRECT ID ISSUE CODE FOR RECORD STATUS OR PART B OPTION.
23-113	INVALID OR INCORRECT ID ISSUE CODE.
24-113	INVALID OR INCORRECT ID ISSUE CODE.
25-113	INVALID OR INCORRECT ID ISSUE CODE.
26-113	INVALID OR INCORRECT ID ISSUE CODE.
27-113	INVALID OR INCORRECT ID ISSUE CODE OR PART B OPTION.

PROCESS NAME IS MCDU114-RP-EDITS

01-114	PART B TERM DATE MUST BE NUMERIC.
02-114	INVALID OR INCORRECT PART B TERM DATE.
03-114	INVALID OR INCORRECT PART B TERM DATE.
04-114	INVALID OR INCORRECT PART B TERM DATE.
05-114	INVALID OR INCORRECT PART B TERM DATE.
06-114	PART B TERM DATE NOT VALID FOR THIS PART B OPT CODE.
07A-114	XX-XXXX NOT ALLOWED FOR PART B TERM DATE FOR ACTIVITY 20.
07B-114	XX-XXXX NOT ALLOWED FOR PART B TERM DATE FOR ACTIVITY 20.
08-114	PART B TERM DATE NOT VALID FOR THIS PART B OPT CODE.
09A-114	ENTRY NEEDED IN PART B TERM DATE.
09B-114	XX-XXXX IN PART B TERM DATE INVALID FOR ACTIVE MOLI.

10-114	INVALID OR INCORRECT PART B TERM CODE.
11-114	INVALID OR INCORRECT PART B TERM DATE OR PART B TERM CODE.
12-114	INVALID OR INCORRECT PART B TERM CODE.
13-114	INVALID OR INCORRECT PART B TERM CODE.
14-114	INVALID OR INCORRECT PART B TERM CODE.
15-114	INVALID OR INCORRECT PART B TERM CODE.
16A-114	INVALID OR INCORRECT PART B TERM CODE.
16B-114	INVALID OR INCORRECT PART B TERM CODE.
17-114	SBI ACC DATE MUST BE NUMERIC.
18-114	INVALID OR INCORRECT SBI ACC DATE.
19-114	INVALID OR INCORRECT SBI ACC DATE.
20A-114	INVALID OR INCORRECT PART B OPT CODE.
20B-114	INVALID OR INCORRECT PART B OPT CODE.
21-114	INVALID OR INCORRECT SBI ACC DATE.
21A-114	INVALID OR INCORRECT SBI ACC DATE.
21B-114	INVALID OR INCORRECT SBI ACC DATE.
22-114	SBI DEL DATE MUST BE NUMERIC.
23-115	INVALID OR INCORRECT PART B OPTION OR SBI DEL DATE.
24-114	INVALID OR INCORRECT SBI DEL DATE.
27-114	INVALID OR INCORRECT SBI DEL DATE.
30-114	PAID THRU DATE CANNOT BE LESS THAN SBI DEL DATE.
31-114	ENTRY NEEDED IN SBI DEL DATE WHEN MOLI PART B OPTION = 8.

PROCESS NAME IS MCDU115-RP-EDITS

01-115	INVALID OR INCORRECT EE SSA NUMBER.
02-115	NO VALID SSA NUMBERS PRESENT.
03-115	INVALID OR INCORRECT EE SSA NUMBER.
04-115	INVALID OR INCORRECT EE SSA NUMBER.
05-115	INVALID OR INCORRECT EE SSA NUMBER.
06-115	INVALID OR INCORRECT EE SSA NUMBER.
07-115	INVALID OR INCORRECT EE SSA NUMBER.

PROCESS NAME IS MCDU116-RP-EDITS

01-116	INVALID OR INCORRECT FORMER BEN SYM / PREFIX.
02-116	INVALID OR INCORRECT FORMER BEN SYM / PREFIX.
03-116	INVALID OR INCORRECT FORMER NUMBER.
04-116	INVALID OR INCORRECT FORMER NUMBER.
04-116	INVALID OR INCORRECT FORMER NUMBER.
05-116	INVALID OR INCORRECT FORMER NUMBER.
06-116	INVALID OR INCORRECT FORMER NUMBER.
07-116	INVALID OR INCORRECT FORMER NUMBER.
08-116	INVALID OR INCORRECT FORMER NUMBER.
09-116	INVALID OR INCORRECT FORMER NUMBER.
10-116	FORMER RRB CL NUMBER CANNOT EQUAL RRB CLAIM NUMBER.

PROCESS NAME IS MCDU117-RP-EDITS

02-117	INVALID OR INCORRECT PART A TERM DATE.
03-117	INVALID OR INCORRECT PART A TERM DATE.
04-117	INVALID OR INCORRECT PART A TERM DATE.
05-117	INVALID OR INCORRECT PART A TERM DATE.
05A-117	USER NOT AUTHORIZED FOR ENTRY TO PART A TERM DATE.
06-117	INVALID OR INCORRECT PART A TERM DATE OR RECORD STATUS.
07-117	INVALID OR INCORRECT ENTRY IN PART A TERM DATE, MOLI PART A
	TERM DATE NOT GREATER THAN CURRENT DATE.
08-117	INVALID OR INCORRECT PART A TERM DATE.
09-117	PART A TERM DATE MUST HAVE VALID ENTRY.
09A-117	PART A TERM DATE MUST HAVE VALID ENTRY.
09B-117	PART A TERM DATE MUST HAVE VALID ENTRY.
09C-117	ONLY XX-XXXX ALLOWED WHEN MOLI RECORD STATUS = 90.
10-117	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
11-117	XX-XXXX IN PART A TERM DATE INVALID, NO MOLI PART A TERM DATE.
12-117	ACTIVITY INVALID FOR INACTIVE MOLI.
13-117	INVALID OR INCORRECT PART A TERM DATE.
14-117	WITH XX-XXXX IN PART A TERM DATE, ID ISSUE CODE MUST = 2.
15-117	PART A TERM DATE MUST HAVE ENTRY, MOLI HAS PART A TERM DATE.

PROCESS NAME IS MCDU118-RP-EDITS

01-118	INVALID OR INCORRECT DATE OF DEATH.
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02-118	INVALID OR INCORRECT DATE OF DEATH.
03-118	INVALID OR INCORRECT DATE OF DEATH.
04-118	INVALID OR INCORRECT DATE OF DEATH.
05-118	INVALID OR INCORRECT DATE OF DEATH.
06-118	INVALID OR INCORRECT DATE OF DEATH.
07-118	INVALID OR INCORRECT DATE OF DEATH.
08-118	XX-XX-XXXX NOT ALLOWED IN DATE OF DEATH.
09-118	XX-XX-XXXX INVALID, NO DATE OF DEATH ON MOLI.
10-118	DATE OF DEATH REQUIRED FOR RECORD STATUS 99.
12-118	RECORD STATUS 99 REQUIRED WITH ENTRY IN DATE OF DEATH.

PROCESS NAME IS MCDU119-RP-EDITS

01-119	ENTER A VALID CLAIM NUMBER.
02-119	INVALID OR INCORRECT BEN SYMBOL / PREFIX.
03-119	CLAIM NUMBER MUST BE NUMERIC.
04-119	INVALID OR INCORRECT CLAIM NUMBER.
05-119	INVALID OR INCORRECT CLAIM NUMBER.
06-119	INVALID OR INCORRECT CLAIM NUMBER.
07-119	INVALID OR INCORRECT CLAIM NUMBER.
08-119	INVALID OR INCORRECT CLAIM NUMBER.
09-119	INVALID OR INCORRECT CLAIM NUMBER.
10-119	INVALID OR INCORRECT CLAIM NUMBER.

PROCESS NAME IS MCDU120-RP-EDITS

01-120	INVALID OR INCORRECT BENEFICIARY FIRST NAME.
02-120	INVALID OR INCORRECT BENEFICIARY FIRST NAME.
03-120	BENEFICIARY MIDDLE INITIAL MUST BE BLANK OR ALPHABETIC.
04-120	INVALID OR INCORRECT BENEFICIARY LAST NAME.
05-120	INVALID OR INCORRECT BENEFICIARY LAST NAME.

PROCESS NAME IS MCDU121-RP-EDITS

01-121	INVALID OR INCORRECT PART B PREMIUM RATE.
02-121	INVALID OR INCORRECT PART B PREMIUM RATE.

PROCESS NAME IS MCDU122-RP-EDITS

01-122	TYPE BENEFICIARY, HI DATE OF BIRTH, PART A EFF DATE, PART B EFF DATE INCONSISTENT BETWEEN ACTIVITY AND MOLI.
02-122	TYPE BENEFICIARY, HI DATE OF BIRTH, PART A EFF DATE, PART B EFF DATE INCONSISTENT BETWEEN ACTIVITY AND MOLI.
03-122	TYPE BENEFICIARY, HI DATE OF BIRTH, PART A EFF DATE, PART B EFF DATE INCONSISTENT BETWEEN ACTIVITY AND MOLI.
04-122	TYPE BENEFICIARY, HI DATE OF BIRTH, PART A EFF DATE, PART B EFF DATE INCONSISTENT BETWEEN ACTIVITY AND MOLI.
05-122	TYPE BENEFICIARY, HI DATE OF BIRTH, PART A EFF DATE, PART B EFF DATE INCONSISTENT BETWEEN ACTIVITY AND MOLI.
06-122	ACTIVITY INVALID AGAINST DUAL ANNUITANT.
07-122	ACTIVITY INVALID FOR INACTIVE MOLI.

08-122	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
09-122	PART B OPTION DOES NOT EQUAL MOLI PART B OPTION.
10-122	ACTIVITY INVALID FOR INACTIVE MOLI.
11-122	ACTIVITY INVALID FOR INACTIVE MOLI.

PROCESS NAME IS MCDU123-RATE-CALC

001-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE NO SMIB RATE TABLE RECORDS IN THE DATABASE
002-123	PART B PREM RATE NOT EQUAL TO MOLI PREM RATE ACTIVITY 22 SHOULD BE USED TO CHANGE THE PART B PREM RATE
003-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE INVALID PART B OPTION
004-123	PART B PREM RATE NOT EQUAL TO MOLI VAR BASE RATE
005-123	PART B PREM RATE NOT EQUAL TO MOLI PREM RATE
006-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE FELL THROUGH ACTIVITY WITH PART B OPTION 1, A OR 4
007-123	PART B PREM RATE NOT EQUAL TO MOLI VAR BASE RATE
008-123	PART B PREM RATE NOT EQUAL TO MOLI PREM RATE
009-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE FELL THROUGH ACTIVITY WITH PART B OPTION 5, B OR 6
010-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE FELL THROUGH ACTIVITY WITH PART B OPTION C
011-123	PART B PREM RATE NOT EQUAL TO MOLI VAR BASE RATE
013-123	PART B PREM RATE NOT EQUAL TO CURR VAR BASE RATE
016-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR

019-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
020-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE FELL THROUGH ROUTINE 1
021-123	PART B PREM RATE NOT EQUAL TO MOLIVAR BASE RATE
022-123	PART B PREM RATE NOT EQUAL TO CURRVAR BASE RATE
026-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
029-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
030-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE FELL THROUGH IEP ENROLLMENT IN ROUTINE 2
031-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE HI DATE OF BIRTH AND TYPE BENEFICIARY CONFLICT
032-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE POSITION 1 OF TYPE BENEFICIARY NOT 0, 1 OR 2
033-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE NOT IEP OR GEP AND NO EQUITABLE RELIEF
034-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE 1ST EP PENALTY STOPPING POINT
035-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE 1ST EP PENALTY MONTHS
037-123	PART B PREM RATE NOT EQUAL TO MOLIVAR BASE RATE
039-123	PART B PREM RATE NOT EQUAL TO MOLIVAR BASE RATE PLUS CALC PEN AMT
041-123	PART B PREM RATE NOT LESS THAN OR EQUAL TO MOLIVAR BASE RATE PLUS CALC PEN AMT
043-123	PART B PREM RATE NOT EQUAL TO CURRVAR BASE RATE PLUS CALC PEN AMT
045-123	PART B PREM RATE NOT EQUAL TO CURRVAR BASE RATE PLUS CALC PEN AMT

046-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CURR CAT EFF DATE IS GREATER THAN NEXT YEAR
048-123	PART B PREM RATE NOT LESS THAN OR EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT
050-123	PART B PREM RATE NOT LESS THAN OR EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT
051-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CURR CAT EFF DATE IS GREATER THAN NEXT YEAR
054-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
055-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
056-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE VAR SCREEN ADDED - CURR VAR RATE CD NOT V OR N
059-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
060-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
061-123	PART B PREM RATE MUST BE BLANK WHEN PART B OPTION IS 2 OR 3
064-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE HI DATE OF BIRTH AND TYPE BENEFICIARY CONFLICT
065-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE INVALID MOLI SMI OPT CD
066-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE POSITION 1 OF TYPE BENEFICIARY NOT 0, 1 OR 2
067-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE MOLI SMI EFF DATE NOT IEP OR GEP AND NO EQUITABLE RELIEF
068-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 1ST EP PENALTY STOPPING POINT
069-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 1ST EP PENALTY MONTHS

070-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE INVALID MOLI SMI OPT CD
071-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE NOT IEP OR GEP AND NO EQUITABLE RELIEF
072-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 2ND EP PENALTY STOPPING POINT
073-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 2ND EP PENALTY MONTHS
075-123	PART B PREM RATE NOT EQUAL TO MOLI VAR BASE RATE
077-123	PART B PREM RATE NOT EQUAL TO MOLI VAR BASE RATE PLUS CALC PEN AMT
079-123	PART B PREM RATE NOT LESS THAN OR EQUAL TO MOLI VAR BASE RATE PLUS CALC PEN AMT
081-123	PART B PREM RATE NOT EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT
083-123	PART B PREM RATE NOT EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT
084-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CURR CAT EFF DATE IS GREATER THAN NEXT YEAR
086-123	PART B PREM RATE NOT LESS THAN OR EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT
088-123	PART B PREM RATE NOT LESS THAN OR EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT
089-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CURR CAT EFF DATE IS GREATER THAN NEXT YEAR
092-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
093-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
094-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE VAR SCREEN ADDED - CURR VAR RATE CD NOT V OR N

097-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
098-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
101-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE HI DATE OF BIRTH AND TYPE BENEFICIARY CONFLICT
102-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE INVALID MOLI SMI OPT CD
103-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE POSITION 1 OF TYPE BENEFICIARY NOT 0, 1 OR 2
104-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE MOLI PREV SMI EFF DATE NOT IEP OR GEP AND NO EQUITABLE RELIEF
105-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 1ST EP PENALTY STOPPING POINT
106-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 1ST EP PENALTY MONTHS
107-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE INVALID MOLI SMI OPT CD
108-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE NOT IEP OR GEP AND NO EQUITABLE RELIEF
109-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 2ND EP PENALTY STOPPING POINT
110-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 2ND EP PENALTY MONTHS
112-123	PART B PREM RATE NOT EQUAL TO MOLI VAR BASE RATE
114-123	PART B PREM RATE NOT EQUAL TO MOLI VAR BASE RATE PLUS CALC PEN AMT
116-123	PART B PREM RATE NOT LESS THAN OR EQUAL TO MOLI VAR BASE RATE PLUS CALC PEN AMT
118-123	PART B PREM RATE NOT EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT

120-123	PART B PREM RATE NOT EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT
121-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CURR CAT EFF DATE IS GREATER THAN NEXT YEAR
123-123	PART B PREM RATE NOT LESS THAN OR EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT
125-123	PART B PREM RATE NOT LESS THAN OR EQUAL TO CURR VAR BASE RATE PLUS CALC PEN AMT
126-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CURR CAT EFF DATE IS GREATER THAN NEXT YEAR
129-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
130-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
131-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE VAR SCREEN ADDED - CURR VAR RATE CD NOT V OR N
134-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
135-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
142-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE MOLI SMI EFF DATE IS GREATER THAN NEXT YEAR
146-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CURR CAT EFF DATE IS GREATER THAN NEXT YEAR
150-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE MOLI SMI EFF DATE IS GREATER THAN NEXT YEAR
151-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE INVALID MOLI SMI OPT CD
152-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE POSITION 1 OF TYPE BENEFICIARY NOT 0, 1 OR 2
153-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE NOT GEP AND NO EQUITABLE RELIEF

154-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 1ST EP PENALTY STOPPING POINT
155-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CANNOT DETERMINE THE 1ST EP PENALTY MONTHS
156-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE VAR SCREEN ADDED - CURR VAR RATE CD NOT V OR N
157-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE VAR SCREEN NOT ADDED - MOLI VAR RATE CD NOT V, N OR SPACE
158-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE MCWU005-MC-VAR-PART-B-ADDED-SW NOT Y OR N
159-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE VAR SCREEN ADDED - CURR VAR RATE CD NOT V OR N
160-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE VAR SCREEN NOT ADDED - MOLI VAR RATE CD NOT V, N OR SPACE
161-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE MCWU005-MC-VAR-PART-B-ADDED-SW NOT Y OR N
162-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE FELL THROUGH ROUTINE 8
166-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CURR CAT EFF DATE IS GREATER THAN NEXT YEAR
170-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE MOLI SMI EFF DATE IS GREATER THAN NEXT YEAR
171-123	CURR PEN PERCENT NOT LESS THAN OR EQUAL TO CALC PEN PERCENT
172-123	CURR PEN PERCENT NOT EQUAL TO CALC PEN PERCENT
179-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
186-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
187-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR

191-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE PART B EFF DATE IS GREATER THAN NEXT YEAR
194-123	PART B PREM RATE NOT EQUAL TO A CURRENT YEAR TABLE PREM RATE WITHIN THE RANGE OF THE BASIC RATE AND THE CALC PREM RATE
198-123	PART B PREM RATE NOT EQUAL TO A LATEST YEAR TABLE PREM RATE WITHIN THE RANGE OF THE BASIC RATE AND THE CALC PREM RATE
200-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE EFFECTIVE YEAR SMIB RATE TABLE RECORD NOT IN THE DATABASE
201-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE CURRENT YEAR SMIB RATE TABLE RECORD NOT IN THE DATABASE
202-123	UNABLE TO CALCULATE AND VERIFY THE PART B PREM RATE LATEST YEAR SMIB RATE TABLE RECORD NOT IN THE DATABASE

PROCESS NAME IS MCDU131-RP-MOLI

01-131	INCORRECT ACTIVITY CODE - NO MOLI RECORD EXISTS.
02-131	INVALID RECORD STATUS 01, 02, 03, 04 OR 05 FOR ACTIVITY.
03-131	INVALID RECORD STATUS 90 OR 99 FOR ACTIVITY.
04-131	INVALID SMI OPTION CODE 9 FOR ACTIVITY.
05-131	INVALID RECORD STATUS 98 FOR ACTIVITY.
06-131	INVALID RECORD STATUS 99 FOR ACTIVITY.
07-131	INCORRECT ACTIVITY CODE - MOLI RECORD EXISTS.
08-131	INVALID ACTIVITY CODE.
09-131	DATABASE ERROR, NO MOEROLR RECORD.
10-131	DATABASE ERROR - NO MOMEDIR.

11-131	DATABASE ERROR, NO MOEROLR RECORD.
12-131	RECORD ON DATABASE, BENEFICIARY SYMBOL DOES NOT MATCH.
13-131	RECORD ON DATABASE, BENEFICIARY SYMBOL DOES NOT MATCH.
14-131	RECORD ON DATABASE, BENEFICIARY SYMBOL DOES NOT MATCH.

PROCESS NAME IS MC28DAY-EDITS

PROCESS NAME IS MC30DAY-EDITS

PROCESS NAME IS MC31DAY-EDITS

PROCESS NAME IS MCAGE65

PROCESS NAME IS MCAGENOW

PROCESS NAME IS MCSSASUF-FORMER-YES

6 - YES INVALID OR INCORRECT SSA CLAIM NUMBER.

7 - INVALID OR INCORRECT SSA CLAIM NUMBER.

PROCESS NAME IS MCSSASUF-FORMER-NO

8 - NO INVALID OR INCORRECT SSA NUMBER.

9 - NO INVALID OR INCORRECT SSA NUMBER.

PROCESS NAME IS MC-ACF2-EDITS

NO ACF2 CLEARANCE.

Retirement Claims Manual (RCM)

Section RCM 9

9.1.1 Scope of Chapter

This chapter describes, in very general terms, the functions of the major retirement and survivor EDP (Electronic Data Processing) programs. Special attention is given to explaining the action required on retirement cases being paid under RASI. Directions for preparation of data input forms are contained in the appendices at the end of this chapter. Basic instructions on the proper manner of completing forms, (e.g., acceptable abbreviations, titles, etc.), can be found in Chapter 8.1, Appendices B through D. For more information on the various topics discussed, consult the references given throughout this chapter.

9.1.2 Summary Of Retirement EDP Programs

Listed below are brief descriptions of the major EDP programs involved in retirement cases. Check the RCM cross-references for additional details.

- A. RASI - The basic retirement EDP program is RASI (Retirement Adjudication System - Initial). RASI adjudicates, calculates, and awards initial employee and/or spouse annuities under the provisions of the 1974 Railroad Retirement Act.

RASI accepts applications and proofs into the system, requests data from examiners when necessary (see [RCM 9.2](#)), mechanically makes TRIC requests and RUIA clearances, and produces mechanical referral messages (see [RCM 9.3](#)). RASI awards annuities in the majority of cases entered into the system. Those cases that cannot be paid mechanically, including some that must be denied, are dumped for manual handling. RASI produces award forms for every paid case; some require review before filing, others do not. In cases where it appears that an overpayment could occur, RASI will produce a "computation only" referral to aid examiners in adjusting the annuity. SMIB deductions are never made on RASI initial awards, but are handled mechanically where necessary after the cases have paid final. When the proper data is received, RASI will award IMPACT (partial) awards in employee age and service cases and SPAR (partial) awards in spouse cases.
- B. SAARA (SUPPLEMENTAL ANNUITY AND RETIREMENT ATTAINMENTS) - When an employee attains age 65 or age 60 and is eligible for a supplemental annuity, MAP (Monthly Attainment Program) calls the case up for processing by SAARA, which is part of RASI's post-adjudication program. See RCM 9.2 for further information about the post-adjudication program.
- C. CAPRA - CAPRA (Calculate and Pay Retirement Annuities) Not currently operational.
- D. TRIC - TRIC (Telecommunicated Request for Interagency Coordination) secures earnings and benefit data through the EDP systems of SSA and RRB. RASI

routinely requests, through TRIC, SSA wage and benefit data for all employee and spouse applications. Examiners can generate a TRIC request by submitting a Form G-60 to RASI, RCM 7.4 describes TRIC in greater detail.

- E. MAP - MAP (Monthly Attainment Processing) produces referral messages for selected cases requiring examiner handling because an annuitant or an IPI has attained an age where an annuity adjustment is required. For instance, MAP will produce referrals in cases where a child attains age 16 or 18 or a student attains age 22.
- F. TACAL - TACAL (Tax Credit and Liability) produces quarterly reports of employer tax liabilities and credits involved in supplemental annuity payments. TACAL produces a monthly microfilm of the tax credit master file which reflects current tax liability/credit activity. RCM 9.3 explains TACAL referral messages produced to identify discrepancies in the TACAL record.
- G. Medicare Enrollment - Five months before an employee or spouse attains age 65, MAP selects the case to establish a health insurance (HI) record, to determine the annuitant's eligibility to Medicare Coverage and to transmit the record to SSA for the establishment of the Health Insurance Master (HIM) file maintained at SSA - BDP in Baltimore. RCM 3.2 and 3.3 contain more information about Medicare enrollment operations.
- H. APPLE – APPLE (Application Express). Please refer to FOM 1, Section 1581 for detailed instructions and functions of APPLE.

9.1.3 Summary Of Survivor EDP Programs

The major EDP programs involved in death cases are briefly described below. Cross-references to more detailed descriptions in the RCM have been provided.

- A. SURCAL - The basic survivor EDP program for monthly and non-monthly awards is SURCAL (Survivor Calculations, formerly known as the "360 program"). SURCAL performs three separate operations: (1) Awarding an initial recurring annuity; (2) Awarding a spouse-to-widow(er) conversion; or (3) Awarding one-payment-only cases such as LSDP, RLS or accrued annuities. Operation (1) is accomplished by Forms G-360/G-360a and is more completely described in Section 9.1.60 below and in Appendix B (G-360/G-360a instructions) to this chapter. Operation (2) is accomplished by Form G-360 and is more completely described in Section 9.1.61 below and in Appendix B (G-360 instructions) to this chapter. Operation (3) is accomplished by Forms G-359a and G-359b and is more completely described in section 9.1.62 below and in Appendix B (G-359a and G-359b instructions) to this chapter.
- B. SURVEA - When a survivor annuitant attains a certain age, examiner handling may be required, e.g., child attains age 18 or student attains age 19 or age 22. The selection and referral of these cases to examiners is accomplished by

SURVEA (Survivor Electronic Attainments). Referral messages are issued which describe the reason for selection. If necessary, examiner action is taken. The "diary" conversion EDP program that mechanically recertified such cases is not currently operational.

- C. Medical Enrollment - The process of Medicare enrollment in survivor cases is identical to that described in Section 9.1.2G above. The only difference is that SURVEA is the selection program in survivor cases rather than MAP as used in retirement cases.
- D. TRIC - Earnings and benefit data are secured through the EDP systems of SSA and RRB by TRIC (Telecommunicated Request for Interagency Coordination). In survivor cases, TRIC automatically releases requests for the wage record of deceased employees when the examiner prepares a Form G-73a. All initial requests for benefit and wage data for survivor annuitants must be done manually by completing Form G-60. TRIC is described more fully in RCM 7.4. Instructions for completing Form G-60 can be found in Appendix C to this chapter.

9.1.4 Summary Of Benefit Payment Operation Programs

The Benefit Payment Operation is comprised of three subsystems. One operates on a daily, another on a monthly, and the third on an annual basis. The total system, comprised of over 50 programs, provides for the accumulation and maintenance of records necessary for the issuance of payments under the Railroad Retirement Act and for the control of data to report to the Internal Revenue Service on the amounts of supplemental annuity payments made during the year.

A. Daily Subsystem

1. DAISY - DAISY (Daily Activity Input System) produces a record of all award activity, involving mechanical or manual payment of benefits. DAISY edits all award records to insure completeness; checks money amounts to insure correctness of individual manual award actions; and balances individual voucher batches. DAISY's output becomes the input of the Chico program described below.

DAISY also verifies the ZIP code on all awards and change of address actions. If the ZIP code is missing or wrong on any action, and the city and state is mechanically identifiable, DAISY adds the correct ZIP code to the record, producing a file notice of the change.

2. Chico - Chico is the benefit payment check-writing operation. This program screens all awards and termination/suspension (G-96) actions against the master benefit payment file. In its screening process, Chico updates the master with new award actions, and changes rates in

recertification actions. Chico's output is a comprehensive file of all award and termination activity.

3. Processing Daily Accrual/Reject Awards - This system prepares listings of accepted and rejected award actions, as well as an accrual tape for the Treasury Department's disbursing operation. Also, it accumulates all daily awards for processing in the monthly operation.
- B. Monthly Update Subsystem - The monthly subsystem involves several programs which: (a) create the check issue file in ZIP code sequence; (b) produce tables showing distribution of payments by state by type of benefit; (c) create a tax credit file; (d) create the supplemental annuity 1099 files; and (e) select a testing file involving 1% of annuity awards.
- C. Annual Subsystem - This system accumulates, from check records, the amount paid in supplemental annuities for the preceding calendar year. Then, a Form G-1099 is printed for each beneficiary for income tax purposes and a tape file report is prepared for the Internal Revenue Service.

9.1.5 Routing Of G-626

Refer to [FOM1 1581.35.4](#)

9.1.6 Correction Of RASI Application Input Rejects

APPLE includes many of RASI's application input edits, so input rejects should be rare. If RASI does reject an application, a referral is produced. These referrals are e-mailed to RBD for handling.

9.1.7 Recording Claims Data

Refer to [FOM1 1581.13](#) for APPLE Instructions.

9.1.9 Notice Of Death

- A. Employee - If notice of death is received in a pending RASI case, submit a type code 991 screen dump the case.

When REQUEST shows that the case has been dumped:

- If a partial award has already been made, take action to terminate it.
- Route the folder to Survivor Initial Claims, noting on the G-26 "1st Notice of Death."

- B. Spouse - If the spouse dies while his/her claim is pending on RASI, dump it. Take action as above if a partial payment has been made. Send the case to

Retirement Initial Claims for development of accrued annuities due but unpaid at death, if necessary.

If a spouse-only claim is pending on RASI when the employee dies, dump the spouse claim and handle in accordance with A above.

9.1.20 Initial Handling In Module

- A. General - Develop an annuity claim to the fullest extent possible without waiting for a computer referral. If the G-230 shows the required evidence was previously submitted, and REQUEST indicates the evidence is still pending, check the proofs in the file for acceptability and submit the appropriate data to RASI via KeyMaster - "RASIFORM."

Form G-227 should be stapled to the front of each claim folder containing an initial retirement application when it is received in BRB. This form was revised in 1996, to provide additional controls to ensure complete case adjudication. Enter the filing date and ABD in the appropriate spaces to ensure that our customer service commitment is met. The form can also be used for dormant file call-up purposes.

When the case is initially examined, notate the ACTIONS NEEDED section to establish a checklist of actions necessary to complete the initial award. These items should be crossed off as they are completed. Any actions taken, such as RASIFORM entries, should be listed under ACTIONS TAKEN. Any post actions needed after the initial award has been completed should be listed in the bottom section of the form. The case should then be forwarded to the post section to handle any listed actions. After the case is paid final and all actions have been completed, the form should be removed from the folder and discarded.

- B. Representative Payee - Check each claim folder for evidence of incompetency of the applicant and develop, through the field, for a representative payee if necessary. While waiting for this information, enter a type code 997 RASIFORM screen with the appropriate code indicating a representative payee is required but not yet appointed. Once a representative payee is required but not yet appointed. Once a representative payee has been chosen, prepare a second 997 screen to enter the name of the representative payee.
- C. Disability Cases - Disability cases on RASI are handled by BDMO.
- D. Annuity Beginning Date - RASI cannot recognize a spouse case in which the ABD depends on the date the spouse first has a child in her care or the date of the child's adoption. If the ABD should be the first day of the month the spouse first has a child in her care or the first day of the month of the child's adoption, complete a type code 996 RASIFORM screen to enter that date into RASI.

In a case where the applicant demonstrates "an intent to retire" (see RCM 1.7.21) before the last period of employment shown on the application started, prepare a type code 991 RASIFORM screen to dump the case from RASI. Pay the case manually.

RASI cannot recognize a case in which the spouse files for a reduced annuity and the ABD could be retroactive to a period during which she received an unreduced annuity based on having a child in her care. In such a case, prepare a type code 996 RASIFORM screen to change the ABD to the first day of the month following the month her unreduced annuity terminated to avoid an overpayment.

Each time RASI is programmed to process cases with a cost-of-living increase, the earliest ABD that can be handled by RASI will change. In general, RASI will handle a case with an ABD two years retroactive from COL effective date. For instance, when adjusting for the 1-96 COL increase, RASI will not be able to handle a case with an ABD earlier than 1-1-94.

- E. Review of G-346 - Check the G-346 submitted with spouse applications to determine whether the employee has certified that the applicant is in fact his/her spouse. Also determine if any previous marriage has been terminated and if the present marriage is valid. If further development is necessary, set a manual OP code (RCM 9.4) to prevent payment of the claim until these determinations can be made.
- F. Cancellation - If an individual files an application for an annuity and then advises (s)he wishes to cancel his/her application, prepare a type code 991 RASIFORM screen to dump the case from RASI. The 991 may also be used to dump a case after it has been paid final by RASI. For example, when an individual wishes to cancel the original application after RASI has made final payment and submits a second application, if the original application still appears on REQUEST and if there is no overpayment (e.g., annuitant returns his check), prepare a 991 with applicable code 147 or 149 to drop the first application from RASI. RASI will then accept any subsequent applications submitted by the individual. Any case where an overpayment exists must be manually handled.

9.1.21 Manual Coding Of Supporting Data

When the claim folder is initially sent to RIS, the data on the G-230, the application, the G-88A.2 and the G-91, if submitted with the application, have already been entered into RASI. Any necessary data received later must also be entered into RASI via the appropriate RASIFORM screen(s). Make the appropriate notation on the G-227 that the data was entered, along with your initials and the current date.

Any tracing action for a particular document should be ignored if the G-227 shows that the data was submitted to RASI within the previous seven-day period.

9.1.22 Current Connection (C/C) Determination

RASI will create a 947 call-up for an examiner C/C determination if:

1. The year the employee last worked in the RR industry is more than three years before the year in which the annuity will begin; and
2. The year in which he last worked outside the RR industry according to his application) is more than two years after the year he last worked in the RR industry; or,
 - the employee was involuntarily separated from RR employment and his C/C could be deemed; or,
 - the employee claimed federal employment after the DLW-RR; or,
 - the employee is a Canadian citizen performing service in Canada for a U.S. employer.

In cases without examiner input, review the C/C determination made by RASI if:

1. The applicant is rated disabled under Section 2(a)4; or if
2. A supplemental annuity is involved,

Since a C/C is needed for eligibility for both types of annuities.

If review determines RASI's C/C determination is incorrect and no recertification is required, notate the file and prepare Form G-59r. The Research record must be corrected to establish a call up at age 65 for age annuities with at least 25 years of service, or at age 60 for D/A case with at least 30 years of service for supplemental annuity development. If the employee is currently eligible for a supplemental annuity, or within 90 days, control case and initiate payment.

9.1.23 Proof Of Age (POA)

If a document establishing proof of age is submitted, prepare a type code 900 RASIFORM screen. Documentary evidence is accepted by RASI if it agrees with the claimed month and year of birth.

Prepare a type code 996 RASIFORM screen (see RCM 9.4) for correction of the claimed DOB if a different DOB is proven but still permits payment. If a DOB is proven which make the applicant ineligible, dump the case and handle manually.

POA is always required before final payment can be made in disability cases. If payment must be made without POA to expedite a 2(a)5 case, submit a 900 to verify claimed DOB. Control folder after payment until an acceptable POA is obtained.

9.1.24 Lag Compensation

Forms G-88A.2 are routed from the mailroom to RIS for entry into RASI. If the DLW shown on the G-88A.2 is different than the claimed DLW, the DLW shown on the G-88A.2 is accepted by RASI.

If two lag employers are claimed on the annuity application, the field will release two employer lag Forms G-88A.2. Consolidate the service months and compensation data from both Forms G-88A.2 and enter that data into RASI on a type code 958 RASIFORM screen. This, in effect, will be treating service months and compensation as though reported by a single employer.

9.1.25 Manual OP (OPERATION) Code

A manual OP code is a computer code, which allows acceptance of an application into the system and develops it to the point of calculation, but will not allow payment. RASI will set a manual OP code for any one or more of the following reasons:

- Employee
- Previously filed an annuity application with RRB.
- EE indicates entitlement to a non-covered service pension.
- Spouse
- Previously filed an annuity application with RRB.
- Invalid spouse SSA number.
- EE felony conviction indicated.
- Employee or Spouse
- Rejected input on a type code 996 RASIFORM screen.
- Self-employment indicated, and the field office has determined that BRB examiner review required.

RASI will also set a manual OP code if the Manual Review block on the Form G-230 is checked. The field office should request Manual Review when a question of eligibility exists and a review by the BRB examiner is necessary before any payment is released. A request for Manual Review zeros out the IMPACT and/or SPAR. Some situations where Manual Review would be indicated are:

- The applicant is still working and the field office is concerned that alleged LPE or SE is actually RR employment.

- M/S or lag required for eligibility and not previously verified and IMPACT rate entered.
- Marital status or validity of marriage is questionable and SPAR rate entered.
- There is an overpayment established in the case.

If an examiner wishes to prevent payment on a case, he can set a manual OP code by using the appropriate code on a 995. After all necessary action has been taken on the claim and if a final review of the case indicates there is nothing to impede payment, submit another 995 to change manual OP code. (See RCM 9.2 for 995 instructions.)

9.1.26 RUIA Clearances

- A. Pre-Clearances - When an application for an age and service annuity is entered into RASI, a pre-clearance (without the annuity rate and ABD information) is released to SUBS computer operations. If SUBS has a record of an RUIA claim for the current or preceding benefit year or an overpayment still outstanding, a reply is sent to RASI that a record exists and thus further clearance is required. If SUBS has no record of an RUIA claim for the current or preceding benefit year, the tape is returned to RASI showing "No Record". When an annuity claim is ready for an award and the tape record shows that a "No Record" pre-clearance has been received, payment is made without further RUIA clearance.

There is no pre-clearance for disability applications, due to the stronger likelihood that an RUIA record may be created after RASI receives the application. Therefore, RASI obtains RUIA clearance with rate and ABD information for all disability awards.

- B. Final Clearances - If the pre-clearance indicates that a record exists in an age and service case or if this is a disability case, RASI sends a partial or final clearance request, showing the annuity rate and ABD to SUBS when the annuity claim is ready for payment.
- C. RUIA Clearance on Award Form - Item 35 of the G-354r shows the amount of any RUIA payments that are being recovered from the annuity, or "NO REC" if the pre-clearance was returned as a "No Record" case, or "NONE" if there was a record, but no overpayment.

NOTE: When there is a large RUIA amount to be recovered but insufficient annuity accrual to recover the amount, RASI will withhold payment for a month if there is enough accrual to recover the RUIA amount. In final awards, if the RUIA amount cannot be recovered with the extra month's accrual, RASI will produce a "Compute Only" award. In partial awards, if the RUIA amount cannot be recovered with an extra month's accrual, RASI will not pay the partial rate, but will withhold payment until a final rate can be paid.

- D. Dump Cases Involving RUIA Clearances - See RCM 5.9.12 for handling RUIA clearance in claims dumped because of death. In cases dumped for denial, transfer to SSA, or other reasons that will not result in award, no further action on RUIA clearance is required. The need for RUIA clearance in cases dumped for ROC award is indicated on REQUEST, Screen 12 - "BUSI CLR."

If the contents of this location is a 2, 3, 4, or 7, RUIA clearance is required. Prepare Screen 17 (BUSI Clearance) on ROC for regular clearance. The "Remarks" block should show "Cancel previous clearance," if any. (Code was any other than 7.)

If the code is "1-NO REC," no further RUIA clearance is required unless a RUIA folder record is in file (see RCM Chapter 5.9.40-5.9.44 for handling cases where a RUIA folder record is involved) OR one of the requirements in RCM 5.9.12 is applicable.

If the code is 5 or 6, RUIA clearance has been received. If the ABD and rate will not be changed on the ROC award, and the type of action (partial, final or recert) lines up with the previous recovery, (5 = CASE COMPUTED FINAL; 6 = CASE COMPUTED PARTIAL) no further RUIA clearance is required for this particular action. If there is an RUIA recovery, a money amount will be shown in the "RECOVBUSOC" or "RECOVBUSRT" fields of REQUEST, Screen 13.

If the ABD is being changed in the ROC adjustment, note this in the "Remarks" section of Screen 17 (ROC) - BUSI Clearance. Also note the amount and date of entitlement of any social security benefit the annuitant may be receiving.

- E. Rates Involving Work Deductions - Clearance is secured based on the annuity rate before temporary work deductions are applied. Therefore, it is possible that a RASI W/D case could result in a situation where "BUSI EXCEEDS ACCRUAL." If a case is dumped from RASI for this reason, examiners should certify the case using the rate which is actually going to be paid (rate after W/D's).

In RASI W/D cases where the accrual amount after W/D's is sufficient to recover the requested RUIA amount, RASI will make final payment based on the clearance received. Although SUBS should be furnished the rate paid, no further clearance action should be taken until end-of-year policing. This is because the W/D applied by RASI is a temporary deduction. In these cases the actual monthly rate payable is not known until permanent work deductions are applied. Therefore, the RUIA clearance based on the actual rate payable will be secured by RBD as part of end-of-year policing. These end-of-year clearances will also be secured in those cases where a "BUSI EXCEEDS ACCRUAL" situation occurred.

9.1.27 Work Deductions

RASI assesses temporary work deductions (TWD's) based on application or Research data. RASI considers factors such as employee or spouse LPS, excess earnings indicators for the employee or spouse, non-work months, the employee's work deduction insured status, and the annuitant's annuity components subject to deductions. RASI can apply either recurring or non-recurring deductions.

- A. Regular TWDs - RASI uses the PIA 2 and VDB amounts computed for the current month and applies those amounts to all months subject to deductions in the accrual period. In reduced age 62 cases, the ABD age reduction factor is applied to the work deduction components.

RASI does not make tier 1 work deductions in any month the annuity is reduced for social security benefits.

RASI does not apply any TWD's to tier 1 or the VDB in months or years the applicant expects earnings to be under the monthly or annual exempt amounts. (However, a spouse's tier 1 is subject to TWD's for the employee's excess earnings.)

- B. LPS TWDs - RASI reduces tier 2 and the supplemental annuity, if any, by one dollar for every two dollars of LPS earnings; however, RASI will not deduct more than 50% of the net tier 2 and sup annuity.

RASI considers up to two periods of non-RR employment beginning before the ABD. Calculations are based on the average monthly salaries; TWD's may be reduced or eliminated in the month after non-RR employment ends.

RASI applies LPS TWD's to a spouse annuity for LPS earnings of the employee, the spouse or both.

More information about RASI's TWD processing is in RCM 5.7.50 and 5.7.115.

9.1.28 Cases With Voluntary Military Service In The 6-15-48 Thru 12-15-50 Period

- A. General - Prior to the 1988 amendments, only involuntary MS in the 6-15-48 through 12-15-50 period was creditable as compensation. Effective 12-1-88, voluntary MS in this period can be credited as compensation. After leaving MS, the employee must have returned to RR service in the same or next year without any intervening non-railroad earnings.

In TRIC requests beginning 4/03/90, RASI provides SEARCH with MS data for as many as four periods, including codes for the MS means of entry (voluntary or involuntary). RASI also provides an intervening earnings code from the AA-1.

Before this data was available, BCC made all creditability determinations in these cases and reentered them to SEARCH.

- B. Employee ABD 12-1-88 and Later - Cases with a G-90 "Re-entry - A" date of 2-21-89 and later have the M/S creditable as compensation information correctly provided, if applicable. If the "Re-entry - A" date is 2-20-89 or earlier, the M/S was credited without considering the 1988 Amendments. A RASI award message will appear in Remarks. A new G-90 should be secured. (See RCM 9.3.13 "POSSIBLE 1988 AMENDMENT M/S CASE. G-90 RE-ENTRY DATE BEFORE 1988 AMENDMENT COULD BE CONSIDERED.")
- C. Employee ABD Before 12-1-88 - When there is voluntary M/S in the 6-15-48 thru 12-15-50 period, RV&AD-CCS will determine if the M/S is creditable as compensation effective 12-1-88 based on the 1988 Amendments. If it is, the M/S will be credited as wages, in order to get the case paid on RASI without an overpayment. (RASI would use all the M/S as compensation from the ABD, but the correct payment should consist of one rate from the ABD thru 11-30-88 (using M/S creditability rules in effect prior to the amendment), and a second rate effective 12-1-88 using the additional M/S period provided by the 1988 Amendment.)

In order to avoid any RASI overpayments, RASI will pay with the M/S credited as wages, and an award message will appear in these cases. (See RCM 9.3.13 "POSSIBLE 1988 AMENDMENT M/S CASE. CONSIDER M/S AS COMPENSATION", to alert examiners that the cases may need further manual action.)
- D. Effect of Non-covered Employment - RASI and SEARCH were revised in April, 1990, to recognize the intervening earnings code from the AA-1. Until then, voluntary 1948-50 MS could have been erroneously credited as compensation, if the employee's intervening earnings as discussed in "A" above were from non-covered employment. Employment such as civil service is not included in wage records from SSA and would not have been identified by BCC without special procedures.

In these cases, claim representatives were instructed to cut off proof of MS periods at 6-14-48. CR's notated the summary screen of APPLE and showed the full MS period. Prepare a G-563 in such cases to see if the MS can be credited and used as wages.

9.1.41 Employee And Spouse EDP Award Forms

RASI generates two basic types of award forms. The criteria used to determine the type of form generated in a given case is whether or not initial payment was made prior to October, 1981.

Forms G-354E are used to pay supplemental annuities to employees who were initially paid on RASI prior to October, 1981. These forms are printed horizontally and show a breakdown of only the most current rate payable. They are similar to the award forms used prior to the enactment of the 1981 Amendments; however, revisions have been made because of new age reduction and windfall cutback provisions.

Forms G-354R and G-355R are used to pay employees and spouses whose initial payment date is after September, 1981. These forms are printed vertically and show break down of up to six rates.

If the employee and spouse are awarded on the same voucher, "SPOUSE ALSO" is printed in "Remarks" of the G-354R and "EMPLOYEE ALSO" in the "Remarks" section of the G-355R.

9.1.43 Computer Output For Awards

- A. Preparation and Release of Award Letters - ALTA produces the RL-20e award letter for the award notification process. The numbers of the code paragraphs used on the award letters are shown on the award form. After the computer prints the RASI awards and the corresponding RL-20e's, the letters are forwarded to the mailroom for release.
- B. Other Computer Output - The remaining computer output is routed in the following manner:
 - Award forms are sent to the examining units.
 - The disposition records tape is held in BIS to be used in the monthly report operation.
 - The checkwriting tape is held in BIS to be used in the daily disbursement award operation.
 - The research tape is sent to update that file.

9.1.44 Examiner Review Of Final Award

A. General

Certain awards paid final by RASI require examiner review of the printed award to determine if additional action is necessary to finalize the case or the award contains elements vulnerable to error. This is called an "EDP Review".

When an award is paid final by RASI, either "REVIEW" or "NO EDP REVIEW MESSAGE" will be in the Remarks section.

"REVIEW" in Remarks means that additional development and/or adjudicative action is required, or the award contains particular elements vulnerable to error. One or more review messages identifying the additional development required and/or the error-prone area(s) to review also are displayed. The messages and the required examiner action are described in [RCM 9.3.14](#).

"NO EDP REVIEW MESSAGE" in Remarks means that additional development is not required to finalize the initial award and no error-prone elements are present.

NOTE: Although additional adjudicative action usually is not required when "NO EDP REVIEW MESSAGE" is in Remarks, a review of specific types of these cases may be requested at certain times. For example, Policy and Systems may request a review of all RASI awards in December and January to verify routine revisions made for the annual cost-of-living job; or in May, after the annual earnings update in SEARCH and Lag Recycle in RASI.

B. Awards That Do Not Require "EDP Review"

Prior to the implementation of USTAR, examiners reviewed all paper copies of awards paid final by RASI which contained a "Review" message in Remarks. In some cases, a USTAR referral is now established when the award is received. An "EDP Review" of these awards is not required.

An "EDP Review" is not required when any of the following applies:

1. A referral is established in USTAR. The "Review" messages for which USTAR referrals are established are identified in [RCM 9.3.14](#) with this notation:

"A referral is established in USTAR (RIS-XXX) upon receipt of the award. An examiner EDP Review is not required".
2. There is a notation following the "Review" message in [RCM 9.3.14](#) stating either that the message does not require review and examiner action is not necessary or that the message is obsolete.
3. "NO EDP REVIEW MESSAGE" is shown in Remarks (see "NOTE" in Section A for exception).

C. Awards That Require "EDP Review"

An award with a "Review" message in Remarks requires an "EDP Review" by an examiner when none of the situations described in Section B, above, apply.

Do the following when an "EDP Review" is necessary:

- Thoroughly review the entire award.

- **Sign and date** the award when the review is complete, then send it to Imaging.
- Take all required action indicated in the "Review" message(s).
- Review specific areas identified in the "Review" message(s).
- Take all other necessary action identified in the review.

D. Guidelines for Review

Use these guidelines when handling all awards paid final by RASI with a "Review" message in Remarks.

1. General – Employee and Spouse Awards

- Take all action indicated by the messages in Remarks (e.g., Release G-88p, test the O/M, process SALSA OPO, trace proof of M/S);
- Review specific areas identified in Remarks (e.g., TWD's, RRA Maximum, M/S);
- Review areas currently under study, as requested by the section chief or P&S-RAC (e.g., recalculate the RRA Max reduction);
- In addition to reacting to the review message(s), review the following items to make sure the information is correct and any pending action has been completed:
 - Name and address;
 - Correct tier information passed to RASI from PREH in spouse only awards;
 - Outstanding proofs;
 - Current Connection;
 - Other pending actions - spouse award, SOLAR award action, SALSA;
 - Unanswered inquiries;
 - Additional development.

2. Employee Awards

a) M/S

- Check use of M/S as wages or compensation for VDB entitlement.
- Look for 805 rejects for proof of M/S. If the employee had more M/S periods than RASI can accommodate (currently four), develop the creditability of the remaining M/S.
- Review proof of M/S for acceptability (see [FOM1 955](#)). Specifically consider beginning and ending dates of active duty, method of entry, and type of discharge. Compare the periods of active duty, supported by proof of M/S, to actual periods considered on the G-90.
- Review multiple periods of M/S, consecutive periods of M/S and RV&AD-CCS's creditability determinations, with special attention to voluntary enlistment or re-enlistment, during the period 1-1-47 to 12-15-50.
- Check G-90, item 2, for overlapping M/S months.

b) Lag

If lag was required for eligibility, compare the number of months credited with the G-88A.2 information.

3. Spouse-Only Awards

Verify that the tier data is the most current available. If the employee has been recertified since the data was received from Research, the spouse's annuity must be recertified.

4. Compute-Only Awards

Each situation which results in this type of award is listed in the award messages in [RCM 9.3.14](#). Although RASI passes data to Rate History in some of the situations, it is still necessary to prepare a full set of the appropriate award forms so that TCIU will receive the information. The "COMPUTE ONLY - MECHANICAL ZERO RATE" cases are an exception to this rule. See [RCM 9.3.14](#).

Compute-only awards should be checked for accuracy in the same way as regular awards, but should be processed to conclusion as directed in the award message instructions, depending upon the compute-only reason.

9.1.45 Partial Certifications

A. Employee Awards

1. General - To expedite payment in initial cases, RASI pays cases under IMPACT (Initial Monthly Partial Annuity Certification in Tiers). Under this program, field representatives compute a partial rate for most employee

applicants at the time the applications are taken and note the tier amounts on the G-230. If the SSA number can be verified and there is no pending name or address change, RASI will pay IMPACT rates in age and service cases within a few days.

The field will also submit IMPACT rates for selected disability cases. For those disability cases in which the field office is satisfied that all eligibility requirements are met other than the allowance of disability, the district office will compute an IMPACT rate and enter it on Form G-230. However, RASI will not pay the IMPACT rate until Form G-325 (type code 970) is received with a disability rating. At that point, RASI will determine an IMPACT ABD and pay a partial rate, unless the case is ready for final payment. In that case, RASI will pay a final rate based on a final ABD.

Examiners may also enter an IMPACT rate into RASI with a type code 911 screen. An examiner-initiated IMPACT rate will override a manual OP code already established in a case. However, RASI will not pay the final rate until the manual OP code is cleared.

RASI pays the partial rate effective with the first day of the month the application is processed, if the month is later than the month the employee last worked in RR service. If the application filing date and DLW RR are in the same month, RASI pays the partial rate effective the first day of the month following the filing month. RASI will not pay a partial rate of less than one month's accrual. If the ABD is in a future vouchering month, RASI will pay the partial rate effective with the first day of the month a full month's annuity accrual can be paid. If the case is ready for final payment before the partial rate is paid, RASI pays the final rate instead of the partial rate.

When field office personnel determine that manual review of the case is needed and mark the G-230 accordingly, they can also compute and enter an IMPACT rate on the G-230, if they are sure the employee is eligible for an annuity.

The IMPACT rate for these cases will be picked up by RASI, but the presence of the manual review code on the G-230 will cause the rate to be zeroed out. RASI will continue to issue a manual OP code referral, which will show the IMPACT rate zeroed out. If, upon review, the IMPACT rate can be paid, enter the rate shown on the G-230 into RASI with a type code 911 screen. RASI will then determine an ABD for the IMPACT rate and pay it.

NOTE: RASI will not zero out an IMPACT rate when a manual OP code is established for a reason other than "manual review." For example, if the application shows self-employment, RASI will set a manual OP code

pending examiner review to determine if it is LPE, but the IMPACT rate will not be zeroed out.

More information on IMPACT awards is found in Exhibit 5 of this chapter.

2. Examiner Action - No examiner action is required to pay the IMPACT rate. Once the partial rate is keyed from the G-230, RASI will pay that rate without requesting any additional information from examiners.

Continue to process applications in the usual manner required to pay a final rate. If a case where an IMPACT rate has been paid is dumped or suspended before a final certification is made, the partial payments made must be considered in the subsequent adjustment.

If the final rate computed is less than the partial rate paid and an overpayment results and cannot be recovered from the accrual, RASI will produce a "Computation Only" award form and dump the case for manual handling. If the overpayments can be recovered from the accrual, RASI pays the case and releases code paragraph 426A.

When the "Computation Only" award form is received, examiners must make a manual certification to pay the case final and recover any overpayment.

- B. Spouse Awards - SPAR (Spouse Partial Annuity Rate) is the payment system which makes partial payments to spouse applicants.

1. Field Initiated SPARS. Field representatives compute a partial rate for most spouse applicants at the time the applications are taken and note the tier amounts on Form G-230.

All payments will be effective the first of the month prior to the current voucher month. If the G-230 is marked "Manual Review," RASI will create a manual OP code, zero out the SPAR rate and generate a manual OP code referral, showing the SPAR rate zeroed out.

Review the folder. If the SPAR rate can be paid, enter the rate from the G-230 on a type code 911 screen. DO NOT recompute the SPAR rate. Only the rate that was put on the G-230 by the field office should be entered.

After the SPAR rate has been entered into RASI, RASI will determine an ABD and pay a SPAR rate unless a restriction applies as listed in #2 below.

2. Examiner Action - Examiners may also enter a SPAR rate into RASI with a type code 911 screen. An examiner-initiated SPAR rate will override a

manual OP code already established in a case. However, RASI will not pay the final rate until the manual OP code is cleared.

RASI will not pay an examiner (or field)-entered SPAR rate if any of the following conditions exist:

- a. The actual ABD is after the first of the current month, causing insufficient (less than one month's) accrual.
- b. The employee has not been paid at least a partial award.
- c. A name or an address correction is pending.
- d. The PREH record does not contain the employee's benefit data in spouse-only cases.
- e. The case has been coded for final payment, or coded for a denial, or a partial payment is pending or has already been made.
- f. (Reserved)
- g. The spouse's ABD is zero.
- h. The spouse has a W/D insured status and excess earnings are indicated. (Examiner-initiated SPARS only.)

Exhibit 6 has further information on SPAR rates.

9.1.60 Initial Survivor Recurring Benefit (SURCAL) Program

Almost all types of initial monthly survivor cases can be awarded on the computer in the SURCAL program. Forms G-360 and G-360a are used to produce an award. Based on the information punched from the G-360 and G-360a, the program will compute the annuity rate, extend the accrual, and produce a G-364d award form, an RL-43d award letter (with the appropriate code paragraphs) and tapes for checkwriting and Research.

The program, however, is not designed to handle all the situations which can arise. For a full description of the conditions under which the program cannot handle a particular case see Appendix B (G-360 instructions) of this chapter.

9.1.61 Spouse-To-Widow(er) Annuity Conversion (SURCAL) Program

Almost any spouse annuity can be converted to a widow(er)'s annuity electronically on the SURCAL conversion program.

The conversion program begins when the G-96 is processed to terminate an employee's annuity after his death. The G-96 electronically sets up a special record called an interim widow(er) (IW) tape for the spouse annuitant whose payments are in

force. When all necessary additional data has been received from the new widow(er), the conversion is effected by the completion and processing of Form G-360. The information on the G-360, combined with the information already on the checkwriting tapes is sufficient for the SURCAL program to compute the widow(er)'s annuity rate, extend the accrual, make deductions in previous payments and produce a G-364d award form, an RL-43d award letter (with appropriate code paragraph) and tapes for checking and Research.

The program, however, is not designed to handle all the situations which can arise. For a full description of the conditions under which the program cannot handle a particular case see Appendix B (G-360 instructions) of this chapter.

9.1.62 LSDP, RLS Or Accrued Annuity Awards By EDP

Payments of most types of LSDP's, RLS's, and some accrued annuities due but unpaid at death can be awarded on the computer in the SURCAL program. Forms G-359a and G-359b are used to produce such awards electronically. Based on the information punched from the G-359a and G-359b, the program will award the correct payment, produce a G-364d award form, an RL-43d award letter (with appropriate code paragraphs), and tapes for checkwriting and Research.

This program, however, is not designed to handle all situations which can arise. For a full description of the conditions under which the program cannot handle a particular case see Appendix B (G-359a instructions) of this chapter.

9.1.63 Preparation And Release Of Award Letters And Checks

After the SURCAL awards are processed on the computer and the RL-43d award letters are printed, the letters are sent to the Payment Control Coordination Group (PCC) where enclosures are attached, if appropriate. The letters are sent to the mailroom for release. Foreign address letters are sent regular mail.

The Treasury Department encloses Form G-178 with the check.

9.1.64 SURCAL Award Form And Notifications

- A. G364d (Survivor Benefit Determination of Award or Printout Record) - This G-364d is used as the award form and as the printout for referral messages for lump-sum and recurring awards. There is a single copy printed for the folder record; no other copies of this form are prepared.
 - Referral Printouts - If the form is used as a referral for examiner handling, the "Remarks" block will show "THIS CASE NOT PROCESSED FOR REASONS STATED BELOW" and a message indicating the reason for the referral. (See RCM 9.3.20 for the list of referral messages and the action required for each message.)

- Award Printouts - If an EDP award has been made, the voucher number appears at the top of the G-364d. This form also shows the amount paid, the payee's name and address, which code paragraphs were printed on the award letter and which enclosures (if any) were sent to the beneficiary.

This form contains basically the same information as the G-359 for lump-sums and the G-364.1 for monthly annuities and are largely self-explanatory.

1. Annuity Awards - The computer prints entries in the applicable items on the G-364d. An award form is produced for each payee code and payment data pertaining only to that payee code appears on the form.
2. Lump-Sum Awards - The computer prints entries in the applicable items on the G-364d. An award form is produced for each payee code.
3. Disposition - The G-364d is sent to the appropriate module for association with the folder. The computer automatically produces a disposition record for the award.

B. Award Letter - RL-43d is the award letter used for both a monthly annuity and a lump-sum payment. A copy is not filed in the folder because only one RL-43d is printed and that is sent to the beneficiary.

1. Preparing RL-43d - The computer is programmed to print on the RL-43d the following code paragraphs as required:
 - For monthly annuities: 407, 500, 500.4, 500.5, 500.6, 500.7, 500.9, 502, 506, 506.1, 506.2, 506.3, 509, 512, 520.2, 523, 524, 524.1, 524.2, 525, 530, 531, 531.1, 540, 547, 561, 562, 702, 833, 834, 836, and 836.1, and 836.2, 3104;
 - For LSDP: 500, 500.2, 500.8, 502.1, 503, 504, 504.1, 504.2, 519.2, 519.3, 520.1, 520.2, 520.3, 520.4, 520.6, 520.7, 521, 521.1, 521.2, 535, 542, 570.1, 570.2;
 - For RLS: 500.1, 514, 515, 516, and 517, 3100;
 - For Accrued Annuities: 504.3, 521.2, 538, 538.1, 539, 539.1, 570.3, 570.4, 711.3, 711.4, 3100, 3101, and 3102.

The computer-printed RL-43d will also show if RB-5, RB-7, or G-475 is an enclosure.

2. Routing and Releasing RL-43d - The RL-43d award letters are sent to the Payment Control Coordination Group (PCC) where the enclosures are attached. Award letters for all SURCAL cases are mailed by RRB while the checkwriting tape is sent to Treasury. Treasury includes Form G-178 with the check.

- C. Other Notices - Claims examiners will prepare any required notification other than that given in Form RL-43d. If the applicant has requested additional information, furnish it by separate letter. If anyone else must be notified of the award take appropriate action to furnish such notice. For instance, when necessary, take the proper action to:
- Notify a Congressman, labor official, or person holding power of attorney; or
 - Notify SSA when an RLS is awarded (see RCM 8.1.67); or
 - Notify payee of a share assigned to him by an eligible person; or
 - Notify a D/O of a decision; or
 - Notify the applicant who authorized payment to the funeral home that payment has been made (see RCM 8.1.68).
- D. 805 Referrals - When an award based on G-360, G-360a or G-359a, G-359b input data is not possible, the computer may issue a referral message on an 8" X 5 1/2" (805) sheet. (See RCM 9.3.20 for the list of referral messages that will be issued in these cases.)

9.1.65 SURCAL 6 Month Notices

6 Month Notice In Spouse-To-Widow(er) Cases - 805 referrals are issued by SURVEA six months after the employee's date of death. If the DOD is unknown at the time of termination, Research uses an assumed DOD, 1 month prior to the time of termination. (Their records are earmarked that this is an assumed DOD.) If an assumed DOD was used and the employee was enrolled in Medicare, send the case to HB to correct their records after all other action is completed.

Appendices

Appendix B

G-359a - Request for EDP Award of LSDP, RLS, or Accrued Annuity (NCR Paper)

(Original and One Copy)

Use

Used with a G-359b to produce an electronic LSDP award when the employee acquired his 120th month of RR service before 1-1-75. Also used with a G-359b to produce an electronic RLS or accrued annuity award.

General Information

Payment of most types of LSDP's and some accrued annuities due but unpaid at death can be awarded by this EDP program. However, handle the case manually, if it falls in one of the following categories:

- An INITIAL award of an accrued annuity, or
- A case not shown in item 3 of Form G-359a (e.g., a widow's RLS payment in a no-election case); or
- Payment is to be made to more than six beneficiaries; or
- A deferred LSDP award to a widow when she is entitled to a WCIA; or
- An LSDP or RLS award was previously made and the check is being reissued; or
- A parent elected the RLS; or
- The last check which is being deducted from the LSDP involves transfer of funds (RRB is paying the SS annuity or a SUP ANN is involved); or
- Payment can be made to both the funeral home and P B/E, and the total reimbursable burial expenses are greater than the LSDP and/or accrued annuity; or
- Two or more P B/E are involved, and the priority of B/E is different, and the total reimbursable B/E is greater than the LSDP and/or accrued annuity; or
- a check or EFT payment is being recovered from the LSDP, and 2 or more beneficiaries are being awarded.

Preparation

1. Item 1 - Enter the RRB claim number, showing the prefix in column 3. If there are fewer than nine digits in the claim number, leave the unused boxes blank. The last box on the right must contain the last claim number digit.
2. Item 2 - Enter "1" under the appropriate symbol for each payee on this award; enter "X" for each previous or potential payee. This applies for RLS, LSDP and accrued annuity payments. For example, if an RLS is to be awarded to three children but only two have filed applications at the time of the award, enter "1" in each of the first two boxes and "X" in the third. When the third application is received and ready to be paid, enter "X" in the boxes under L-1 and L-2 and "1" in the third box.

3. Item 3 - Enter the applicable "Type of Payment" code. If payment does not fall into one of the types indicated in this item, handle it manually.

The "types of payment," and a brief explanation of each payment is given below:

Code on G-359a	Explanation
1	LSDP to widow(er).
2	Deferred LSDP to widow(er).
3	LSDP minus EE's last check to widow(er).
4	LSDP plus accrued annuity to widow(er).
5	LSDP Plus accrued annuity to payer of burial expenses.
6	LSDP to payer of burial expenses or funeral home.
7	RLS is elected.
8	RLS to one or more in equal shares
9	RLS to two or more in unequal shares.
A	Accrued annuity to payer of burial expenses (includes payment of windfall).
B	Accrued to widow(er) or relatives (widow(er) or relatives do not need to be eligible to receive an annuity). Also use this code if the recipient is receiving the accrued annuity partly as a relative, and partly as a payer of burial expenses. NOTE: For codes A & B, if an RUIA transfer is involved, pay manually.
C	LSDP minus withheld EFT to payer of burial expenses.
D	LSDP minus withheld EFT to widow(er). NOTE: Codes C and D should be used if outstanding not-due EFT payments are being withheld, i.e., the TFS133 is not in file. These codes can be used in cases where the EE's last check includes SS benefits and/or supplemental annuity since no transfer of funds is involved.

E	Last check previously withheld, now returned.
F	Partial Payment. This code should be used when incomplete information in file is preventing timely processing of monthly recurring award and the field has requested immediate payment. Continue to send cases to the Director's Office when such cases are specifically requested by the Director. In all other 'dire need" type cases, you can continue to send them thru the Director's Office, or you can make the payment on OPO SURCAL. Exhibit 1 gives a schedule in making an OPO payment on SURCAL. If the OPO SURCAL can be used instead of going thru the Director's Office. Document the file to show how the amount of payment is arrived at. Research will not receive any information until the case is paid final.
G	LSDP minus last check to payer of burial expenses. NOTE: A "G" can easily look like a "6" to a keypunch operator. To avoid confusion, if you can't write a capital "G" different from a "6," write a small "g".
H	Last EFT previously withheld, now returned.
J	Widow(er)'s last check due at death. The code applies to those cases where the widow(er) was in CPS, died, and one or more last checks (or EFT payments) are due. If there is any change in the computation, payment should be made on the manual award forms.
K	WF one payment only. Use this code when making an accrued WF payment to: <ul style="list-style-type: none"> • survivors of a deceased EE • survivors of a widow(er) • widow(er) being paid survivor benefits by SSA, WF one payment only due as a spouse • widow(er) being paid by RRB, WF one payment only due as a spouse (no increase mechanically because of interim widow status) • remarried widow(er), previous WF entitlement as a spouse or widow(er) NOTE: A G-59 must be sent to Research.
L	LSDP minus outstanding overpayment to FH. "Outstanding

	overpayment" includes both EFT payments and checks.
M	LSDP minus EFT payment(s) to payer of burial expenses. Use this code if the TFS133 is in file.

4. Item 4 - Employee information:

- a. Item 4(A) - Enter the deceased employee's first name, middle initial, and last name. Leave one space between initials and names. If more than 20 characters (including spaces) are required to enter the first name, middle initial, and last name, change the first name to an initial. If the name is still too long, omit the middle initial. If the last name exceeds 18 characters, omit both the first and middle initials and enter the last name only.
- b. Item 4(B) - Enter the employee's SS account number.
- c. Item 4(C)-(G) - Self-explanatory. Do not complete these parts if an accrued annuity or partial payment is the only benefit being awarded.

5. Item 5 - Enter the beneficiary's own SS account number if the beneficiary is the widow (or widower).

6. Item 6 - Always enter in blocks 70-76 the total benefit payable. Include the amount to be paid on this award, as well as any shares that have already been paid, or that are being withheld for future payment.

Complete the portion below "Total benefit(s) payable" ONLY if adding or subtracting the last check(s) or EFT payment(s). When necessary, complete this portion as follows:

- Enter the amount of the LSDP next to the top "S" sign.
- Check the "+" box and enter the amount of any annuity due but unpaid being awarded with the LSDP or check the "-" box and enter the amount of the last check or EFT payment which is being deducted from the LSDP.

The result is the total benefit payable to be entered in blocks 70-76.

Blocks 1-54 are for future use, and should be left blank.

7. Item 7 - Complete this item as explained below.

- a. Item 7(A) - Complete this item only if awarding an LSDP. No entries are required if the RLS or an accrued annuity is the only benefit being awarded.
- b. Item 7(B) - Complete this item only if awarding an LSDP. No entries are required if the RLS or an accrued annuity is the only benefit being

awarded. Enter "1" if it appears the widow(er) will be eligible for an annuity at age 60 or "2" if there is no widow(er) or if the widow(er) will not be eligible for a WIA.

c. Item 7(C) - Enter:

- "1" when awarding an LSDP to a widow(er), or a dependent parent, and all RLS would be payable to the payee on election (code "1" will cause a G-475 to be enclosed with the award letter).
- "2" when the beneficiary has inquired about an RLS and information about it will be furnished later (code "2" will release code paragraph 520.3).
- "3" when the beneficiary has inquired about an RLS and it is not payable because benefits paid exceed the employee's gross RLS (code "3" will release code paragraph 542).
- "4" when awarding a LSDP or accrued annuity to applicant who claimed excess burial expenses in Greece or other foreign country as explained in RCM 2.8.117. Use specifically when "type of payment" code in item 3 is 5, 6, A, C, G, or M. Entering a "4" in this item will release code paragraph 521. In these cases, enter the amount of B/E that can be paid in item 6 on the G-359a and the actual B/E paid in items 12 and 13 on the G-359b.
- "5" when awarding an applicant when a portion of an LSDP or accrued annuity is withheld pending an application from a legal representative of an estate. Use specifically when "type of payment" code in Item 3 is 5, 6, A, C. Entering a "5" in this item will release code paragraphs in 570.1 and 570.2 if a LSDP is involved; or code paragraphs 570.3 and 570.4 if an accrued annuity is involved.
- "6" when awarding a RLS, LSDP or accrued annuity to one payee, in which a share of the award has been assigned (e.g., there are two P's of B/E, and one is assigning his share of the LSDP to the other. Entering a "6" in this item will release code paragraph 521.2. (This code can only be used when one payee is involved, because if there are two or more payees, SURCAL would not know who should get CP 521.1.)

NOTE: If paying the LSDP, include the burial expenses paid by the assigner in the amount of burial expenses paid by the payer.

- "9" when awarding a payment in which no mechanical award letter should be released. This could be used for any of the "types of payment" in item 3 when something special must be said that is not provided in the routine code paragraphs normally released with that type of payment. If "9" is used, a special letter should be manually prepared and released at the time the award is authorized for payment.

8. Item 8 - Enter the widow(er)'s DOB if a widow(er) survives AND an LSDP or RLS is being awarded. If an accrued annuity is the only benefits being awarded, make no entry in this item.
9. Item 9 - Enter "1" for final award. Do not use "2" in any OPO SURCAL payment. A "2" is now obsolete.
10. Item 10 - Enter examiner and authorizer numbers:
 - a. Item 10(A) - Enter your examiner number.
 - b. Item 10(B) - The authorizer should enter his number after authorizing the code sheet.

NOTE: See section 9.1.64 for information about award forms and notifications and Chapter 9.3 for a list of referral messages produced by the EDP survivor program.

G-359b - Request for EDP Award of LSDP, RLS, or Accrued Annuity

(Continued from G-359a), (NCR Paper - Original and One Copy)

Use

Used with a G-359a to produce an electronic LSDP award when the employee acquired his 120th month of RR service before 1-1-75. Also used with a G-359a to produce an electronic RLS or accrued annuity award. (See the G-359a instructions for when a manual award must be made.)

General Information

At least one G-359b must be completed in every case. Section I of the G-359b should be completed only when awarding an RLS, an accrued annuity (alone), or an LSDP to PB/E or to a funeral home. Complete section II of G-359b in all cases. Section II of G-359b accommodates only two payees but, by using additional forms, a lump-sum payment can be made to as many as six payees. When additional code sheets are necessary, complete only section II. For example, if the forms are being completed to award an RLS to six children, complete one G-359a, one G-359b in full and two additional G-359b's, section II only.

Preparation

SECTION I

Complete this section only if you are awarding:

- An RLS;

- An accrued annuity; or
- An LSDP to the PB/E or to the funeral home.

Make no entries in this section if you are awarding the LSDP to a L/W widow.

1. Item 11 - Complete this item only if awarding an RLS.
 - a. Item 11(A) - Enter the amount of the gross residual.
 - b. Item 11(B) - Enter the total deductions for other benefits to be made from the RLS.
 - c. Item 11(C) - If an election has been made, enter "1" if the employee is insured at SSA on wages only or "2" if he is not insured. Otherwise, leave blank.
 - d. Item 11(D) - Enter "1" if payment of the RLS is being made to the payee because he is the designated beneficiary; otherwise, leave blank. Skip to item 13 if you are awarding an RLS in UNEQUAL shares.
2. Item 12 - Complete this item if the type of payment in item 3 on the G-359a is: 5,6,A,C,G,L or M. If payment is being made to the P B/E enter the amount of the reimbursable B/E. If code 4 is entered in item 7(C) on G-359a, enter the actual amount of burial expenses paid. If payment is being made to the funeral home, enter the unpaid amount of the B/E incurred by or through the funeral home.

Make no entry unless the award is based on reimbursement for, or payment of, B/E.

3. Item 13 - Complete this item as follows:

<u>ITEM 3 ON G-359a IS:</u> <ul style="list-style-type: none"> • B or 9 • 5,6, (if P B/E), A,C,G or M • 6 (if FH), or L 	<u>ENTRY</u> <p>The amount payable to each payee on this award.</p> <p>The amount of B/E paid by each payee on this award.</p> <p>The same amount as entered in item 12 on the G-359b. (If more than one FH is involved, enter the amount payable to each FH.)</p>
<u>ITEM 7(C) ON G-359a IS:</u>	

<ul style="list-style-type: none"> • 4 • 6 	<p>The actual amount of B/E paid by each payee on this award.</p> <ul style="list-style-type: none"> • The amount payable to the payee on this award.
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SECTION II

Complete one "Name and Address Block" for each payee. Make the entries in the same manner as you would on an award form. Although separated into two parts for keypunching, the five lines in each address block on the G-359b correspond to those on award forms. If more than two payees are involved, complete "Name and Address Blocks", as required, on additional Forms G-359b. When using additional Forms G-359b, no entries are required in items 11, 12, or 13. Be sure to show the claim number on all Forms G-359b where indicated in columns 1-12.

1. Cols. 1-12 - Enter the RRB claim number; show the prefix in column 3. If there are fewer than nine digits in the claim number, leave the unused boxes blank. The last box on the right must contain the last digit of the claim number.
2. Cols. 13-32, 33-52, and 53-72 - Enter the first three lines of the payee's name and address (indicate the beginning of the address by a group mark). When paying the LSDP to a funeral home, be sure to show the legend "FOR ACCT OF" and the employee's name either on the second line which begins with keypunch block number 33, or on the third line, which begins with 53. (The legend triggers the printing of Code Paragraph 535 on the award letter.)
3. Cols. 74-76 - Enter the application number as shown in items 24, 25, and 26 of the G-663 (601, 602, 603, etc.).
4. Col. 78 - Enter the same payee symbol NUMBER which is printed above your entry for this payee in item 2 of G-359a. (Enter "1" for L1, "2" for L2, etc.).
5. Col. 80 - Enter "1" if the name and address requires more than three lines and is continued to at least one more line. Enter "2" if address continuation is not required.
6. Cols. 13-32 and 33-52 - If "1" is entered in col. 80 (see 5 above), enter the fourth line of the address in cols. 13-32 and, if required, enter the fifth line in cols. 33-52.
7. Col. 78 - Enter the same payee symbol number as you did in the preceding col. 78 (see 4 above).

8. Second Name and Address - If there is more than one payee, complete the second name and address block of the form for the second payee in the same way as the first (except that no entry is made in cold. 1-12).
9. Examiner and Date - Self-explanatory.
10. Disposition
 - (a) Examiner Action - Attach both copies of the code sheets with a gem clip to the material filed on the right side of the folder and route the claim to authorization. If the entry in item 3 of the G-359a is 4, B, F, J or K and the accrued annuity is taxable, route the case to TAX-IAS after payment. Taxable accrued annuities include any tier 1, tier 2 or VDB payable for a period after 11-83 and supplemental annuity accrual payable for any period.
 - (b) Authorizer Action - Sign and date the form in the space provided. As instructed by your supervisor, send the original code sheets for keypunching, file and duplicate in the folder, and have the folder controlled until the G-364a is received.

NOTE: See section 9.1.65 for information about award forms and notifications and Chapter 9.3 for a list of referral messages produced by the EDP survivor program.

G-360 - CAL Worksheet For Monthly Benefits

(NCR paper - original and one copy)

Use

Used with one or more G-360a to produce an electronic award of a monthly survivor annuity.

The following pages provide detailed information concerning payments made by SURCAL.

Note: After recert cut-off in November 1993, SURCAL will process recertification and initial awards with OBD's of 12-1-92 and later.

General Information

1. Requesting An EDP Award - A G-360 and G-360a are needed in all initial and recertification (spouse to widow(er) or partial-to-final) cases. A separate G-360a is required for each payee code. Each G-360a should contain only information for the particular beneficiary under that payee code.

Based on the data entered on the G-360 and G-360a, SURCAL determines the survivor's rate(s) and produces a G-364d award form, an RL-43d award letter and tapes for Rate History.

The accrual check and award letter are mailed separately. In most cases, the letter will be mailed one day before the accrual check is released by Treasury. Form G-178 will be enclosed with the check by Treasury. Foreign address letters will be sent by regular mail.

If any item on the G-360 and the G-360a does not apply, make no entry in that item.

NOTE: If an item is being completed, unless otherwise specified, enter zeroes in any unused spaces before the entries.

Always use an ink pen when completing Form G-360 and G-360a.

2. When SURCAL Cannot Make An EDP Award - SURCAL is not programmed to correctly award claims with unusual circumstances, so these cases must be handled manually. Cases which should not be paid on SURCAL include those in which the following circumstances exist.
 - A. SURCAL Cannot Make A Correct Award On An Initial Award Or A Recertification Award When:
 - The OBD requires more than two date breaks.
 - A J&S annuity is payable.
 - A waiver of annuity is involved.
 - An employee annuity restored amount computation is required and the vested dual benefit basic amount shown on Form G-90 is not based on an AMR and increment years.
 - A widow(er) is entitled to a transitionally insured social security benefit.
 - The employee had no earnings after 1936.
 - The deceased employee was a pensioner (claim number prefix "H").
 - The sole survivor minimum may apply for a single child or parent and an AIME, TRANS, or 1977 O.S. PIA is involved.
 - The TRANS PIA applies and the year of eligibility is 1980 or later.
 - The 1977 O.S. PIA is involved.

- A widow(er) and a divorced young mother/father are entitled.
 - There is a retirement (RR or SUPP) overpayment to both the employee and the spouse.
 - There is a survivor other than the applicant in current pay status.
 - The widow(er) is receiving monthly social security benefits and her social security claim number suffix is other than "A," "D," "E," or "F".
 - The report of the employee's death is erroneous. (If only the date of death was reported incorrectly, the claim can be paid on SURCAL.)
 - A RIB limitation must be considered in a case where the employee's ABD is 1-1978 or later, more than one accrual rate must be computed, and either:
 - 1) the RIB limit amount should be ARF'ed; or
 - 2) the employee was born on the first day of the month.
 - A RIB limitation must be considered, there is no entry in item 29, and either:
 - 1) the current RIB PIA is a SPEC. MIN. PIA; or
 - 2) a female employee's ABD or age 62 birthday is before 8-1961.
 - A RIB limitation applies and the widow(er) is entitled to the alternative PIA.
 - A RIB limitation must be considered and the employee was born in 1896 or earlier.
 - Delayed retirement credits (DRC's) must be considered and the case involves a maximum or a RIB limitation.
 - PIA #1 and PIA #9 are different, DRC's are involved and the OBD is in the same year as the year of the EE's death.
 - A 1974 Act Tier II is payable.
 - The Frozen Minimum PIA applies. The Frozen Minimum PIA may apply if the year of eligibility is 1979, 1980 or 1981; the PIA is an AIME or Trans; and the PIA on the OBD is \$261.20 or less for 12/92 or \$267.90 or less for 12/93.
- B. SURCAL Cannot Make A Correct Initial Award When:
- A recertification is required, e.g., a widow(er) is receiving a Mother's/Father's Annuity but is being recertified to a Widow(er)'s Annuity during the accrual period.

- All children or both parents do not receive the same social security benefit rate.
- The widow(er) is entitled to an Alternative PIA and the Family Maximum applies.
- More than nine payee codes are involved.
- A remarried widow(er) or disabled remarried widow(er) has an age reduction based on a previous widow(er)'s annuity or disabled widow(er)'s annuity.
- The family group composition changes during the accrual period.
- All annuitants do not have the same OBD.

C. SURCAL Cannot Make A Correct Recertification Award When:

- The spouse annuity must be suspended or terminated for any reason.
- Before the employee's death, RRB was paying only an social security wife's benefit.
- Three deduction rates must be considered.
- The spouse annuity has been adjusted for partial withholding which will continue after the OBD.
- All members of the family group do not have the same deduction amount.
- The tier II portion of the spouse annuity has a work deduction component that is being withheld.

Use the following guide for paying initial and recertification awards.

Cases Paid On December 1993 or Later Vouchers

Survivor OBD:	Case Involves:	Examiner Action:
November 1992 or earlier	All cases	Pay manually
November 1993 or earlier but not before 12-1-92	Exception in 9.1	Pay manually
November 1993 or	No exceptions as	Pay mechanically on

earlier but not before 12-1-92	shown in 9.1*	SURCAL
December 1993 or later	No exceptions as in 9.1**	Pay mechanically on SURCAL

For a spouse-to-widow(er) conversion, if the employee's 1-2-94 check was released be sure to check to determine if the spouse 1-2-94 check was actually increased. If so and,

* if the widow(er)'s OBD is November or earlier, there will be two spouse rates involved. The OBD spouse rate should be entered in item 46, the increased spouse rate in item 50 and the correct spouse minimum guaranty rate in item 47.

** if the widow(er)'s OBD is in December or later, only one spouse rate is involved. The correct spouse minimum guaranty rate for tier 2 must be computed and entered in item 47.

D. Actions SURCAL cannot do

SURCAL is not programmed to provide Research with the necessary information in the following situations.

1. If the annuitant is within 4 months of attainment of a terminating event, SURVEA will not release an attainment notice.
2. If the annuitant is a dual annuitant, a G-59 must be released to Research.
3. If the annuitant is more than 64 and 2 months, the Medicare enrollment must be done manually.
4. If a reduction amount is reduced to zero in a partial-to-final case, a G-59 must be released to Research.

Item	Entry
G360-1	<p><u>RRB Claim Number and Page Number</u> - Enter the prefix (i.e., A or D) and claim number. If there are fewer than nine digits in the claim number, enter zeroes in the unused boxes. The last box on the right must contain the last claim number digit.</p> <p>Note: The SURCAL program will mechanically assign the correct check</p>

symbol based on the type of beneficiary being paid.

SECTION A - GENERAL INFORMATION

G360-2	<p><u>Type of Request</u> - Enter one of the following codes which indicates the type of award that is being requested.</p> <p>1 - Recert (all spouse-to-widow(er) conversions)</p> <p>2 - Final (all initial cases)</p> <p>3 - Both (spouse-to-widow(er) conversion and initial award.)</p> <p>4 - Partial-Final (recertification if the survivor is already in pay status)</p> <p>8 - Partial - Reserved for future use. Do not use.</p>
G360-3	<p><u>Beneficiary Symbol by Payee Code</u> - Enter the appropriate beneficiary symbol according to the payee code. If the symbol is a single character, enter it in the first box and leave the second box blank. Enter subscripts as necessary.</p> <p>Refer to RCM 8.9, Form G-364 instructions for a listing of the beneficiary symbols and their subscript(s).</p>
G360-4	<p><u>Original Beginning Date</u> - Enter the month and last two digits of the year of the survivor's beginning date. For example, if the beginning date is December 1989, enter "12" and "89."</p>
G360-5	<p><u>Second Date Break</u> - Reserved for future use, do not complete.</p>
G360-6	<p><u>Type of Computation</u> - Always enter a "2".</p>

SECTION B - EMPLOYEE INFORMATION

G360-7	<p><u>Deceased Employee's Name</u> - Enter the deceased employee's first name, middle initial and last name. Leave one space between the initial and names. If more than 20 characters (including spaces) are required to enter the first name, middle initial and last name, change the first name to an initial. If the name is still too long, omit the middle initial. If the last</p>
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	name exceeds 18 characters, omit both the first and middle initials and show only the last name.
G360-8	<u>Employee's SS Account Number</u> - Enter the employee's SS account number unless it is the same as the RRB claim number entered in item 1.
G360-9	<u>Employee's Date of Birth</u> - Enter the employee's date of birth.
G360-10	<u>Employee's Date of Death</u> - Enter the employee's date of death.
G360-11	<p><u>Marital Status at Death</u> - Enter the employee's marital status at death:</p> <ul style="list-style-type: none"> • Code "1" - Male married; or • Code "2" - Male single, widowed, or divorced; or • Code "3" - Female married; or • Code "4" - Female single, widowed, or divorced.
G360-12	<u>Employee's ABD</u> - Enter the employee's annuity beginning date if the employee received an annuity before he died. If the employee's application is pending, the ABD should be determined. If an annuity was never awarded, enter "999999."
G360-13	<u>EE Contribution Amount</u> - Reserved for future use, do not complete.
G360-14	<p><u>EE SSA Insured Status</u> - Enter "1" if the employee has an insured status under the Social Security Act. Enter "2" if the employee does not have an insured status. If the insured status of the employee is unknown, enter "1."</p> <p>The insured status of the employee, for SSEB purposes, can be determined by looking at the G-90. If the employee does not have an insured status, the retirement G-90 will show "9999" for SSEB PIA. The survivor G-90 will have the notation, "No SS insured status for SSEB."</p>
G360-15	<u>M/S Needed for Eligibility</u> - Enter "1" if the employee's military service is needed to give the employee 120 service months.
G360-16	<u>88 Amend 48-50 M/S Code</u> - Complete this item if the employee has military service in the period from 6-15-48 through 12-15-50. Under the 1988 Amendments the military service is creditable if it was voluntary, preceded and followed by the required railroad service and the employee and not have intervening non-railroad employment. Prior to the 1988 Amendments, involuntary military service is creditable as compensation. (For further information on the creditability of 1948-50 military service under the 1988 Amendments, refer to RCM 5.4.7-5.4.10.)

	<ul style="list-style-type: none"> • <u>Tier II increase from OBD</u> - Enter code "1" if the employee has military service in the period from 6-15-48 through 12-15-50, the military is creditable as compensation under the 1988 Amendments (as described above) and it is used to increase the annuity from the OBD (OBD is 12-1-88 or later). • <u>No tier II increase</u> - Enter code "3" if the employee has military service in the period from 6-15-48 through 12-15-50 and the military service is creditable as compensation under the 1988 Amendments (as described above) but does not increase tier II because it is used as wages. • <u>Not creditable under the Amendments</u> - Enter code "4" if the employee has military service in the period from 6-15-48 through 12-15-50, but it is not creditable as compensation under the 1988 Amendments either because it was involuntary, or because it was not preceded and followed by the required railroad service, or because the employee had intervening non-railroad employment. Note that military service in that period which was involuntary could have been creditable before the 1988 Amendments.
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SECTION C - TIER I COMPONENT DATA

G360-17	<p><u>Year of Eligibility</u> - The death PIA to be used in a survivor's annuity computation is determined by the employee's year of eligibility. In general, the employee's year of eligibility is the earlier of:</p> <ul style="list-style-type: none"> • the year the employee died; or • the year the employee's disability freeze began; or • the year the employee attained age 62. <p>Enter "9999" if the year of eligibility is prior to 1979 or the appropriate year if the year of eligibility is 1979 or later.</p>
G360-18	<p><u>PIA Code</u> - Enter the code to denote the type of PIA entered in item 19. Enter one of the following codes:</p> <p>"1" - AIME PIA</p> <p>"3" - TRANS. PIA (Only if year of eligibility is 1979)</p>

	<p>"4" - AMW PIA</p> <p>NOTE: If the survivor's annuity was initially paid using an AMW PIA based on a disability freeze and the alternative PIA now applies, AIME PIA information must be entered in items 18 thru 20. Refer to RCM 8.9 G-364.1 Special Situations 14.</p>
G360-19	<p><u>Employee Regular PIA on OBD</u> - Enter the PIA, corresponding to the code entered in item 18, that is applicable on the survivor's OBD. If the original beginning date is prior to a PIA increase, SURCAL will update to the current PIA in the same manner as is done on manual awards.</p> <p>SURCAL cannot compute a case when the TRANS PIA applies and the year of eligibility is 1980 or later, or if a 1977 O.S. PIA is involved. Therefore, pay these cases manually.</p> <p>SURCAL will compute the sole survivor minimum in cases involving an AMW PIA.</p> <p>If the sole survivor minimum for 1 child, or 1 parent may apply in a case involving an AIME or TRANS PIA, SURCAL cannot compute the correct original rate. Pay such a case manually. The sole survivor minimum may apply if only 1 child is involved <u>and</u> an AIME or TRANS PIA is involved and the 12-1992 PIA is less than \$348.20, or the 12-1993 PIA is less than \$357.20.</p> <p>The sole survivor minimum may apply if only 1 parent is involved <u>and</u> an AIME or TRANS PIA is involved and the 12-1992 PIA is less than \$316.50, or the 12-1992 PIA is less than \$324.70.</p>
G360-20	<p><u>Employee AIME/AMW</u> - Enter the employee's AMW or AIME used for the regular PIA shown in item 19 above.</p>
G360-21	<p><u>Total Family Max</u> - In initial cases, where the benefit conversion saving clause does not apply, make no entry; SURCAL will compute the SSA family maximum, if applicable. If the employee's annuity was payable under a savings clause in the month before he died, enter the established unrounded SSA family maximum in effect on the survivor's original beginning date. (For further details on savings clauses, refer to RCM 8.9, G-364.1 instructions.) If the OBD is prior to a PIA increase, SURCAL will determine the new SSA family maximum.</p>
G360-22	<p><u>Years of Coverage</u> - Enter the employee's actual number of years of coverage even though such years are less than 20 or more than 30.</p> <p>If there are no years of coverage, because the employee's combined RR and SS earnings were less than 25% of the maximum creditable amount</p>

	<p>for every year, leave this item blank.</p> <p>Complete items 23-25 only if the widow(er)'s alternative PIA will be used in the computation of tier I.</p>
G360-23	<u>Alternative Year of Eligibility</u> - Enter the alternative year of eligibility. If AIME PIA information is not entered in items 18 thru 20, the case will reject.
G360-24	<u>Alternative PIA or OBD</u> - Enter the alternative PIA that is applicable on the survivor's OBD.
G360-25	<u>Alternative AIME</u> - Enter the AIME on which the alternative PIA is based.
G360-26	<p><u>Red RIB PIA</u> - Enter the PIA (PIA #1, PIA #9, or SPC MIN PIA) that will be used in the computation of the RIB limitation on the survivor's OBD. If the original beginning date is prior to a PIA increase, SURCAL will update to the current PIA in the same manner as is done on manual awards.</p> <p>An entry is required if the employee was considered entitled to a reduced RIB before he died as explained in RCM 8.9, G-364.1 instructions and:</p> <ul style="list-style-type: none"> • The fictional RIB PIA and survivor tier I PIA are the same and the screening guide (see RCM 8.9, G-364.1 instructions) indicates that the WIA may be subject to the RIB limitation; or • The fictional RIB PIA and the PIA for the survivor tier I computation are different. In these cases, do not use the screening guide. However, in most cases, the fictional RIB and the regular death PIA will be the same. <p>Always enter the RIB PIA in item 26 if the RIB limit must be considered.</p> <p>In most cases, SURCAL will compute the RIB limit based on the employee's DOB and ABD. However, if the employee was born on the first of the month, the widow(er)'s OBD is before the EE would have attained age 62 or if the RIB limit must be ARF'ed, SURCAL cannot compute the correct RF months. In these cases, the RIB amount must be computed manually and entered in item 29. If the employee's ABD is 12-1977 or earlier, SURCAL will update this rate for a COL increase. If the employee's ABD is 1-1978 or later, the case must be paid manually if more than one date break must be computed.</p> <p>SURCAL cannot compute the initial RIB limit if the RIB PIA is a SPEC. MIN. PIA or if a female employee's ABD or age 62 birthday is before 8-1961. In these cases, the RIB amount must be computed manually and entered in item 29. SURCAL will update this rate for a COL increase, if applicable.</p>

G360-27	<u>Reduced RIB AIME/AMW</u> - Enter the AMW or AIME on which the PIA in item 26 is based.
G360-28	<u>Reduced RIB YOC</u> - Enter the employee's fictional RIB years of coverage even though such years are less than 20 or more than 30. Leave this item blank if the employee had no fictional RIB years of coverage.
G360-29	<u>RIB Limit Amount</u> - If SURCAL cannot compute the RIB limitation, enter the deceased employee's fictional RIB limitation applicable on the survivor's OBD, if the employee is entitled to such a computation. In such cases, items 26-28 should also be completed. Refer to item 26 for an explanation of when the RIB limitation must be computed manually. If the ABD was 1-1978 or later, use a G-59, item 7 to notify Research and TAX-IAS of the number of RF months involved.
G360-30	<p><u>DRC Code</u> - Enter the code which indicates the percentage of increase to the PIA that should be used:</p> <ul style="list-style-type: none"> • "1" for 1/12 of 1%, the employee must have attained age 65 before January 1982. • "3" for 1/4 of 1%, the employee must have attained age 65 in or after January 1982 and before December 1989. • "4" for Other, if one of the following circumstances applies: <ul style="list-style-type: none"> • 7/24 of 1%, the employee must have attained age 65 in or after January 1990 and before December 1991. • 1/3 of 1%, the employee must have attained age 65 in or after January 1992 and before December 1993. • Refer to G-364.1, Section A description of items 26-39 for information on additional percentages. <p>Note: In the space provided, enter the percentage that will apply.</p>
G360-31	<u>DRC Months</u> - Enter the number of DRC months from "01" to "84."
G360-32	Reserved for future use, do not complete.
G360-33	Reserved for future use, do not complete.
G360-34	Reserved for future use, do not complete.

SECTION D - TIER 2 COMPONENT DATA

NOTE: No entry should be made in this section if a 1981 amendment beneficiary (remarried widow(er), remarried disabled widow(er), remarried young mother/father, surviving divorced spouse, surviving divorced disabled spouse, divorced young mother/father or 1983 amendment parent) is the only beneficiary being paid on this award.

G360-35	<u>Tier 2 Code</u> - <u>Always</u> enter a "2."								
G360-36	<p><u>Tier 2 Takeback Code</u> - Complete this item in all cases. Enter one of the following takeback codes:</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Actual EE takeback (T/B)</td> </tr> <tr> <td>2</td> <td>Fictional EE takeback (T/B)</td> </tr> <tr> <td>3</td> <td>No takeback (T/B)</td> </tr> </tbody> </table> <p>Use the T/B chart in RCM 8.9 G-364.1 instructions for determining the appropriate code to enter.</p> <p>If the survivor tier 2 before takeback is \$10 or less, SURCAL will internally change the code from "1" or "2" to code "3". If the tier 2 is \$10.00 or less and the takeback applies, do not enter code "3" since the award will reject.</p>	Code	Description	1	Actual EE takeback (T/B)	2	Fictional EE takeback (T/B)	3	No takeback (T/B)
Code	Description								
1	Actual EE takeback (T/B)								
2	Fictional EE takeback (T/B)								
3	No takeback (T/B)								
G360-37	<u>Tier 2 Total 4(g) Takeback Amount</u> - Complete this item in all cases. Enter the total 4(g) takeback amount to be recovered, if applicable. If no takeback is involved, enter "999999." See RCM 8.9 G-364.1 and G-364.7 Instructions for the proper way to determine the takeback amount.								
G360-38	<u>OBD Employee Tier 2</u> - Enter the 1981 Amendment employee tier 2 amount as computed on Form G-364.4. If the computed tier 2 is zero, the case must be paid manually.								
G360-39	<u>Employee Tier 2 Service Months</u> - Enter the number of service months shown on the survivor wage record that corresponds to the tier 2 amount being used.								
G360-40	<u>Employee Tier 2 AMC</u> - Enter the AMC amount shown on the survivor wage record that corresponds to the tier 2 amount being used.								
G360-41	<u>Employee VDB for Tier 2</u> - Complete this item only if the employee can								

	<p>be deemed to be vested for a vested dual benefit in the month of the survivor OBD. Refer to RCM 8.9 G-364.1 and G-364.4 instructions for additional information on when the vested dual benefit amount should be computed.</p> <p>Enter the vested dual benefit amount computed on Form G-364.4, item 5(a) or 5(b).</p>
G360-42	Reserved for future use, do not complete.
G360-43	Reserved for future use, do not complete.
G360-44	Reserved for future use, do not complete.
G360-45	Reserved for future use, do not complete.

SECTION E - SPOUSE INFORMATION

NOTE: If paying a recert award when the survivor is in current pay status, items 46, 50, 51, 52, 53 and 54 will be the only items completed.

G360-46	<u>OBD Spouse Rate</u> - Enter the gross spouse rate on the OBD, after any vested dual benefit cutback or withholding for work deductions but before SMIB, tax withholding and actuarial adjustment.
G360-47	<p><u>Tier 2 Spouse Minimum Guaranty Rate</u> - This item represents the spouse minimum guaranty. Although it may not cause an actual additional amount to be paid, it must be completed in each spouse to widow(er) conversion.</p> <p>Enter the total of the spouse annuity net tier 1, net tier 2 and <u>any vested dual benefit</u> after cutback (whether a wife's vested dual benefit or RIB/DIB vested dual benefit before withholding for work deductions), <u>less</u> any age reduction payable in the month before the month in which the employee died.</p>
G360-48	Reserved for future use, do not complete.
G360-49	<p><u>"Gotches" Case - Date of Second Deduction Amount</u> - Complete this item only in a "Gotches" type case.</p> <p>Enter the month and year of the second deduction rate if it is different than the second rate break.</p>

G360-50	<p><u>Second Deduction - Spouse Rate</u> - If two rates must be used as deductions in a recertification case, enter the gross spouse rate as defined in item 46 or survivor rate for the second deduction amount.</p> <p><u>Tier Information Items 51-56</u></p> <p>SURCAL will compute the accruals by tiers. In order to compute the deduction amount, the tier breakdown for each rate break must be entered.</p> <p>If the tier amount is equal to zeroes, enter all zeroes. If the spouse or survivor does not have a tier component, leave the item blank.</p>
G360-51	<p><u>OBD Spouse Tier 1 Amount</u> - Enter the spouse or survivor tier 1 amount on the OBD.</p> <p>If the spouse was paid under the O/M, the entire spouse rate is considered tier 1.</p>
G360-52	<p><u>Second Deduction - Spouse Tier 1 Amount</u> - Enter the spouse or survivor tier 1 amount for the second deduction amount, if applicable.</p> <p>If item 49 is completed, enter the tier I after the SS benefit has been restored.</p>
G360-53	<p><u>OBD Spouse Tier 2 Amount</u> - Enter the spouse or survivor tier 2 amount on the OBD. If applicable, this amount is after reduction for the work deduction component.</p>
G360-54	<p><u>Second Deduction - Spouse Tier 2 Amount</u> - Enter the spouse or survivor tier 2 amount for the second deduction amount, if applicable.</p>
G360-55	<p><u>OBD Spouse VDB Amount</u> - Enter the spouse vested dual benefit amount on the OBD.</p>
G360-56	<p><u>Second Deduction - Spouse Amount</u> - Enter the spouse vested dual benefit amount for the second deduction amount.</p>
G360-57	<p><u>Actuarial Adj Amount</u> - If the spouse has an overpayment that is being recovered by actuarial adjustment, enter the amount of the actuarial adjustment.</p>
G360-58	Reserved for future use, do not complete.
G360-59	Reserved for future use, do not complete.
G360-60	Reserved for future use, do not complete.

G360-61	Reserved for future use, do not complete.
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SECTION F - WIDOW(ER)'S ANNUITY RESTORED AMOUNT

Section F must be completed if a widow(er) (aged, disabled, or young mother/father) is being paid. If a widow(er) - type annuitant is not being paid, leave the items in Section F blank.

NOTE: An aged or disabled widower must establish dependency to receive an employee annuity restored amount.

If a widow(er) is being paid, who is entitled to an employee annuity restored amount computation on her WIA OBD, enter code "3" in item 62 and complete items 63 through 72. Otherwise, enter code "4" in item 62. If a code "4" is entered in item 62, do not complete items 63 through 72.

NOTE: Code "4" is always entered for a young father, remarried widow(er) and surviving divorced spouse.

G360-62	<p><u>Restored Amount Code</u> - Enter:</p> <ul style="list-style-type: none"> • <u>Code "3"</u> if the widow(er) is entitled to an employee annuity restored amount computation on the widow(er)'s annuity beginning date. • <u>Code "4"</u> if the widow(er) is not entitled to an employee annuity restored amount computation. <p>NOTE: Complete items 63 through 72 only if item 62 is coded "3."</p>
G360-63	<p><u>Employee Restored Amount Basic Amount</u> - Enter the employee's basic amount based on pre-1975 compensation.</p> <p>NOTE: If the employee died after 12-1974, the employee annuity restored basic amount may differ from the LSDP basic amount.</p> <p>NOTE: If the basic amount that is to be entered in item 63 is not based on an AMR and increment years, pay the case manually.</p>
G360-64	<p><u>Employee Restored Amount AMR</u> - Enter the employee's AMR upon which the basic amount entered in item 63 is based.</p>
G360-65	<p><u>Increment Years</u> - Enter the increment years upon which the basic amount entered in item 63 is based.</p>

G360-66	<u>Employee 6-74 PIA</u> - Enter the employee's 6-1974 regular PIA (PIA #8).
G360-67	<u>Employee 6-74 AMW</u> - Enter the employee's 6-1974 AMW, used for the regular PIA shown in item 66.
G360-68	<u>Employee 6-74 Years of Coverage</u> - Enter the employee's years of coverage based on combined earnings through 12-31-74 even though such years are less than 20 or more than 30.
G360-69	<u>Widow's 6-74 PIA</u> - Enter the widow(er)'s PIA #21.
G360-70	<u>Widow's 6-74 AMW</u> - If the AMW for the widow(er)'s 6-1974 PIA is available, enter the widow(er)'s 6-1974 AMW; otherwise, leave this item blank.
G360-71	<p><u>Employee Restored Amount Code</u> - The codes entered in this item indicate if the SS benefit 1968-70 computation offset applies. The offset applies if the widow(er)'s employee PIA #4 is less than the PIA #21 entered in item 69. Refer to RCM 8.9 G-364.3 instructions for further information.</p> <p>Enter:</p> <ul style="list-style-type: none"> • Code "1" - If the widow(er)'s PIA #4 is less than the PIA #21 entered in item 69 (if applicable, also complete item 72). • Code "2" - If a PIA #21 exists and conditions listed under codes "1" and "3" are not met. • Code "3" - If: <ul style="list-style-type: none"> • No PIA #21 exists; or • The widow(er)'s PIA #4 equals or exceeds the PIA #21; or • The widow is entitled to a 1937 Act employee annuity.
G360-72	<p><u>Widow Employee Annuity Offset Amount</u> - Complete this item only if item 71 is coded "1."</p> <p>Enter the difference between the widow(er)'s PIA #21 minus his or her employee annuity PIA #4.</p>
G360-73	<u>Examiner Number</u> - Enter your examiner number.
G360-74	<u>Authorizer Number</u> - After all examiner entries have been verified the authorizer's number should be entered.

G360-75	<u>Examiner Name and Date</u> - The examiner's name should be signed and the current date entered.
G360-76	<u>Authorizer Name and Date</u> - The authorizer's name should be signed and the current date entered.

G-360a - SURCAL Worksheet for Monthly Benefits (Continuation Sheet) (NCR paper - original and copy)

Use

Use with the G-360 to produce an electronic award of a monthly survivor annuity.

General Information

A separate G-360a is required for each payee code. Each Form G-360a should contain only information for the beneficiary under that payee code. However, only one G-360 is required even though more than one G-360a must be completed for each payee code.

If any item on Form G-360a does not apply, make no entry in the keypunch block.

In items that apply, enter zeros in any unused spaces to the left of the entries, except when completing any name item.

Always use an ink pen when completing Form G-360a.

G360a-1	<p><u>RRB Claim Number</u> - Always complete this item. Enter the prefix (i.e., A or D) and claim number. Leave the first two boxes before the prefix blank. If there are fewer than nine digits in the claim number, enter zeros in the unused boxes. The last box on the right side must contain the last claim number digit.</p> <p><u>Page</u> - Enter the page number in the two boxes provided. The first G-360a must be numbered page 2, because the G-360 is pre-printed page 01. Therefore, additional Form G-360a's should be numbered from page 3 through 10 depending on the number of payee codes involved in the award. If there is only one digit to the page number, enter zeros in front of unused boxes, i.e., 02, 03, 04, etc.</p>
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SECTION A - IDENTIFYING INFORMATION

G360a-2	<u>Payee Code</u> - Enter the appropriate payee code.																
G360a-3	<p><u>Beneficiary Symbol</u> - Enter the beneficiary symbol for this payee code. If the symbol is a single character, enter it in the first box and leave the second box blank. Enter subscripts as necessary.</p> <p>Refer to G-364 instructions for a listing of the beneficiary symbols.</p>																
G360a-4	<p><u>Application Number</u> - Enter the application number in the first block as shown on the chart below. The next boxes are used for the number of applications that have taken, i.e., 101, 201, etc.</p> <p><u>Application Number To Be Entered in Item 4</u></p> <table> <tr> <td>Application No.:</td> <td>Code</td> </tr> <tr> <td>AA-17, or G-476c</td> <td>1</td> </tr> <tr> <td>AA-18</td> <td>2</td> </tr> <tr> <td>AA-19</td> <td>3</td> </tr> <tr> <td>AA-19a</td> <td>4</td> </tr> <tr> <td>AA-19s</td> <td>7</td> </tr> <tr> <td>AA-20</td> <td>5</td> </tr> <tr> <td>AA-17b and AA-17</td> <td>8</td> </tr> </table>	Application No.:	Code	AA-17, or G-476c	1	AA-18	2	AA-19	3	AA-19a	4	AA-19s	7	AA-20	5	AA-17b and AA-17	8
Application No.:	Code																
AA-17, or G-476c	1																
AA-18	2																
AA-19	3																
AA-19a	4																
AA-19s	7																
AA-20	5																
AA-17b and AA-17	8																
G360a-5	<u>Filing Date</u> - Enter the month, day and year in which the application on which this award is based was filed. Precede a single digit entry with a zero to fill all boxes.																
G360a-6	<p><u>Rep Payee Code</u> - Complete this item only if there is a representative payee receiving payment for the beneficiary.</p> <p>Enter one of the following codes:</p> <ul style="list-style-type: none"> • "1" if the payee is court-appointed; • "2" if the payee is neither court-appointed nor parent for child; • "3" if the payee is a parent of a child. 																
G360a-7	Reserved for future use, do not complete.																

SECTION B - BENEFICIARY DATA

G360a-8	<u>Beneficiary Name</u> - Enter the beneficiary's first name, middle initial and last name. Leave one space between the first name and the middle initial and the last name.
G360a-9	<u>Beneficiary SS Number</u> - Enter the beneficiary's own social security account number. If the beneficiary has no social security number, enter "0000-00-0000."
G360a-10	<u>Beneficiary Date of Birth</u> - Enter the beneficiary's date of birth.
G360a-11	<u>Beneficiary Sex</u> - Enter the code which indicates if the beneficiary is male or female.
G360a-12	<u>Tier 1 Restricted</u> - Reserved for future use, do not complete.
G360a-13	<u>Tier 1 Restricted Code</u> - Reserved for future use, do not complete.
G360a-14	<p><u>Family Code</u> - Complete this item only if the beneficiary is a young mother/father - type beneficiary, or a minor child or disabled child whose entitlement to a child's annuity is used to entitle a young mother/father - type beneficiary to an annuity. The codes entered in this item are used to tie a young mother/father - type beneficiary to the particular child who creates her/his entitlement.</p> <p>Enter "1" on the G-360a for payee code 1 and on each G-360a for any child/disabled child who causes the young mother/father's entitlement. Enter "9" for any child/disabled child included in the award who does not cause the young mother's/father's entitlement. See RCM 2.3 Appendix C for more information about assigning, correcting, and deleting family codes.</p>
G360a-15	<p><u>MDC (Minor Disabled Child Code)</u> - Enter "1" if the beneficiary is:</p> <ul style="list-style-type: none"> • a minor child, age 16 or 17, who was rated disabled in order to extend tier I payments to a young mother/father - type beneficiary; and • the young mother/father - type beneficiary whose entitlement to tier I is continued.
	Therefore, in any case in which this code is used, it should be used for at least two beneficiaries.
G360a-16	<u>Twin Code</u> - Complete this item only if:

	<p>1) more than one beneficiary entitled to benefits on the same claim number has the same DOB; or</p> <p>2) there are parent beneficiaries with beneficiary symbols of P and F, or of LP and LF.</p> <ul style="list-style-type: none"> In situation (1), enter code "1" for the first beneficiary and "2" for the second, "3" for the third, etc. In situation (2), enter code "1" for F or LF, "2" for P or LP. <p>A beneficiary who is assigned a twin code retains the twin code for as long as annuity entitlement continues, even if the other beneficiaries with twin codes lose entitlement.</p>				
G360a-17	<u>Grandchild</u> - Enter "1" only if the beneficiary is entitled as a minor grandchild, a disabled grandchild or a student grandchild.				
G360a-18	<p><u>Youngest Child Date of Birth</u> - Complete this item if the beneficiary is a young mother/father type annuitant.</p> <p>Enter the date of birth of the youngest child whose entitlement to an annuity qualifies the young mother/father.</p> <p>Note: This item contains a four position year. Enter December 25, 1993 as 12251993.</p>				
G360a-19	<p><u>Medicare Paragraph</u> - If a disabled widow(er) is being awarded, there must be an entry in this item. A disabled child may be paid without an entry in this item.</p> <p>Enter the appropriate Medicare code paragraph number; i.e., 833, 834, 836, 836.1, 836.2, or 9999. The last box on the right side must contain the last digit of the Medicare code paragraph number. "9999" should be entered if awarding a disabled widow(er) who does not require a Medicare code paragraph, e.g., widow(er) already has Medicare under a State buy-in plan.</p> <p>The appropriate entry in this item should be determined as follows:</p> <table> <thead> <tr> <th>Situation</th><th>Entry in Item 19, Medicare Paragraph Number</th></tr> </thead> <tbody> <tr> <td>(a) Disabled Widow's Annuity Award - Medicare allowance before age 65</td><td>0833</td></tr> </tbody> </table>	Situation	Entry in Item 19, Medicare Paragraph Number	(a) Disabled Widow's Annuity Award - Medicare allowance before age 65	0833
Situation	Entry in Item 19, Medicare Paragraph Number				
(a) Disabled Widow's Annuity Award - Medicare allowance before age 65	0833				

	<p>NOTE: If paragraph 833 is used, an entry is also required in item 20. See the item 20 instructions for further details.</p> <p>(b) Disabled Widow(er)'s Annuity Award - Medicare denial notice will be sent separately 0834</p> <p>(c) Disabled Child's Annuity Award - Medicare allowance payments made directly to child 0836</p> <p>(d) Disabled Child's Annuity Award - Medicare allowance, child has representative payee 836.1</p> <p>NOTE: SURCAL will compute the Medicare effective data for the paragraph inserts in code paragraphs 836 and 836.1 by adding 24 months to the survivor's OBD.</p> <p>(e) Disabled Child's Annuity Award - Medicare allowance, child now on direct bill 836.2</p> <p>(f) Disabled Widow(er)'s Annuity Award - no Medicare paragraph needed 9999</p>
G360a-20	<p><u>Medicare Paragraph Insert</u> - Enter the month and year of the Medicare effective date. For example, if the Medicare effective date is October 1995, enter "1095". The Medicare effective date is the latest month and year as follows:</p> <ul style="list-style-type: none"> the 30th full month after disability began (add 29 months to the date entered in item 28b of G-325), or the 25th month of Railroad Retirement benefit entitlement.
G360a-21	<p><u>SSA Disability Onset Date</u> - If the widow(er), remarried widow(er) or surviving divorced spouse has been rated disabled under the Social Security Act, enter the month and year of the first full month of disability. Refer to Form G-325 item 28(b) and SSA-831 item 15(a) or 28(c) for the onset date. This entry is before any waiting period that may be required.</p>

G360a-22	<u>SSA Disability Term Date</u> - If the widow(er), remarried widow(er) or surviving divorced spouse has been rated disabled under the Social Security Act, and that disability has ended, enter the month and year the disability was terminated. Refer to Form G-325a item 7 and SSA-831 item 15(b) or 28(c) for the termination date.
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SECTION C - PARTIAL RATE

G360a-23	Reserved for future use, do not complete.
G360a-24	Reserved for future use, do not complete.

SECTION D - MILITARY SERVICE ACCOUNTING

G360a-25	<u>Tier 1 Military Service Accounting</u> - Reserved for future use, do not complete.
G360a-26	Reserved for future use, do not complete.
G360a-27	<u>Tier 2 Military Service Accounting</u> - Reserved for future use, do not complete.
G360a-28	Reserved for future use, do not complete.

SECTION E - NAME AND ADDRESS

G360a-29	<p>Name and Address - Complete this item in <u>ALL CASES</u>, for each beneficiary.</p> <p>Enter the name and address, including those of a representative payee, in the same manner as entered in manual awards on the G-364 payment sheet. Always indicate the beginning of an address by a group mark.</p> <p>The G-360a has spaces for 22 characters in lines 1 through 5. The last</p>
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	<p>two boxes in lines 1 through 4 and the last three in line 5 are for future use. <u>Do not make entries in these boxes.</u></p> <p>Line 6 on Form G-360a is for future use. <u>Do not make entries in line 6 of the address portion of Form G-360a.</u></p>
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SECTION F - REDUCTIONS

NOTE: When paying a partial-to-final award, if a previously used reduction amount is reduced to zero, a G-59 must be sent to Research and TAX-IAS.

G360a-30	<u>OBD Public Service Pension Amount</u> - If the beneficiary is subject to a public service pension reduction, enter the exact amount of the public service pension the beneficiary was receiving on the OBD.
G360a-31	<u>2nd Deduction - Public Service Pension Amount</u> - Enter the exact amount of the public service pension the beneficiary was receiving on the second rate break.
G360a-32	<p><u>PSP RED Status</u> (Public Service Pension Reduction Status) - Complete this item in all cases in which the annuitant is receiving a public service pension. Enter:</p> <ul style="list-style-type: none"> • "1" Exempt - If the tier 1 portion of the annuity will not be reduced for the public service pension because of an exemption. • "2" Lump Sum - If the amount of the reduction is based on a lump sum that was previously paid to the beneficiary. • "3" Recurring - If the tier 1 portion of the annuity is being reduced because of receipt of a monthly public service pension.
G360a-33	<p><u>PSP Source</u> (Public Service Pension Source) - Complete this item in all cases in which the annuitant is receiving a public service pension. Enter:</p> <ul style="list-style-type: none"> • "1" OPM - If the annuitant's public service pension is paid by the federal government. • "2" NON-OPM - If the annuitant's public service pension is paid by a state or local government agency.
G360a-34	<u>OBD Social Security Amount</u> - If the beneficiary is subject to a social security benefit reduction, enter the social security benefit rate payable

	<p>to the annuitant on the OBD.</p> <p>The tier 1 social security benefit reduction amount is equal to the amount of the social security benefit payable to the annuitant, after reduction for age, public service pension and worker's compensation, but before work deductions.</p>
G360a-35	<p><u>2nd Deduction - Social Security Amount</u> - Enter the social security benefit rate payable to the annuitant on the second rate break.</p> <p>The tier 1 social security benefit reduction amount is equal to the amount of the social security benefit payable to the annuitant, after reduction for age, public service pension and worker's compensation, but before work deductions.</p>
G360a-36	<p><u>Social Security Benefit PIA</u> - Enter the latest PIA on which the beneficiary's social security benefit is based.</p>
G360a-37	<p><u>Social Security Benefit Claim Number</u> - When the beneficiary is entitled to an Social Security Act benefit based on someone else's earnings record, enter the social security claim number; otherwise, leave this item blank.</p> <p>Never enter the deceased employee's social security claim number. (Even though the deceased employee may have the social security earnings, a social security benefit cannot be paid on his/her social security earnings because these earnings have been combined with his/her RR earnings.) Never enter the beneficiary's own social security account number. If (s)he is receiving social security benefits based on his/her own earnings, that number should be entered in item 9 "Beneficiary's SS Number."</p>
G360a-38	<p><u>Social Security Benefit Suffix</u> - If the beneficiary receives a monthly SS Act benefit, enter the beneficiary's SSA claim number suffix code. For example, if the widow(er) is receiving an RIB at SSA, enter "00A," in this item. Disregard any subscripts.</p>
G360a-39	<p><u>Social Security Benefit Indicator</u> - Reserved for future use, do not complete.</p>
G360a-40	<p><u>Basis of Employee Annuity Reduction</u> - Enter the code which indicates the type of employee annuity reduction:</p> <ul style="list-style-type: none"> • "1" - Net tier 1 - Enter code "1" if either the employee or widow(er) had railroad earnings prior to 1975. The tier 1 of the widow(er)'s annuity will be reduced by the amount of the net tier 1 of the employee annuity.

	<ul style="list-style-type: none"> "2" - Total employee annuity - Enter code "2" if neither the employee nor the widow(er) had railroad earnings prior to 1975. The entire widow(er) annuity will be reduced by the entire employee annuity.
G360a-41	<p><u>OBD Employee Annuity Reduction Amount</u> - If item 40 is coded "1" (Net Tier 1), enter the amount of the employee annuity net tier 1 (i.e., the tier 1 after reductions for age, social security benefits, military service, worker's compensation or public disability benefits) paid to the widow(er) or parent that corresponds to the OBD. If the employee net tier 1 is zero, enter "0000.10."</p> <p>If item 40 is coded "2" (Total EE annuity), enter the total amount of the employee annuity that correspond to the OBD.</p> <p>NOTE 1: Research needs to be notified if the beneficiary's employee annuity is paid under P.L. 94-547. Furnish this information to Research on a G-59. In item 1, show the deceased employee's claim number. In item 7F, show the widow(er)'s employee annuity claim number and explain that the widow(er) is also entitled to an employee annuity paid under P.L. 94-547.</p> <p>NOTE 2: If the survivor annuity is an initial "D" or "A" case and is awarded after the employee annuity is in pay status, complete Form G-59, showing the widow(er)'s employee annuity claim number in item 1, to notify Research of the dual entitlement. In item 7f, show the deceased employee's claim number, explain that the employee is also entitled to a widow(er)'s annuity rate and month of voucher. The SURCAL case should be pended for the SURCAL output sheet, G-364d, in order to get the widow(er)'s annuity rate. Then, the G-59 should be completed and released to Research.</p>
G360a-42	<p><u>Second Deduction - Employee Annuity Reduction Amount</u> - If item 40 is coded "1," enter the amount of the employee annuity net tier 1 (i.e., the tier 1 after reduction for age, social security benefits, military service, worker's compensation or public disability benefits) corresponding to the second rate break. If the employee net tier 1 is zero, enter "0000.10."</p> <p>If item 40 is coded "2," enter the total amount of the employee annuity that corresponds to the second rate break.</p>
G360a-43	<p><u>Employee Annuity Gross Tier 1</u> - Enter the gross employee tier 1 to which the beneficiary is entitled on the latest computational rate break.</p>
G360a-44	<p><u>Employee Annuity Claim Number</u> - If the widow(er) or parent is entitled</p>

	to an employee annuity, enter the claim number under which it is being paid, <u>only if the claim number is a six-digit serial number</u> . If there are fewer than six digits in the claim number, enter zeros in unused boxes.
G360a-45	Reserved for future use, do not complete.
G360a-46	Reserved for future use, do not complete.

SECTION G - OVERPAYMENT DATA

All overpayments will be recovered from payee code 1. Complete items 47-55 and item 63, if the overpayment was made to the employee.

G360a-47	<u>Employee Railroad Annuity Overpayment</u> - Enter the amount of the employee's regular RR annuity overpayment that is to be recovered on this award.
G360a-48	<u>Employee Supp Annuity Overpayment</u> - Enter the amount of the employee's supplemental annuity overpayment that is to be recovered on this award.
G360a-49	<u>Employee Social Security Benefit Overpayment</u> - Enter the amount of the employee's social security benefit overpayment that is to be recovered on this award. NOTE: When an entry is made in item 49; items 53, 54 and 55 must all be completed.
G360a-50	<u>Employee Non-Tax Overpayment</u> - Enter the amount of any overpayment that is not an overpayment in tier 1, post-1983 tier 2, post-1983 vested dual benefit, Supp or SS, that is being recovered from this award. For example, use this item to recover a HI-SMI overpayment.
G360a-51	<u>Last Check</u> - Enter a "1" if the overpayment being recovered is the employee's last check.
G360a-52	<u>PREV EST Overpayment</u> (Previously Established Overpayment) - Enter a "1" if the overpayment being recovered was previously established. A previously established overpayment is an overpayment that was discovered and calculated before the current award action. Simultaneous discovery and recovery of the overpayment is not considered previously established.

	For example, a last check or an employee overpayment that was calculated at the request of the survivor section is not considered previously established. However, an overpayment that was calculated prior to the employee's death would be considered previously established.
G360a-53	<u>Employee SS Benefit Overpayment Claim Number</u> - If item 49 is completed, enter the social security claim number on which the benefits to be recovered were paid.
G360a-54	<u>SS Benefit Suffix</u> - If item 49 is completed, enter the social security benefit suffix that corresponds to the social security claim number entered in item 53. The suffix should be entered beginning with the first box of the item. Any unused boxes should be left blank.
G360a-55	<u>Employee SS Benefit Overpayment Fund Code</u> - When item 49 is completed, enter either: <ul style="list-style-type: none"> • Code "8" - Overpayment entered in item 49 will be transferred to the OASI Trust Fund; or • Code "7" - Overpayment entered in item 49 will be transferred to the DI Trust Fund.

Complete items 56-62 and item 63, if the overpayment was made to the spouse or widow(er).

G360a-56	<u>Spouse Railroad Overpayment</u> - Enter the amount of the spouse/widow's RR annuity overpayment that is to be recovered on this award. This includes recovery of the RLS.
G360a-57	<u>Spouse SS Overpayment</u> - Enter the amount of the spouse's social security benefit overpayment that is to be recovered on this award. NOTE: When an entry is made in item 57; items 60, 61 and 62 must also be completed.
G360a-58	<u>Spouse Non-Tax Overpayment</u> - Enter the amount of any overpayment that is not an overpayment in tier 1, post-83 tier 2, post-83 vested dual benefit, RLS or SS that is being recovered from this award. For example, use this item to recover an LSDP overpayment.
G360a-59	<u>Type of Overpayment</u> - Enter the code which indicates the type of

	overpayment being recovered: "1" - Last check "2" - Previously established overpayment "3" - RLS																								
G360a-60	<u>Spouse SS Benefit Overpayment Claim Number</u> - If item 57 is completed, enter the social security claim number on which the benefits to be recovered were paid.																								
G360a-61	<u>SS Benefit Suffix</u> - When item 57 is completed, enter the social security suffix that corresponds to the social security claim number entered in item 60. The suffix should be entered beginning with the first box of the item. Any unused boxes should be left blank.																								
G360a-62	<u>Spouse SS Benefit Overpayment Fund Code</u> - When item 57 is completed, enter either: • Code "8" - Overpayment entered in item 57 will be transferred to the OASI Trust Fund; or • Code "7" - Overpayment entered in item 57 will be transferred to the DI Trust Fund.																								
G360a-63	<u>Overpayment Code Paragraphs</u> - Enter the code which corresponds with the code paragraph(s) that should be printed. <table><thead><tr><th>Code</th><th>Code Paragraph</th><th>Description</th></tr></thead><tbody><tr><td>01</td><td>520.2</td><td>Employee last RR and/or SS payment outstanding.</td></tr><tr><td>02</td><td>531</td><td>Spouse last SS payment outstanding.</td></tr><tr><td>03</td><td>520.2 & 531</td><td>Employee last RR and/or SS and spouse last SS payment outstanding.</td></tr><tr><td>04</td><td>530</td><td>Other overpayment to employee or spouse.</td></tr><tr><td>05</td><td>520.2 & 530</td><td>Employee last RR and/or SS payment outstanding and other overpayment.</td></tr><tr><td>06</td><td>531 & 530</td><td>Spouse last SS payment outstanding and other overpayment.</td></tr><tr><td>07</td><td>525</td><td>RLS recovery.</td></tr></tbody></table>	Code	Code Paragraph	Description	01	520.2	Employee last RR and/or SS payment outstanding.	02	531	Spouse last SS payment outstanding.	03	520.2 & 531	Employee last RR and/or SS and spouse last SS payment outstanding.	04	530	Other overpayment to employee or spouse.	05	520.2 & 530	Employee last RR and/or SS payment outstanding and other overpayment.	06	531 & 530	Spouse last SS payment outstanding and other overpayment.	07	525	RLS recovery.
Code	Code Paragraph	Description																							
01	520.2	Employee last RR and/or SS payment outstanding.																							
02	531	Spouse last SS payment outstanding.																							
03	520.2 & 531	Employee last RR and/or SS and spouse last SS payment outstanding.																							
04	530	Other overpayment to employee or spouse.																							
05	520.2 & 530	Employee last RR and/or SS payment outstanding and other overpayment.																							
06	531 & 530	Spouse last SS payment outstanding and other overpayment.																							
07	525	RLS recovery.																							

	08 531.1 LSDP recovery.
G360a-64	<u>Partial Code Paragraph</u> - Enter "1" in the box if the rate being paid is NOT based on a final wage record or for any reason the rate is not considered the final annuity rate.
G360a-65	<u>Examiner Name</u> - The examiner's name should be signed and the current date entered.
G360a-66	<u>Authorizer Name</u> - After all examiner entries have been verified, the authorizer's name should be signed and current date entered.
G360a-67	<u>Remarks</u> - Use as needed to explain any unusual circumstances involving the award to facilitate reading the file.

Disposition

Examiner Action - Attach the G-360 and G-360a code sheets with a gem clip to the right side of the folder.

Authorizer action - Send the original sheets for keypunching, file the duplicate on the left side of the folder and control the folder until the G-364d is received.

Print Out

A single copy of Form G-364d is printed for the folder record; no other copies are prepared. This form shows the payment data, the payee's name and address and the numbers of the code paragraphs which were printed on the RL-43d award letter. The G-364d does not show HIB or SMI information. If SMI deductions are applicable, it will be necessary to deduct the appropriate premium from the monthly rate.

Special Situations

- Assumed DOD Used

If the DOD is unknown at the time of the termination, Research uses an assumed DOD, 1 month prior to the time of termination. (Their records are earmarked that this is an assumed DOD.) If an assumed DOD was used and the employee was enrolled for Medicare, send the case to BDMO to correct their records after all other action is completed.

Appendix C

G-60 - TRIC Request for Wage and MBR Information (Original and folder copy)

Use

Use as an input data sheet to: (1) initiate a tape request for SS earnings (except for a deceased employee), PIA computations, and SS benefit data for employees and (2) initiate a request to SSA to update or delete an MBR earmark.

NOTE: Effective July 1999, RRB paper form G-60 is obsolete. Use the G-60/G-60S PC Program to enter all G-60 requests on-line. RCM 9.1 Appendix C (G-60) procedure has been retained to assist in completing the on-line forms.

Completion

PART I - IDENTIFICATION

Item 1: Enter the prefix, using "A," "D," or "H." Enter the RRB claim number. If the employee has a 9 digit claim number, enter only A, D, or H in the first space provided. If the claim number has less than six digits, precede with zero(s).

Item 2: Enter the employee's social security account number.

NOTE: Do not release a G-60 if the employee has no SS account number. In this type of case, release a G-563 to Claims Certification Unit for a manual computation of any needed PIA.

Item 3: Enter the appropriate numeric unit designation code as shown in this item.

Retirement Units	Survivor Units	Other Units
02 = RIS	03 = SIS	04 = RECON
12 = RPS-A	11 = SPS	05 = DRD
13 = RPS-B2		06 = MS
14 = RBD Director		07 = DSUBD
22 = RPS-B1		08 = PES
		09 = BTRS
		15 = CI
		16 = SPARC
		17 = SPEED
		18 = OIG
		20 = P&S Manual
		21 = RESCUE

Item 4: Enter the employee's surname (up to ten letters) and the first and second initials of the employee's given name.

Item 5: Enter the employee's date of birth. Use preceding zeros where necessary.

Item 6: Enter code "1" if the employee is male; code "2" if female.

PART II - ANNUITY REQUEST INFORMATION

Item 7: Complete this item as follows:

- Enter code "1" if the employee's annuity is in current payment status at RRB.
- Enter code "2" if the employee's annuity is in suspense at RRB.
- Enter code "3" if the employee's annuity has been terminated by RRB.
- Enter code "4" if Item 13 is coded "91." See instructions for Item 13.

NOTE: The Item 7 code is instrumental in earmarking and maintaining RR data in SSA's MBR. RRB should not initiate MBR earmarking if a RR annuity is not in payment status. Therefore, leave Item 7 blank if initial payment action is pending or if a G-90 is being requested for annuity estimate purposes only.

When a PAM Award or MOR is received with the Review Message "ALERT-EARMARK MBR WITH CORRECT RR CLAIM NUMBER/PREFIX" the examiner must check the DPA DATA section of the transmittal for the employee's total service months. If 120 or more months are shown, enter code "1" in this item.

Item 8: Enter the beginning date of the employee's RR annuity. Enter preceding zeroes where needed.

Item 9: Enter the RRA disability onset date for all disability type requests. This item opens for entry only after items 14 and 15 have first been completed. It opens up for disability annuity codes "03" or "08".

The RRA disability onset date may be obtained from the following:

- Item 17 of OLDDS, or
- Item 18 of OLDDS.

Item 10: Complete this item in all cases in which the employee has a current connection. Enter code "3" if the employee had a current connection on 12-31-74 but not on his ABD. Enter code "4" if the employee has a current connection on his ABD, whether the ABD is before or after 12-31-74.

If the employee does not have a current connection, leave this item blank.

NOTE: In order to change the vesting year for determining eligibility to a vested dual benefit, an examiner can obtain corrected PIA's with a type request 13, together with

completion of the vesting year, quarters of coverage through the vesting year, the insured status indicator, and, if M/S is involved, the M/S-as-used code. A type of request 01 will also change the vesting year on the requested G-90 with the corrected c/c data. It will still be necessary to correct the Research record with a G-59 or award action with the correct G-90 date.

Item 11: Enter the date of the employee's last railroad work. Enter preceding zeroes where needed. In recomp cases, leave this item blank.

Item 12: Enter the date of the employee's last non-railroad work. Enter preceding zeroes where needed. In recomp cases, leave this item blank.

Item 13: Enter the appropriate request code as follows:

A. Regular PIA Calculations

- Use code "01" for an initial request for an earnings record and MBR information for a 1981 or 1983 Amendment employee based on his/her own account number. This request will generate PIA (and latest 19 recomps, if applicable, for type annuity other than reduced 60/30) and Tier II calculations. Use this code only for an initial request when no folder record exists or Tier II calculations are required. Do not use this code for 1974 Act Cases (see code "10"). For cases paid under the 1937 Act, see "B."
- Use code "10" for an initial request for an earnings record and MBR information for a pre-1981 Amendment employee, whose ABD is 1-1-75 or later, based on his/her own account number. This request will generate PIA and AMC calculations. A code "10" in this item should only be used for initial requests when no folder record exists or because AMC calculations are required. Do not use this code for cases paid under the 1937 Act.

When this item is coded "10," Item 36 must be completed or the request will reject.

NOTE: In 1974 Act cases, where the ABD is prior to 1-1-75, use request code "13." A code "01" or "10" in this situation will cause the request to reject. If AMC calculations are required, they must be requested manually from CCU via Form G-563.

- Code "16" - Blank, do not enter.
- Use code "62" in conjunction with a code "05" in Item 14 to request recalculated PIA's and latest 19 applicable recomps for reduced 1983 Law Year (LY) 60/30 cases. An AGE 62 RECALC cannot be calculated prior to December 1st of the year the employee is age 61.

- Use code "88" to request recalculated PIAs, AMCs and Tier II for cases in which M/S creditability has changed due to the 1988 Act Amendments.
- Use code "90" in conjunction with a code "1," "2," or "3" in Item 7 to update the MBR (e.g., to indicate a name change for a female employee, etc.). Complete only Items 1, 2, 3, 4, 5, 6 and 7.
- Use code "91" in conjunction with a code "4" in Item 7 to remove an MBR earmarking (e.g., denials, wrong SSA number earmarked, etc.). Complete only Items 1, 2, 3, 4, 5, 6 and 7.

NOTE: Codes "90" and "91" will not produce a reply from SSA. Once the G-60 information is transmitted, assume that the proper action was taken by SSA. For additional information concerning MBR earmarking see RCM 7.4.60 through RCM 7.4.67.

B. Recomp and '37 Act PIA Data

- Use code "13" to request recomp PIA data, or PIA's for cases paid under the 1937 Act. When this code is used, the G-90 program will consider the SS wages earned in and after the ABD year in the PIA computations. (See "SPECIAL SITUATIONS" for a description of the data provided for '37 Act or "conversion" cases. If different or additional computations are required, they must be specifically requested with a G-563.

NOTE: Do not request recomp PIA data before September of the year following the ABD year. If the G-60 is submitted for recomp PIA data before September of the following the ABD year, the G-60 will reject.

Do not request recomp PIA's for a reduced '83 law year 60/30 employee using code "13." When a request is made for recalculated PIA's when the employee attains age 62 (a code 62 is entered in this item as explained above), the recalculated PIA's will include earnings in and after the ABD through the year before age 62 is attained. The latest 19 recomp PIA's will also be supplied that will include earnings in and after the year age 62 was attained. Recomp PIA's for 60/30 '74 Act cases should be requested as usual using a code "13" in Item 13 and a code "1" in Item 14.

- Code "17" - Blank, do not enter.
- Code "18" - Blank, do not enter.

C. Other

Use code "04" to request the MBR only on the employee's own account number. Complete Items 1, 2, 3, 4, 5, 6, 7, 13 and 15.

Item 14: Enter the code that describes the type of annuity the employee is receiving as follows: (For an explanation of which Railroad Retirement Act or Amendment provisions apply, see RCM 8.6, G-357a instructions for Item 11.)

For PIA calculations under the 1983 Amendments:

- Enter code "05" if the employee is receiving an '83 LY 60/30 annuity and has no disability freeze. If the employee is receiving an '83 LY 60/30 annuity, and has a disability freeze, refer the folder to M&P-A. In the remarks section of the route slip enter "83 LY 60/30 with DF.
- Enter code "03" if the employee is receiving a disability annuity, and also meets the '83 LY 60/30 criteria.

For PIA calculations under the 1981 Amendments:

- Enter code "01" if the employee is receiving a full annuity based on age 65 or for recomp PIA data based on 60/30.
- Enter code "02" if the employee is receiving a reduced age annuity.
- Enter code "03" if the employee is receiving an annuity based on an "occupational" or "total and permanent" disability regardless of whether the employee has 60/30.
- Enter code "04" if the employee is receiving an age and service annuity based on 60/30 and also has been granted a disability freeze.
- Enter code "05" on an initial request if the employee is receiving an age and service annuity based on 60/30. The TRIC program will automatically change to a type "01" if it determines age 60 and 360 service months were acquired prior to 7-1-84. Do not use this code for recomp PIA data when associated with a type "13" in Item 13.

For PIA calculations under the 1974 Act:

- Enter code "01" if the employee is receiving a full annuity based on full age 65 or on a '74 Act 60/30 annuity.
- Enter code "02" if the employee is receiving a reduced annuity.
- Enter code "03" if the employee is receiving a disability annuity, whether "total and permanent" or "occupational" regardless of whether the employee has 60/30.
- Enter code "04" if the employee is receiving an age and service annuity based on 60/30 and also has been granted a disability freeze.

For PIA calculations under the 1937 Act:

- Enter code "06" if the employee is receiving a full annuity based on age 65 or based on 60/30 with no disability freeze.
- Enter code "07" if the employee is receiving a reduced annuity.
- Enter code "08" if the employee is receiving a disability annuity, whether "total and permanent" or "occupational."
- Enter code "09" if the employee is receiving an age and service annuity based on 60/30 and also has been granted a disability freeze.

Item 15: Complete this item as follows:

- Enter code "2" if the employee is a pre-1981 amendment employee.
- Enter code "4" for a 1981 amendment employee who filed before 4-1-82.
- Enter code "6" for a 1981 amendment employee who filed after 3-31-82.

Item 16: Enter the month, day and year the application was filed. Enter preceding zeroes where needed.

Item 17: Enter code "1" if a regular 1959 calculation is required. If code "1" is used, compensation will be limited to \$4550.00 for 1959.

Enter code "2" if the gross 1959 calculation was considered in the original computation of the annuity. If code "2" is used, compensation will be limited by the SS earnings maximum of \$4800.00 for 1959.

NOTE: Examiners can determine whether Reg '59 or Gross '59 earnings were considered by checking the G90 date into system and the "1959 Gross Amount" of the G-90 originally used to finalize the annuity. If the G90 has a date into system of 10-16-87 or later and the "1959 Gross Amt" is blank, the Reg '59 amount was considered. If the G90 date into system is prior to 10-16-87 and the "1959 Gross Amt" shows \$4800 or less, the Gross '59 amount was considered.

Note: NCSP calculations are provided if eligibility year (EY) is greater than 1985. If the ey is prior to 1986 then a g563 is required.

Item 18: ~~Blank, make no entry~~Enter the initial effective date to apply the non-covered service pension (NCSP). Date must be 1/1/1986 or later. The day field, DD, must be '01'.

Item 19: ~~Blank, make no entry~~Enter the NCSP amount.

Item 20: ~~Blank, make no entry.~~ Enter the total number of post 1956 non-covered service months.

Item 21: ~~Blank, make no entry.~~ Enter the total number of non-covered service months.

Item 22: Enter the total number of verified prior service months. (The program will mechanically determine the number of months to be used in the computation.) If Item 14 is coded "06," "07," "08," or "09," leave this item blank.

Item 23: Enter the amount of the prior service average. If Item 14 is coded "06," "07," "08," or "09," leave this item blank.

PART III - DISABILITY FREEZE INFORMATION

Item 24: Blank, make no entry.

Item 24a: The DF date may be obtained from the following:

- Item 24 of OLDDS, or
- Item 15(A) of Form SSA-831-U3, or
- Item 25 of Form G-325, or
- Item 4 of Form SSA-415.

If a closed period of disability or two or more separate periods of disability have been established for the employee, the mechanical system cannot correctly calculate the employee's PIAs. Request manual PIA calculations from CCU for these cases (see RCM 8.11.122).

NOTE: Form G-60 will reject if a date is entered in this item and Item 14 (Annuity Code) is completed with "01" or "06" (full age), or "02" or "07" (reduced age). If a DF is established for this type of annuitant, refer to RCM 8.11.15D to determine if the DF will affect the PIA calculations.

Manual PIA calculations must be requested from CCU via Form G-563 if it is determined that PIA's will be affected by the DF.

Item 24b: Blank, make no entry.

Item 25a: Blank, make no entry.

Item 25b: Blank, make no entry.

PART IV - LAG INFORMATION

Item 26: A "lag code" must be shown indicating whether lag service is involved and should be considered in the PIA/Tier 2 calculations.

- Enter code "1" if lag service is not involved, or for retirement applications filed May 1, 1988, or later, lag service is involved, but was not developed because it is not needed to establish eligibility for a regular annuity.
- Enter code "2" if lag service is involved and was developed for the year of the employee's retirement (1 lag year).
- Use code "3" if lag service is involved and was developed for both the year of the employee's retirement and the prior year (2 lag years).

If code "2" or "3" was entered in Item 26, complete Items 26a as follows:

Item 26a: Enter the current year, the reported (actual) service months and the deemed service months, if any. Enter preceding zeroes where necessary. If there are no deemed service months, leave both deemed SM boxes blank.

Item 26b: No entry is required. This box is shaded.

Item 26c: No entry is required. This box is shaded.

Item 27: If Item "3" was entered in Item 26, complete Item 27a, as follows:

Item 27a: Enter the prior year, the reported (actual) service months and the deemed service months, if any. Enter preceding zeroes where necessary. If there are no deemed service months, leave both deemed SM boxes blank.

Item 27b: No entry is required. This box is shaded.

Item 27c: No entry is required. This box is shaded.

PART V - M/S INFORMATION

SEARCH processing now accesses and uses the M/S data stored on the EDM database for all types of G-90 requests. Therefore, if M/S is shown on EDM, do not complete M/S Items 28-35. (If the M/S data is incorrect, it is necessary to complete Form G-59MS to revise or delete the M/S data on EDM. See Form G-59MS instructions in RCM 9.4).

EXCEPTION: If any M/S period shown on EDM is being "used" differently than how it is "credited", the G-90 request must show how each M/S period is being "used". Complete M/S data for each M/S period, including the "use" data, must be shown on the G-90 request. The following "use" codes are to be used when applicable:

1 = used as compensation

3 = used as wages

4 = not used

If "use" data is shown for any M/S period, "use" data must be shown for all M/S periods in Items 29c, 30c, 31c, and 32c.

If no M/S data is shown on EDM, follow the instructions below. Your actions will both include the M/S on the requested G-90 and store the M/S data on EDM.

Item 28: Enter the appropriate code to show whether the employee has M/S which should be considered in the PIA computations on the G-90. If no M/S is claimed, all items from 28 through 35 can be left blank.

- Enter code "1" if there is one period of military service and it has been claimed and verified.
- Enter code "2" if there are two periods of military service which are claimed and verified.
- Enter code "3" if there are three periods of military service which are claimed and verified.
- Enter code "4" if there are four periods of military service which are claimed and verified.
- Enter code "5" if there are more than four periods of military service which are claimed and verified.

NOTE: The date of enlistment or induction is used to determine the creditability of military service. Therefore, if the enlistment or induction date and the date the active military service duty began are the same, it is not necessary to have a determination made as to the creditability of the military service before entering it on the Form G-60. If the dates are not the same, use a Form G-563 to obtain a determination from the Claims Certification Unit as to the creditability of the military service. However, if the information in the folder shows the employee had the required RR service prior to the enlistment or induction date, it will not be necessary to use a Form G-563. The Form G-60 can be used, but only enter the active military service dates.

Items 29a, 29b, 30a, 30b, 31a, 31b, 32a, 32b: Any period of M/S with a beginning date within the 6-15-48 through 12-15-50 period must be listed separately on the G-60. Therefore, some consecutive M/S periods which were previously shown as one period must now be shown as two periods (if either period began within the 6-15-48 through 12-15-50 period).

Example:

M/S Periods

Listed Previously As:

New Listings:

06-30-49 to 05- 15-50

06-49 to 05-51

06-30-1949 to 05-15-1950

05-16-50 to 05-30-51

05-16-1950 to 05-30-1951

(Consecutive periods of M/S, when neither begin during the period of 6-15-48 through 12-15-50, may still be shown as one period.)

Item 29a: Enter the month, day and year the first period of verified active military service began.

Item 29b: Enter the month, day and year the first period of verified active military service ended.

Items 29c, 30c, 31c, 32c: The use code should be entered on a PIA recomp G-60 request (Code "13" in Item 13) and any age 62 recalculation G-60 requests (code "62" in Item 13). Make no entry for all other codes in Item 13.

Enter code "1" to indicate that the applicable military service period is being used as compensation, or a code "3" to indicate that the military service is being used as wages. This entry will be used when the military service has previously been credited and used. If creditability is unknown for any military service period, leave the items blank for all periods, as the system must develop creditability determinations.

Item 29d: Only complete this item if the military service from Items 29a-29b includes any post 12-31-46 military service. Enter code "1" when the means of entry for the first period of military service is voluntary. Enter code "2" when the means of entry for the first period of military service is involuntary.

Items 29e, 30e, 31e, 32e: The number of overlapping military service months should be entered on a PIA recomp G-60 request (code "13" in Item 13) and any age 62 recalculation G-60 request (code "62" in Item 13); precede with a zero if necessary. Make no entry for all other codes in Item 13.

Enter the number of overlapping military service months for the military service period shown. This number can be located from any previous G-90.

Overlapping military service months are defined as those M/S months which are not creditable as service months because RR service has already been credited for these months. Any calendar month cannot be credited as compensation more than once.

If not available, leave this item blank.

Item 29f: Only complete this item if the military service from Items 29a-29b includes all or part of the 6/15/48 through 12/15/50 period.

If EE has answered "Yes" to Item 29 of the AA-1 (9/89), enter an "x" in this item. If the EE has answered "No" to Item 29 of the AA-1 (9/89), leave this item blank.

Item 30a: Enter the month, day, and year the second period of verified active military service began, if any.

Item 30b: Enter the month, day and year the second period of verified active military service ended, if any.

Item 30c: Enter the use code for the second period of verified active military service for PIA recomp G-60 requests and age 62 recalculation G-60 requests (codes "13" and "62" in Item 13 respectively) only.

Item 30d: Only complete this item if the military service from Items 30a-30b includes any post 12-31-46 military service. Enter code "1" when the means of entry for the second period of military service is voluntary. Enter code "2" when the means of entry for the second period of military service is involuntary.

Item 30e: Enter the number of overlapping military service months for the second military service period for PIA recomp G-60 requests and age 62 recalculation G-60 requests (codes "13" and "62" in Item 13 respectively) only.

Item 30f: Only complete this item if the military service from Items 30a-30b includes all or part of the 6/15/48 through 12/15/50 period if the EE has answered "Yes" to Item 29 of the AA-1 (9/89), enter an "x" in this item. If the EE has answered "No" to Item 29 of the AA-1 (9/89), leave this item blank.

NOTE: If the EE has two periods of military service, both of which include all or part of the 6/15/48 through 12/15/50 period, then an "x" should be entered in both Item 29f and Item 30f. This will restrict the creditability of the M/S to "wages" only. A message will appear in the Remarks section of the G-90 in this situation in order to alert the claims examiner to contact the F/O to determine if the EE had intervening wages between both of the 6/15/48 through 12/15/50 periods of M/S and RR service.

Item 31a: Enter the month, day, and year the third period of verified military service began, if any.

Item 31b: Enter the month, day, and year the third period of verified military service ended, if any.

Item 31c: Enter the use code for the third period of verified active military service for PIA recomp G-60 requests and age 62 recalculation G-60 requests (codes "13" and "62" in Item 13 respectively) only.

Item 31d: Only complete this item if the military service from Items 31a-31b includes any post 12-31-46 military service. Enter code "1" when the means of entry for the third period of military service is voluntary. Enter code "2" when the means of entry for the third period of military service is involuntary.

Item 31e: Enter the number of overlapping military service months for the third military service period for PIA recomp G-60 requests and age 62 recalculation G-60 requests (codes "13" and "62" in Item 13 respectively) only.

Item 31f: Only complete this item if the military service from Items 31a-31b includes all or part of the 6/15/48 through 12/15/50 period. If the EE has answered "Yes" to Item 29 of the AA-1 (9/89), enter an "x" in this item. If the EE has answered "No" to Item 29 of the AA-1 (9-89), leave this item blank.

NOTE: If the EE has more than one period of military service which includes all or part of the 6/15/48 through 12/15/50 period, then an "x" should be entered in those Items 29f, 30f, and/or 31f which correspond to each period of M/S which includes 6/15/48-12/15/50 service. This will restrict the creditability of the M/S to "wages" only. A message will appear in the Remarks section of the G-90 in this situation in order to remind the claims examiner to contact the D/O to determine if the EE had intervening wages between all of 6/15/48-12/15/50 periods of M/S and RR service.

Item 32a: Enter the month, day, and year the fourth period of verified military service began, if any.

Item 32b: Enter the month, day, and year the fourth period of verified military service ended, if any.

Item 32c: Enter the use code for the fourth period of verified active military service for PIA recomp G-60 requests and age 62 recalculation G-60 requests (codes "13" and "62" in Item 13 respectively) only.

Item 32d: Only complete this item if the military service from Items 32a-32b includes post 12-31-46 military service. Enter code "1" when the means of entry for the fourth period of military service is voluntary. Enter code "2" when the means of entry for the fourth period of military service is involuntary.

Item 32e: Enter the number of overlapping military service months for the fourth military service period for PIA recomp G-60 requests and age 62 recalculation G-60 requests (codes "13" and "62" in Item 13 respectively) only.

Item 32f: Only complete this item if the military service from Items 32a-32b includes all or part of the 6/15/48-12/15/50 period. If the EE has answered "Yes" to Item 29 of the AA-1 (9/89), enter an "x" in this item. If the EE has answered "No" to Item 29 of the AA-1 (9/89), leave this item blank.

NOTE: If the EE has more than one period of military service which includes all or part of the 6/15/48-12/15/50 period, then an "x" should be entered in those Items 29f, 30f, 31f, and/or 32f which includes 6/15/48-12/15/50 service. This will restrict the creditability of the M/S to "wages" only. A message will appear in the Remarks section of the G-90 in this situation in order to remind the claims examiner to contact the F/O to determine if

the EE had intervening wages between all of the 6/15/48-12/15/50 periods of M/S and RR service.

Item 33: Blank, make no entry.

Item 34: Blank, make no entry.

Item 35: Enter the total number of overlapping military service months that fall within the period January 1937 through December 1950.

PART VI - SS INFORMATION

Item 36: Only complete this item when the type of request code in Item 13 is "01" or "10."

- Enter code "1" (in a pre-1981 Amendment case) or code "5" (in a 1981 or 1983 Amendment case) if a wage QC breakdown for the period 1937-1952 is not required because a determination has previously been made and the information is documented on a Form G-90.

NOTE: A "1" should be entered in 1981 or 1983 Amendment cases if the case must be expedited. (See the chart on page 17 which describes the G-90 produced by the entries in G-60 Items 13-36.)

- Enter code "2" if a wage breakdown for the period 1937-1952 is required in order to make an insured status/vesting determination, unless expedited payment without vesting information is necessary.

EFFECT OF ITEM 13 AND ITEM 36 ON FORM G-90

If G-60 Item 13 is:	And G-60 Item 36 is:	And the EE's Vesting status is:	Then the G-90 produced will be:
"01"	"1"	Possibly insured using the \$50.00 rule,	A temporary G-90 with the message "37-52 BYPASS - CASE INCOMPLETE" in Item 13. Do not use the M/S in calculation of PIA's or Tier II.
"01"	"1"	Insured based on the \$400.00 rule,	A final G-90 with PIA 4.
"01"	"1"	Insured without a '37-'52 breakdown,	A final G-90.
"01"	"5"	Possibly insured using the	A final G-90 without PIA 4.

		\$50.00 rule,	
"01"	"5"	Insured based on the \$400.00 rule,	A final G-90 with PIA 4.
"10"	"1"	Possibly insured using the \$50.00 rule,	A final G-90 without PIA 4.
"10"	"1"	Insured based on the \$400.00 rule,	A final G-90 with PIA 4.

*See RCM 5.6.21 and 5.6.22 for information on the \$50.00 and \$400.00 wage QC rules.

Item 37: Only complete this item when the Type of Request code in Item 13 is "13" and there is no military service involved.

*Enter code "1" if the employee has an SS insured status for VDB purposes. Enter code "2" if the employee does not have an SS insured status for VDB purposes. If the SS insured status of the employee is unknown or military service is claimed, leave this item blank.

NOTE: The information required to determine if an employee has an SS insured status may be found on a previous G-90. IF THIS ITEM IS COMPLETED, ITEMS 38 AND 39 MUST ALSO BE COMPLETED OR THE REQUEST WILL REJECT.

* When Item 37 is coded "1" and Items 38 and 39 contain the QC's acquired and the vesting year, PIA's 4, 7, and 8 will be mechanically computed. When Item 37 is coded "2," 9999 will be displayed adjacent to PIA 4 of the G-90. In both instances, the G-90 Remarks section will indicate "INSURED STATUS DETERMINATION FROM G-60."

Item 38: Only complete this item when the Type of Request code in Item 13 is "13" and there is no military service involved.

- Enter the number of "Acquired QC's." The number to be entered is displayed in the "WAGES ONLY" field of a previous G-90. Do not enter a figure greater than "40."
- Enter "99" if Item 37 is coded "2" and no QC's are displayed in the "Wages Only" field of a previous G-90.

Item 39: Only complete this item when the Type of Request code in Item 13 is "13" and there is no military service involved.

- Enter the employee's vesting year. This is may be located in the G90 section "Quarters of Coverage." This date will be either the year last worked in the railroad industry or 1974.

- Enter "9999" if Item 37 is coded "2" and no year is displayed in the "Quarters of Coverage" section of the G90.

NOTE: Entries in Items 38 and 39 should be in agreement with each other. For example, if the number of "Acquired QC's" is entered in Item 38, then a valid vesting year must be entered in Item 39. Likewise, if "99" is entered in Item 38, then "9999" must be entered in Item 39.

Item 40: Enter an "F" when there is a discrepancy in the SSA number in RRB records and the one in SSA's records, but we need the wage information on the SSA number in RRB records. Otherwise, leave blank.

PART VII - FUTURE USE

Item 41: Make no entry unless a special G-90 as explained below is being requested. A miscellaneous M/S code entry allows for certain types of G-90 calculations without changing the military service data as stored on EDM. The following miscellaneous codes will provide G-90 calculations as follows:

Code 1: The G-90 will be processed with no M/S. The message "G-90 Includes No Claimed M/S" will be displayed on the G-90.

Code 2: The G-90 will be processed with all M/S data from EDM except the M/S for M/S accounting purposes. The message "This G-90 is for M/S Accounting Purposes Only" will be displayed on the G-90.

By comparing the computations from an M/S accounting G-90 with a final G-90, which includes all M/S period(s), will provide M/S accounting amounts.

Items 42-44: Blank, make no entry.

Special Situations

1) Completion of G-60 for independently-entitled divorced spouses under PL109-280

Independently-entitled divorced spouse annuities require G-90 PIA calculations even though the employee has not yet filed for an annuity, has no ABD, and may still be working in the railroad industry.

Complete the G-60 entries as usual with the following exceptions:

- Item 5, enter the employee's DOB, as usual;
- Item 8, enter the divorced spouse's ABD as the employee's ABD;
- Item 11, enter the date of the employee's last railroad work, but no later than the day before the ABD in item 8;

- Item 13, always enter "01";
- Item 14, enter "01" (full age) or "02" (reduced age) depending on the employee's age on the ABD that you entered in item 8 above;
- Item 16, enter the divorced spouse's filing date;
- Item 26, enter lag only if needed for eligibility.

NOTE: Recomp PIAs involving railroad compensation earned by the employee will need to be requested manually via G-563 from CCU because SEARCH will incorrectly allocate compensation posted for periods after the XA ABD, to the DLW-RR entered.

2) Completion of G-60 for Conversion Cases

Completion of a G-60 in the regular manner will not always produce valid PIA's for conversion cases. Therefore, a separate G-90 program has been created to compute the correct PIA amounts needed for conversion cases. The PIA's which will be computed for conversion cases are:

- PIA 1 - Recomputed pass-thru PIA.
- PIA 4 - Vested Dual Benefit (VDB) - Wages Only Thru 12-1974.
- PIA 7 - Vested Dual Benefit (VDB) - Compensation Only Thru 12-1974.
- PIA 8 - Vested Dual Benefit (VDB) - Wages and Compensation Thru 12-1974.

When a G-60 is completed with a code "13" in Item 13, the G-90 program will consider the following information before computing PIA's 1, 4, 7, and 8:

- PIA 1 (Recomputed Pass-Thru PIA) - The recomputed pass-thru PIA 1 will be furnished only if there are SS earnings in 1974 or later which are high enough to trigger a RECOMP. The recomputed pass-thru will also include any earnings after 1971 that were excluded in the pass-thru PIA computation. If the SS earnings in 1974 or later are not high enough to trigger a RECOMP, the PIA 1 on the G-90 will be left blank.

A pound sign (#) will be shown to the left of PIA 1 on the G-90 and in remarks the legend "12-1986 PIA" will appear. This legend will be changed whenever a new PIA table becomes effective.

If the 1974 earnings trigger a RECOMP, the earliest date an increase can be paid is 1-1-75. In such a case, the recomputed 6-1975 must be retroacted to the 6-1974 PIA for the annuity adjustment in the 1-1975 to 5-1975 period.

- Vesting Status - If the employee is not entitled to an RIB or DIB, the program will look for an insured status as of 12-31-74. If the employee is entitled to an

RIB or DIB, the program will assume an insured status as of 12-31-74 but only if the SS benefit DOE is prior to 1975. Windfall PIA's 4, 7, and 8 will be furnished if the employee meets the vesting requirements.

The revised G-90 program will also produce valid PIA's 10 and 11 based on compensation through DLW, wages through the year preceding ABD.

Signature And Disposition

Sign and date the form in the spaces provided. File the duplicate on the right side of the folder. Put the original in the tray provided to be delivered to the Computer Room. Control the claim in accordance with instructions from the unit supervisor.

The accompanying sample (see paper RCM) of Form G-60 is designed to serve as an examiner guide for determining which entries are required on various types of requests. The darkened boxes indicate no entry is required.

G-60a - Tracer for G-90

This form was replaced with an HSL format effective 9/4/1994. As of 9/17/2001, the HSL tracer is not to be used. You must trace an outstanding G90 through e-G-115, General Inquiry Form via email.

When to trace: If a G90 is pending more than 30 days, you should trace on the status.

How to trace: Please use e-G-115 General Inquiry Form. Open you're email account and click on Public Folders, then Office of Programs, then new e-G-115 General Inquiry Form.

Item to complete: address the email as follows:

- If the claim ends in 00-31 - Donna Burrell
- If the claim ends in 32-65 - Alma Ford
- If the claim ends in 66-99 - Alice Gant

Also provide the RRA claim number, inquiry date and section, inquirer and a message.

G-60s - TRIC Request for Wage and MBR Information - Survivor/ Spouse (Original and folder copy)

Use

Use as an input data sheet to: make a request to SSA to initiate update, or delete an MBR earmark for spouses, widow(er)'s, and other auxiliary beneficiaries. (See RCM 7.4.68 for complete information on earmarking.)

Prior to October 29, 1996, this form produced paper output for various informational purposes which can now be accessed via SSA's on-line MBR or by securing a print-out from the SSA on-site representative. The Data Communications Utility Network (DCU) will be used to obtain information from SSA's Detailed Earnings Query (DEQY) record or the Summary Earnings Query (SEQY) record.

The paper output also provided some calculations, such as PIA #21 which are no longer produced mechanically. If you need a PIA #21 calculation, request one via Form G-563 to CCU. Attach any material relating to the vesting determination to the G-563 request. After having determined that the spouse/widow meets the vesting requirements, CCU will calculate a PIA #21.

NOTE: Effective July 1999, RRB paper form G-60s is obsolete. Use the G- 60/G-60s On-Line PC Program accessed via Boardwalk to enter all G-60s requests on-line. RCM 9.1 Appendix C (G-60s) procedure has been retained to assist in completing the on-line forms.

Completion

PART I - IDENTIFICATION

Item 1: Enter the prefix, using A, D, or H. Enter the employee RRB claim number. If the employee has a nine-digit claim number, enter only A, D, or H in the first space provided. If the claim number has less than six digits, precede with zero(s).

Item 2: Enter the employee's social security account number.

Item 3: Enter the appropriate numeric unit designation code as shown in this item.

<u>Retirement Units</u>	<u>Survivor Units</u>	<u>Other Units</u>
02 = RIS	03 = SIS	04 = RECON
12 = RPS-A	11 = SPS	05 = DRD
13 = RPS-B2		06 = MS
14 = RBD Director		07 = DSUBD
22 = RPS-B1		08 = PES
		09 = BTRS
		15 = CI
		16 = SPARC
		17 = SPEED
		18 = OIG
		20 = P&S Manual
		21 = RESCUE

Items 4,14,24: Complete as follows:

- Enter code "1" if the auxiliary's annuity is in current pay status at RRB.
- Enter code "4" if Item 5, 15, or 25 is coded "91." See instructions for Items 5, 15, and 25 below.

NOTE: The Items 4, 14, and 24 codes are instrumental in earmarking and maintaining RR data in SSA's MBR. RRB should not initiate earmarking if a RR annuity is not in payment status.

When a PAM Award or MOR is received with the Review Message "ALERT - EARMARK MBR WITH CORRECT RR CLAIM NUMBER/PREFIX" the examiner must check the DPA DATA section of the transmittal for the employee's total service months. If 120 or more months are shown, enter code "1" in this item.

Items 5,15,25: Enter the type of request code.

Only the following request codes can be used to earmark a record:

- Enter "05" to earmark an earnings record and MBR for the spouse based on her own account number.
- Enter "06" to earmark an earnings record and MBR for a widow based on her own account number.
- Enter "90" in conjunction with a code "1," "2," or "3" in Items 4, 14, or 24 to update the MBR. Complete only Items 1, 2, 3, 4(14)(24), 6(16)(26), 7(17)(27), 8(18)(28), and 9(19)(29).
- Enter "91" in conjunction with a code "4" in Items 4, 14, or 24 to remove an MBR earmarking (e.g., denials, wrong SSA number earmarked, etc.). Complete only Items 1, 2, 3, 4(14)(24), 6(16)(26), 7(17)(27), 8(18)(28), and 9(19)(29).

NOTE: None of these codes will produce a reply from SSA. Once the G-60 information is transmitted, assume that the proper action was taken by SSA.

Items 6,16,26: Enter the account number of the person whose earnings record is the basis for the earmarking.

Items 7,17,27: Enter the first ten letters of the beneficiary's surname and the first and second initials.

Items 8,18,28: Enter the beneficiary's date of birth. Enter preceding zeroes in the unused boxes.

Items 9,19,29: Enter the beneficiary's sex code; "1" for male; "2" for female.

Items 10,20,30: Enter the auxiliary's status at RRB: "0" if the auxiliary is an employee, "1" if the auxiliary is a spouse. If the auxiliary is a survivor, leave this box blank.

Items 11,21,31: Enter the type of amendment code as follows:

Spouse Requests - For an explanation of which Railroad Retirement Act or Amendment provisions apply, see RCM 8.6, G-357a instructions for Item 11.

NOTE: Only complete this item when the Type of Request code in Item 5, 15, or 25 is "05."

- Enter code "2" if the annuitant is a pre-1981 amendment spouse.
- Enter code "4" or "6" if the annuitant is a 1981 amendment spouse as shown on the form.

Survivor Requests

NOTE: Only complete this item when the Type of Request code in Item 5, 15, or 25 is "06."

- Enter code "2" if the annuitant is a pre-1981 amendment survivor.
- Enter "4" if the annuitant is a 1981 amendment survivor.

Items 12,22,32: Spouse Requests on Own Account Number (Request Code 05) - If code "2" was entered in Item 11, 21, or 31, enter the year in which the RRB employee should have acquired an insured status to be vested for a windfall benefit. If the employee does not have 120 months of service prior to 1975, enter "9999."

If code 4 or 6 was entered in Items 11, 21, or 31, leave Item(s) 12, 22, and 32 blank.

All Other Types of Requests - Leave Item(s) 12, 22, and 32 blank.

Items 13,23,33: Enter "F" when there is a discrepancy in the SSA number in the RRB records and the one in SSA's records, but we need the wage information on the SSA number in the RRB records. Otherwise, leave blank.

Signature And Disposition

Sign and date the form in the spaces provided. File the duplicate on the right side of the folder. Put the original in the tray provided to be delivered to BDP. Control the claim in accordance with the instructions from the unit supervisor.

9.2.1 Key/Master - "RASIFORM"

A. General

Key/Master is an on-line data entry system which can be used to enter data via CRT's into mainframe systems. The program used to enter data into the RASI system is "RASIFORM." Using Key/Master, data can be edited for basic content accuracy at the time of input, thus preventing some input rejects, then batched and held for processing into the next RASI run, which is usually the same day.

How to Access "RASIFORM"

- From the TRAIN screen:

Type "KEYPROD."

Press ENTER.
- The message "STATION (__) LOGGED ONTO KEYMASTER 5.1. PRESS THE ENTER KEY TO CONTINUE" will appear.

Press ENTER.
- The SYSTEM FUNCTION SELECTION screen will appear, giving two options:

"1" Log Off (stops the sign-on process)

"2" Key/Master (Continues the sign-on process)

Type "2" to continue.

Press ENTER.
- The WELCOME TO KEYMASTER screen will appear.

Type your Operator ID next to that item.

Press PF2.
- The OPERATOR COMMANDS screen will appear.

next to COMMAND, type "ENT."

next to APPLICATION NAME, type "RASIFORM."

Press ENTER.

- The BATCH INITIALIZATION screen will appear.

Press ENTER.

- The first screen, RE-ENTRY DATA, will appear. Use the appropriate PF keys, as shown at the bottom of each screen, to access other screens within the program.

B. RASIFORM Data Entry

1. Basic Instructions

Complete Key/Master instructions are available in RCM 15.10; however, some aspects which are specific to RASIFORM are covered in this chapter.

The program consists of ten input screens which can be used for all current RASI examiner input type codes. Instructions for each type code are provided in subsequent chapters.

To enter data, first select the desired screen by pressing the appropriate PF Key, as shown at the bottom of each screen. Type in the required data, entering it on the underscores provided, which indicate the size of the field. Always complete items by starting at the left. Use leading zeroes for numeric items when necessary. Any positions left blank will be passed to RASI as zeroes. The underscores for any unused positions in a field which contains entries must be removed with the space bar. For example, a code name in which the surname has less than four letters will not require all five positions. Space out the last underscore. However, if no entry will be made for an item, no special action is required.

2. Editing and Errors

Following completion of all required items, press ENTER. This activates the edit process. If the data passes the edits, a fresh version of the screen will appear. Enter the same type of data for another case or use a PF key to move to another screen or to close the batch. If the data does not pass the edits, an error message will appear in the upper left corner of the screen, and the incorrect item(s) will be highlighted in red. To correct the error(s), type in the proper data and press ENTER. If it is preferable, or if for some reason the data cannot be corrected immediately, press CLEAR. This will remove the data and provide a fresh screen. This technique can also be used to erase all entries on a screen before ENTER is pressed.

An alternate error signal is the appearance of an EASYLOGIC FACILITY ERROR PROCESSOR screen. This happens when a logic error is made, such as the omission of a type code when it is a required item. When this screen

appears, press CLEAR to return to the data entry screen. The erroneous item(s) will be highlighted in red. Correct as usual.

Some common errors are:

- alpha characters entered in numeric fields, and vice-versa;
- omission of required item(s);
- items partially completed, or underscores not spaced out when all positions in an item are not required;
- items which are incorrect based upon the contents of other items.

3. Closing a Batch

Enter as many type codes and as many screens for each type code as are necessary. Data types can be entered in any order. The data will be processed as a "batch." A batch can also consist of as little as one type code - one case.

To close a batch and log off, press PF-24.

- The BATCH DATA screen will appear.
next to COMMAND, type "OFF."
press ENTER.
The SIGNOFF ACCEPTED screen will appear.
Press ENTER.
- The SYSTEM FUNCTION SELECTION screen will appear.
Type "1."
Press ENTER.
- The TRAIN screen will appear.

NOTE: If it is necessary to correct or delete data in a closed batch, consult your supervisor.

NOTE: It is also possible to "save" a batch, rather than close it. This should be done only when data being entered must be reviewed by another individual prior to its release. It is necessary either to make a note of the batch number and security code of the saved batch, or to ask a supervisor to locate these items in

order to retrieve a saved batch. To save a batch, press PF-22. The batch number and security code will be shown on the BATCH END screen.

C. RASI Processing of KEY/MASTER Input

RASIFORM data is extracted daily as part of the RASI run process. Only closed batches can be extracted. If a batch has been saved, it will not be extracted for RASI processing until it has been closed. (See RCM 15.10.27 for further information.)

All data entered into RASIFORM (in closed batches) will be extracted the same day it is entered. The action will be reflected the following day on REQUEST, provided the affected fields are displayed on REQUEST. Once data has been extracted, it will no longer be available on Key/Master. A listing of all data input through RASIFORM will be produced as part of the RASI output. This listing will be delivered to PES daily.

D. Supervisory Functions

Supervisors and some RAPT personnel are authorized to access and perform certain functions of Key/Master-RASIFORM in addition to data entry. These include:

- the ability to re-open a closed batch;
- the ability to check the status of all current input batches;
- the ability to cancel a batch;
- the ability to obtain the batch identification data (batch number and security code) for any current batch, as well as the number of items per batch, the operator identification number, and the time and date of entry;
- the ability to reinstate a closed or cancelled batch.

Instructions for supervisory functions are available in a separate format provided to applicable personnel.

9.2.2 Re-Entry Data - Type Codes 150/954

9.2.2.1 Re-Entry Data Screen - Use

This screen is used to process data for six type codes:

- I. 150 - Supp Ann Attainments
- II. 954 - Supp Ann Data for Current Cases

- III. 933 - Miscellaneous Spouse Data
- IV. 947 - Current Connection Determination
- V. 948 - Transfer of Credits to SSA or Redcap Determination
- VI. 998 - Prior Service Data

If information for more than one type code is required for one case, complete a separate screen for each type code.

9.2.2.2 Re-Entry Data - Type Codes 150 and 954

A. General

1. TYPE CODE 150 - RASI POST-ADJUDICATION SUPPLEMENTAL ANNUITY AWARDS

Type code 150 is required for supplemental annuity (supp ann) attainment cases when pension rights information is not available in the Research record or when relinquishment of rights (R of R) is necessary. Form G-88p is required to obtain the employer pension data. (See RCM 8.7.)

There is no mechanical tracing system for post-adjudication cases. Therefore, manual controls must be maintained. Also, post- adjudication cases are not considered to be mechanically "active," and thus do not require dumping if they are paid manually.

Monthly Attainment Program (MAP)

Cases are activated for supp ann payment by RASI through MAP, the Monthly Attainment Program. MAP searches the Research record for new attainments two months prior to the supp ABD. Supp attainments are paid on RASI once a month. The monthly run includes cases with dates of birth (DOB's) from the second day of the month through the first day of the following month; e.g., January attainments include DOB's occurring January 2 through February 1. If pension or R of R information is outstanding the first month the supp ann is payable, payment will not be attempted again until the next monthly run.

RASI Awards

There are two other situations in which the post-adjudication program is used to pay supp anns:

- a. If RASI pays the regular annuity, but cannot pay the supp ann because pension information is outstanding, a 150 call-up will remain on REQUEST and on the G-425 for 90 days after the regular annuity

award. During this period, RASI can accept the data entered as either a 150 or a 954 type code.

- b. A 954 referral is produced when an employee is not eligible for a supp ann at the time of the regular annuity award, but will be eligible within three months. Enter the data using type code 954; RASI will hold it until the supp ann is payable. (See 954 data entry instructions.)

NOTE: If an employee is due a supp ann, and a supp call-up is pending but no referral has been issued, or none can be located, use type code 150 to enter the data into RASI. However, even if no supp call-up is pending, meaning the post-adjudication program has not yet been activated, RASI will pay the supp ann if data is entered.

If a supp ann call-up is pending after supp data has been entered, no reject notice has been received, and the supp ann ABD has elapsed, refer the case to BRB-RAPT. There may be a problem with the supp attainment monthly run. An overpayment could result if a manual payment is made after RASI data has been entered. Duplicate accrual checks could be sent to the annuitant if the mechanical payment is made first. If the manual payment is made first, the mechanical payment will reject.

Cases Which Cannot Be Paid on RASI

Following is a listing of the types of supp ann cases which cannot or should not be paid through the post-adjudication program (under either type code 150 or 954):

- The regular annuity is in suspense or terminated.
- The regular annuity was not payable for all months in the supp ann accrual period.
- There is a change in the pension rate which affects the supp ann rate.
- More than one pension is being paid.
- The pension effective date is a future date.
- The case involves a lump-sum pension payment (unless the employer allocates it monthly, as explained in RCM 8.7, Form G-88p instructions.)

Folder Record and Award Notice

A G-354e is produced for 1937 and 1974 Act cases, and a G-354R is produced for all others. An RL-20e is released to the employee.

2. TYPE CODE 954 - REQUEST FOR SUPP ANN DATA FOR CURRENT CASES

Type code 954 is required when the AA-1 indicates that the employee is entitled to a pension from the railroad employer. To pay the supp ann correctly, RASI needs the pension information from the G-88p. If the G-88p is not received before RASI is ready to pay the regular annuity final, the Supp will not be paid. There will be an award message in the remarks section of the regular annuity award instructing the examiner to control for receipt of the G-88p, and to enter the data if it is received within 90 days. After that, RASI will accept type code 954 for only 90 days after it has paid the regular annuity. After that, use type code 150 or pay it manually. When the G-88p is received, enter the data as instructed in "B."

NOTE: RRB field personnel have been instructed to answer AA-1 item 108 (regarding pension entitlement) "YES" when a disability annuitant age 60 - 64 is eligible for a supp ann, has no employer pension, but refuses to relinquish rights pending a settlement. Do not release a G-88p in this situation. Close the supp without award. Also complete a G-138.

B. Data Entry Instructions

Item	Entry
1.	EE SSN - Usual
2.	TYPE CODE - Enter "150" or "954."
3.	TOT SVC MOS (150 ONLY) - Complete <u>only</u> when M/S for supp ann differs from regular annuity. Enter total RR and M/S months.
4.	OTHER BENEFIT - Refer to the entries in item 13 of G-88p.
	"1" - Entitled to pension not based upon collective bargaining. (13a is "YES;" 13f is "NO.")
	"2" - Entitled to pension based upon collective bargaining. (13a and f are "YES.")
	"3" - Entitled to but not receiving pension based on collective bargaining, and not entitled to any other pension. (13a and 13f are "YES," and no pension rates are shown in 13b.) (954 ONLY) Go to item 9.

	"8" - Not entitled to pension, (13a is "NO") or, if entitled, (13a is "YES" and 13f is "NO") pension is either based entirely upon non-creditable service, or has a future effective date. (For pensions based entirely on non-creditable service, employers will show this information in "Remarks" section of G-88p.)
	When code 8 is entered, skip items 5-9. Go to item 21.
	"9" - Dump for manual handling. (954 ONLY) Go to item 21.
5.	<p>PENSION AMOUNT (See NOTE at end of this item.) - This field can accept amounts up to \$999.99. Enter dollars and cents using leading zeroes if necessary. If amount exceeds \$999.99, use "99999". Refer to RCM 8.7, Form G-88p Instructions, for an explanation of the computation of the "Employer Pension" amount. Use that amount in this item.</p> <p>If the employer pension is contributory, items 15 - 16 of Form G-88p will be completed. Otherwise, the employer pension is non-contributory.</p> <p>NOTE: If exact pension amount is unavailable, but clearly exceeds \$43.00, or if the railroad employer has entered a plug figure in item 13b of the G-88p, enter "07777" for a non- contributory pension, or "17777" for a contributory pension. <u>Also</u>, enter "07777" or "17777" if two pension amounts apply for same month and both exceed \$43.00; <u>or</u>, if pension amount is \$1,000.00 or more, enter "99999".</p> <p>However, if employee contributions are involved or if the employee is receiving pensions from more than one employer, item 13b must have the exact amount of the employer pension. It may be necessary to return the G-88p to the railroad for the exact pension rate.</p>
6.	<p>PENSION EFFECTIVE DATE - Enter beginning date of pension. (G-88p item 13c).</p> <p>NOTE: If the pension effective date is in the future, item 4 should be "8". Do not complete this item. (Control case for adjustment of supp ann when pension becomes effective.) Go to item 21.</p>

7.	<p>PENSION AMOUNT REDUCED FOR SUPP (See NOTE at end of this item.) - This field can accept amounts up to \$999.99. Enter dollars and cents, using leading zeroes if necessary. If amount exceeds \$999.99, enter "99999".</p> <p>Refer to RCM 8.7, Form G-88p Instructions, for an explanation of the computations for this item. Use the "Employer Pension Amount" minus the "Reduction in Employer Pension for Supp" as the entry for this item.</p> <p>NOTE: If supp ann is a wipe-out, enter "07777" for non-contributory pension, or "17777" for contributory pension.</p> <p>If a plug figure was used in item 5, a plug figure must be used in this item:</p> <ul style="list-style-type: none"> • If item 14(b) of the G-88p is "NO," use the same plug figure as used in item 5. • If item 14(b) of the G-88p is "YES," reduce the plug figure by the amount in item 14(c) of the G-88p. <p>For example, if the pension is reduced for a supp of \$43.00, and "17777" was entered as the full pension in item 5, enter "13477" in this item. ($177.77 - 43.00 = 134.77$.) If "99999" was used in item 5, and pension is reduced for a supp of \$43.00, enter "95699" in this item.</p>
8.	<p>EE CONTRIBUTION AMOUNT - This item can accept amounts up to \$999.99. Enter dollars and cents using leading zeroes, if necessary.</p> <p>If items 15 - 16 on G-88p are completed, the employer pension includes employee contributions. Refer to RCM 8.7, Form G-88p Instructions, for an explanation of the computations of the "Employee Contributions." Use this amount in this item.</p>
9.	BA NUMBER - Enter whenever items 5-8 are completed, or when item 4 has been coded "3".
21.	EXAM NUMBER - Usual.

9.2.3 Re-Entry Data - Type Code 933 - Request For Spouse Data

A. General

Type code 933 referral is produced when one or more of the following determinations is necessary:

DOM - Date of Marriage

ELG - Spouse Eligibility (AA-3)

DIS - Disabled Child

PM - Previous Marriage

MEDICARE - Spouse Eligibility (AA-7)

Enter a code only in the item(s) indicated in the RASI referral. For Medicare, enter the code in the item labeled "ELG."

NOTE: If information relating to a grandchild is needed, make the necessary entries as if for the employee's child. Following receipt of the award, notify Research that the "child" code should be changed to "grandchild".

B. Data Entry Instructions

Item	Entry
EE SSN	Usual entry.
TYPE	Enter 933
DOM	<p>The Form AA-3 or AA-7 indicates that the claimant has not been married to the employee for at least one year. Use online records and application information to determine if the one-year requirement is waived or was already met for an earlier <u>allowable</u> entitlement. Details of exceptions to the one-year rule are described in RCM 1.3.2B.</p> <p>Enter code 3 - if the one-year requirement is waived or does not apply for the current marriage date.</p> <p>Enter code 4 - if the one-year requirement applies, but is not met, for the current marriage date. (RASI will dump the application for denial.)</p>
ELG	<u>For Retirement Applications</u>
	<p>The AA-3 indicates that the spouse is filing based upon having the employee's child, either minor and/or disabled, in care. Make the ELG determination based upon the spouse's "In Care" statement.</p> <p>Enter code 1 - if the personal service the spouse provides for the</p>

	<p>child qualifies the spouse for an annuity.</p> <p>Enter code 2 - if, within the meaning of the RR Act, the spouse does not have the employee's child in her care.</p> <p>Enter code 3 - if the spouse is eligible based on retirement age and the child status is not pertinent to spouse award.</p>
ELG	<u>For Medicare Applications</u>
	<p>Required for all AA-7 cases. Review evidence in file, in accordance with RCM Chapters 4.3, 4.6, and 3.2, to determine whether the applicant is the employee's spouse and whether the employee's status qualifies the spouse as a QRRB. The employee must be at least age 62 (or age 60 with 30 years of service), or be entitled to a DF before the spouse is qualified as a QRRB.</p> <p>Enter code 1 - if the applicant qualifies as a spouse QRRB as defined in RCM 3.2.9; RASI will establish the earliest entitlement date possible.</p> <p>Enter code 2 - if the applicant does not qualify as a spouse QRRB. (RASI will dump the case.)</p>
DIS	<p>The AA-3 indicates that the spouse is filing based upon having the employee's disabled child in care. Both "ELG" and "DIS" will be shown on the RASI referral. Retirement examiners complete this item after Form G-325 input has been processed for the claimed disabled child.</p> <p>Enter code 1 - if a child is rated disabled. If the child is between 16 and 18 years old, RASI will pay the spouse Tier 1 and Tier 2 based upon current procedure for a disabled child age 18 or older.</p> <p>Enter code 2 - if a child is not disabled. If the child is between 16 and 18 years old, RASI will pay the spouse Tier 2 only, based upon having a child over age 16, but under age 18.</p> <p>Enter code 3 - if the spouse is eligible based on retirement age and a disabled child in care is not pertinent to the spouse award.</p>
PM	<p>The AA-3 or AA-7 application indicates that either the employee or spouse has had a previous marriage. Based upon the information in file such as spouse's statements, AA-1 and Form G-346, Employee's Certification, determine whether any previous marriage still exists. If Form G-346 does not agree with the spouse's application, do not ask the field to reconcile; the current</p>

	<p>spouse may not know the employee's marriage history. Based on your determination, enter one of the following codes:</p> <p>Enter code 1 if the applicant is the employee's current spouse. (Any employee's or spouse's previous marriage is no longer valid.)</p> <p>Enter code 2 if the applicant is currently not the employee's spouse.</p>
EXAM NO.	Usual entry.

9.2.4 Re-Entry Data - Type Code 947 – Request for Current Connection Determination

A. General

Type code 947 is required whenever a current connection cannot be determined mechanically. RASI assumes there is no current connection if:

- The year in which the employee last worked in the railroad industry is more than three years before the year in which the annuity will begin; and
- The year in which the employee claimed on the application to have last worked outside the railroad industry is more than two years after the year last worked in the railroad industry.

In other words, RASI will generate a 947 referral if it appears that the employee broke the current connection after the 30 month period and before the ABD.

RASI also produces a 947 referral when the employee indicates elected public office in item 66 of the AA-1. In most cases, elected public office is not LPE but is regular employment that can break a C/C.

B. Data Entry Instructions

Item	Entry
1. EE SSN	Usual.
2. TYPE CODE	Enter "947"
4. C/C	Make C/C determination according to FOM1 225 Enter one of the following codes:
	"1" - C/C established for both regular and sup

	annuities
	"2" - C/C not established.
	"3" - C/C not established for retirement purposes, but RRB jurisdiction established for survivor benefits due to no SSA wages.
21. EXAM NUMBER	Usual.

9.2.5 Re-Entry Data - Type Code 948 - Request For Possible Transfer Of Credits To SSA Or Request For Redcap Determination

A. General

1. "TR" - A "Transfer" Code is produced whenever "RCU" appears in item 8D of the G-90, indicating the possibility of RRB credits being used at SSA. To make a determination, see the RR and SS earnings shown on the G-90. If it appears that RR credits were used in the computation of SSA's benefit (the RR earnings are higher than SSA's), release a teletype to SSA requesting the return of the credits. In its reply, SSA will indicate whether RRB should recover any overpayment. If the case should be transferred, see RCM 7.2.
2. "RC" - A "Redcap" Code is produced when Board records indicate the possibility of redcap service. Special development is required if redcap service was performed during the period January, 1937, through August, 1941, as those earnings were not reported during that period. See RCM 5.3.100 for more information.

B. Data Entry Instructions

Item	Entry	
1.	EE SSN	Usual.
2.	TYPE CODE	Enter "948."
15.	TR	<p>"1" - RRA Credits were used by SSA and an overpayment of benefits is involved. This will cause the case to be dumped for manual handling.</p> <p>NOTE: If RR credits are not required for SSA eligibility, the RR annuity can be paid using the existing SSA benefit rates for the Tier I offset.</p>

		<p>When SSA recertifies the benefit rate downward to remove the RR credits, the RR annuity can be adjusted to decrease the SSA offset in Tier I. This procedure can be used if SSA's response to our teletype request is delayed.</p> <p>"2" - RR credits were not used by SSA, or credits were used but no SSA overpayment is involved. RASI will continue to process the claim.</p>
16.	RC	<p>"1" - One or more months of redcap service was performed in the period January 1937 through August 1941. RASI will dump the case for manual handling.</p> <p>NOTE: To expedite initial payment, enter code "2" if the employee has sufficient service months without the redcap service. After the final award, determine whether the redcap service will increase the annuity, and adjust the case manually.</p> <p>"2" - The employee was not a redcap, or, if so, did not perform redcap service in the period described above.</p>
21.	EXAM NUMBER	Usual.

9.2.6 Re-Entry Data - Type Code 998 - Request For Prior Railroad Service Data

A. General

1. Retirement Applications

A type code 998 is required when railroad service before 1937 is claimed on the AA-1 and the annuitant has less than 360 months of subsequent service. Thus, a determination regarding the employee's claimed prior service is required. Establish the total number of creditable prior service months and the prior service average, based upon documentation in the folder. If the prior service has not been documented, refer the case to the Retirement Analysis and Systems section.

2. Medicare Applications

a. 120 MOS

A type code 998 is required when the employee has less than 120 months of subsequent service according to RRB records. All creditable service, whether prior, military or lag, should be combined and entered in item 20. See RCM 3.2.58 for information about developing service. Complete items 1-2, 19 and 21.

NOTE: 30 years of service must be verified when the employee is 60-61 but is not under a DF.

b. POA

A type code 998 is required when the Medicare applicant's proof of age is less than weight 30. Complete items 1-2, 20 and 21.

B. Data Entry Instructions

Note: unless specified instructions apply to both retirement and medicare applications.

Item	Entry	
	1. EE SSN	Usual.
2.	TYPE CODE	Enter "998."
17.	P/S AVG	<p>a. <u>RETIREMENT APPLICATIONS</u></p> <p>Required when item 19 is coded "0". Enter prior service average determined according to instructions in RCM 5.3. This item can accommodate figures up to \$999.99. Enter dollars and cents using leading zeroes, if necessary.</p> <p>b. <u>MEDICARE APPLICATIONS</u></p> <p>No entry required.</p>
18.	METHOD	<p>"0" - P/S claimed and verified, and EE has less than 360 months of subsequent service.</p> <p>"8" - P/S not creditable because there is no employment relation.</p> <p>"9" - No P/S verified, or EE has 360 subsequent service months.</p>

19.	P/S MONTHS (120 MOS)	Enter total P/S months verified. Use leading zeroes, if necessary. NOTE: For Medicare applications only, enter total of <u>all</u> types of service which can be established.
20.	VER (POA)	If the evidence in file establishes the claimed DOB, enter "1".
21.	EXAM NUMBER	Usual.

9.2.7 Tier One Offsets - Type codes 950-1 SS Data

A. General

Information from the TRIC reply is fed directly into RASI. However, examiner input of SS data is required when any of the following conditions exists:

- TRIC reply did not match our request on all points of identification, i.e., name, sex, DOB, number;
- More than one reply received with MBR benefit data for the same person under different A/N's, e.g., a spouse receiving benefits as a spouse and also as a wage earner;
- A partial rate is indicated in item 8-Q of G-90;
- Post-entitlement action is indicated on G-90;
- The applicant indicates on the annuity application that (s)he is receiving SS benefits, but no MBR appears on G-90;
- SS benefit is being paid by RRB but TRIC reply indicates no MBR;
- PAM has received a SSADTS transmission for this RR claim number. (PAM activity will trigger a call-up even though TRIC indicates no MBR, SS benefits are not being paid by the Board, and the annuitant did not claim receipt of an SS benefit on the application.)
- The TRIC response was received before SSA began including the December COL-increased rate in the MBR data. RASI sets a 950/951 call-up to allow examiners to update the current rate for the COL. Instructions for this are distributed in an Informational Bulletin at the time of the Mass Adjustment.

If an applicant claims to have filed at SSA, RASI will provide a clearance with checkwriting operations before payment to identify those cases in which the Board is

paying social benefits not reflected in the MBR at the time of TRIC clearance. If the Board is paying social security benefits, RASI will produce a 950/951 referral requesting social security payment data. If there is no indication of SS payments by the Board, RASI will pay the case without reduction.

Acceptable sources of SS benefit information are the G-90, POLO, the MBR, an RR-1a or SOLAR award. If MBR data is shown on the G-90 in a laf code E case but SS payments are not in force, code in the MBR information, check POLO for SS payment activity, and control for a SOLAR award if necessary.

B. Data Entry Instructions

Item	Entry
1	Usual
2	Enter "0" for an Employee.
	Enter "1" for a Spouse.
3	Enter code name for payee code shown in item #2. (First initial and first four letters of surname.)
4	"1" - Applicant is receiving SS benefits.
	"8" - Applicant is not entitled to SS benefits.
	"9" - Dump for manual handling.
5-6	Completion of these items depends upon what code has been entered in item 4. Therefore, complete as follows:
	<ul style="list-style-type: none"> Item 4 coded "1" - Complete in all cases. Use the SS claim number and appropriate BIC code as explained in RCM 7.4, Appendix B, part 1.
	<ul style="list-style-type: none"> Item 4 coded "8" -
	<ul style="list-style-type: none"> Female Employee cases - If employee is <u>not receiving</u> any SS benefits, show current or former spouse's SS number in item 6. No BIC code is required in this instance; the SS number is for information purposes only. If the spouse's number has not been verified, do not enter it. Verify 700 numbers with the Claims Certification Section.
	<ul style="list-style-type: none"> Male employee cases - Leave blank.

	•	Spouse cases - Leave blank.
	•	<u>Item 4 coded "9"</u> - Leave blank.
7	Usual	
8-13	<p>If item 4 is coded 1, list the SS benefit rates and effective dates in order beginning with the earliest effective date and rate and ending with the most recent date and rate. The rate for the most recent effective date must be based upon the applicable PIA as updated for the latest cost-of-living increase. RASI will reject the data if it does not show the latest benefit rate, and will produce an 805 referral message which reads:</p> <p>CURRENT SSA RATE PRIOR TO (effective date of latest COL increase)</p> <p>The latest effective date shown will also be printed on the 805 referral. Upon receipt of the referral, resubmit the data with the latest COL rate to clear the 950/951 call-up. If the latest COL rate is not shown in file, manually update the SS benefit to the COL rate or have the COL rate verified by SSA's on-site representative.</p> <p>Enter the full dollar amount of the SS benefit. Use leading zeroes if necessary, and ending zeroes. For example, \$840.00 should be shown as <u>0 8 4 0 0 0</u>; \$1,012.00 should be shown as <u>1 0 1 2 0 0</u>. Do not enter SS benefit rates reflecting work deductions, always enter the full SS benefit amount before work deductions.</p>	

9.2.8 Tier One Offsets - Type Code 953 - Dual Spouse Data

A. General

RASI sets a 953 call-up when the spouse indicates on the AA-3 that (s)he has previously filed an application with the Board and the claim number of that application is not the employee's claim number. The rates and dates to be entered are the spouse's own employee annuity amounts which RASI needs to reduce the spouse's Tier I.

B. Data Entry Instructions

Item	Entry
1	Usual.
2	Enter "3."

3	Enter the spouse's code name. (First initial and first four letters of surname.) <i>NOTE: If the situation arises that neither the employee nor spouse has railroad service prior to 1975 the case MUST be dumped from RASI and paid manually using PC awards. RASI cannot handle these types of cases.</i>
4	"1" - This is a dual spouse case and should be paid on RASI as such.
	"8" - This is <u>not</u> a dual spouse case and RASI should continue normal processing.
	"9" - Dump case. **See the above note.
	When coded "8" or "9", only item 7 need also be completed.
5-6	Leave blank.
7	Usual
8-13	Enter the spouse's own employee Net Tier I effective dates and amounts in chronological order, beginning with the earliest and ending with the most recent. The earliest date may not precede the spouse's Tier I effective date. Enter the full amount of the net Tier 1. Use leading zeroes and ending zeroes if necessary. For example, \$650.29 should be entered as <u>0 6 5 0 2 9</u> ; \$1,650.20 should be shown as <u>1 6 5 0 2 0</u> ; \$650.00 should be shown as <u>0 6 5 0 0 0</u> .

NOTE - In spouse-only cases in which the spouse's employee annuity has been paid with different datebreaks from those which apply in the spouse annuity, RASI may apply the wrong reduction amounts. Dump and pay manually.

9.2.9 Tier One Offsets - Type Code 957 - Spouse Public Service Pension Data

A. General

RASI sets a 957 call-up when the G-230 has a "G-208" entry or the spouse indicates on the AA-3 that (s)he is entitled to a public service pension. See items 104 and 105 on the AA-3 and the G-208 in file and consult the chart in RCM 1.3.192 to determine the effect of the pension upon the spouse's annuity. Complete the form as follows:

B. Data Entry Instructions

Item	Entry
1	Usual
2	Enter "7"
3	Enter the spouse's code name. (First initial and first four letters of surname.)
4	"1" - PSP applies, RASI will offset SS formula spouse benefit.
	"8" - No PSP reduction required.
	"9" - Dump case.
	When coded "8" or "9," only item 7 need also be completed.
5-6	Leave blank.
7	Usual
8-13	Show up to six sets of dates and rates in chronological order beginning with the earliest and ending with the most recent. The earliest date may not precede the spouse's Tier I effective date. Enter the full amount of the PSP reduction. Use leading zeroes and ending zeroes if necessary. See examples in items 8-13 of the 953 instructions.

The rate entered must be the amount of the PSP reduction being applied, which is not always the same as the PSP amount received. Refer to RCM 1.3.193 and 1.3.194 to determine the correct offset amount and reduction effective date.

The PSP reduction will be the first reduction made in the spouse's gross tier I amount. The amount of the reduction will be shown on the award form.

NOTE: A PSP reduction amount can be entered with an initial PSP date of entitlement in the future. The 957 action will not reject from RASI. If the PSP-DOE is still in the future as of the RASI paid final date, the award review message "PSP EFFECTIVE DATE IS _____, APPLY REDUCTION" will be produced to alert examiner to control case for adjustment or set tickler call-up to insure the timely adjustment of the spouse tier I. (See 9.3.14 EE/SP Award Messages).

NOTE: If the PSP-DOE is later than the spouse ABD and the RRA maximum applies, the award review message "CHECK RRA MAX APPLICATION: PSP INVOLVED AFTER ABD" is produced. (See RCM 9.3.14) The RRA maximum should be redetermined effective with the PSP-DOE. (See RCM 8.6 G-354.4 instructions).

NOTE: If an annuitant is receiving multiple public service pensions it is necessary to take them all into consideration. All public service pension amounts must be added together and the total included in the offset amount. The amounts being paid on the effective dates must be combined.

9.2.10 Lag Service - Form G-88a.1 Listings And Form G-88a.2

A. General

Lag is the time between the last month for which service and compensation has been reported to the RRB and, if it is later, the employee's date last worked. The period from January of the current year through the date last worked is always a lag period; however, the preceding year may also be included in the lag period. This is because the annual service and compensation report for the preceding year is not posted to the Employment Data Maintenance (EDM) until around May 1 of the current year. Therefore, the lag period for applications filed before May can extend from January of the preceding year to the last date worked in the current year.

Determine the lag years required by checking the "CERTHRUDTE" shown on REQUEST screen 13 (CERT THRU DATE). The CERTHRUDTE reflects what is posted on the EDM as of the date on which RASI processes the SEARCH reply for a case. Anything later than that date is considered lag. See the examples below.

1.	DLW-RR	2-15-2001
	CERTHRUDTE	12-1999
	LAG DATA REQUIRED FOR 2000 AND 2001	
2.	DLW-RR	2-15-2001
	CERTHRUDTE	12-2000
	LAG DATA REQUIRED FOR 2001	

NOTE: In May of every year RASI mechanically recycles cases pending lag data through SEARCH to secure the preceding year's service data. If the employee last worked in the preceding year, RASI clears the lag call-up without examiner input and updates the CERTHRUDTE. If the employee last worked in the current year, only the current year lag data need be input to RASI.

If, following the SEARCH recycle, a case is still pending lag data for a year which is now on the EDM, send an E-Mail message to P&S-RAC to have the lag call-up removed.

If an employee's claimed DLW is in a lag year, but the employer changes it to fall in a non-lag year, send an E-Mail message to P&S-RAC to have the lag call-up removed.

Some special payments can affect the DLW-RR in the lag year. For additional information about crediting special payments, see RCM 5.3, under the specific type of payment. For more information about the effects of special payments on the ABD, see RCM 1.7, under the specific type of payment. This special payments are no longer reported on Form G-88a. They should be reported directly to the Employer Service and Training Center of Assessment and Training.

No verification of the DLW-RR is needed if the employee's claimed DLW-RR is more than two years prior to the filing date. In this situation the railroad will be notified through a monthly Form RL-5A listing, if the employer has requested it, or with a copy of the denial letter if the application is denied.

B. Form G-88A.1, Request for Verification of Last Date Carried on Payroll

1. Purpose of Listing

Effective from January 1, 2001, Form G-88A.1 listings are monthly computer generated listings maintained by Policy and Systems - RRA Application and Calculation (P&S-RAC) and forwarded to last railroad employers on record each month. The monthly Form G-88A.1 listings will include cases in which the employees have lag railroad service, but the lag is not required for eligibility. These are employees who have stopped railroad employment within two years of the filing date of the annuity application and have a last date carried on the payroll in the current month or an earlier month. The listings inform the employees' last railroad employer that the employee has retired and request a review of the last date carried on the payroll.

If the employee lists more than one railroad employer or labor union employer within two years of the filing date, he will be on the G-88A.1 listing for each employer. For example, if the employee indicates that he last worked for BA 1621 and BA 8922, he will be listed twice - once on the BA 1621 listing and once on the BA 8922 listing.

a. Items from Annuity Application

The listings indicate each employee's social security number and the following items as they were entered on the employee's annuity application: payroll name, job title, dept-division, job location, the date last worked for the railroad, the ending date of any injury settlement, and, in age and service cases, the date the employee relinquished rights to railroad employment.

3. Release to Railroad

When an application is filed in advance of the annuity beginning date (up to 90 days) and a claimed date last worked after the filing date is involved, P&S-RIS will not list that employee on the Form G-88A.1 until the first work day of the month in which the employee will cease railroad employment.

P&S-RIS mails the listings to the employers monthly. The addresses are based on the addresses for the Compensation Contact Official (Category C, Subcategory 100) in the Employment Data Maintenance (EDM) Contact Official's Data Base.

4. Railroad Completion Items

The railroad contact official is requested to check the dates on this listing against the payroll records. If the later of the date last worked or the ending date of an injury settlement listed for each employee agrees with the railroad's record of the employee's date last carried on the payroll, no action is required.

If the dates shown on the listing do not agree with the railroad's records, the contact official is requested to line out the incorrect information, enter the correct information above it, and sign the form at the bottom of the page. He or she will then fax the corrected page to the Retirement Initial Section (RIS) to correct the annuity. The fax number for (RIS) is included at the bottom of each page of the listing.

5. Processing Returned G-88A.1 Listings

Form G-88A.1 listings returned by the railroad to report changes in the date last worked or date rights relinquished require examiner handling. Since the railroads have been instructed to return this G-88A.1 only if the dates provided are not correct, RASI, or an examiner processing an application manually, will not hold up the final payment pending the receipt of the G-88A.1.

If the employee listed more than one railroad as his employer within two years of the application filing date, he is included on the listings to each of those employers. The listings do not identify the second-to-last employer. Therefore, if the date last worked printed on the listing does not match the date last worked on RASI, determine if the G-88A.1 was returned by the second-to-last railroad employer.

If a corrected date is received, take the following action:

- a. Case on RASI, not paid final - Usually a change in the DLW-RR or DRR of the second-to-last railroad employer does not have to be submitted to RASI since it will not impact the ABD. DLW-RR changes and DRR changes not impacting the ABD can be held, and the date(s) corrected on PREH after the final payment has been made.

Otherwise, a change in the DLW-RR or the DRR can be submitted to RASI at any time prior to the final RUIA clearance/calculation processing. For a date last worked change, the examiner should submit a 996 correcting EEDLWRR. For a date rights relinquished change, the examiner should correct EEDRRLST.

Changes submitted while the final RUIA clearance or calculation processing is pending will not be considered in the calculation processing. If TRIC is pending at the time a DLW-RR change is submitted and the ABD year is changed by the corrected DLW-RR, TRIC will recycle for the corrected ABD. If the DLW-RR change will impact the ABD, attempt to drop the case and process the application on ROC considering the correct DLW-RR.

- b. Case paid final, DLW-RR change - Review the ABD to determine if it is impacted by this change. If so, the case should be recertified to correct the DLW-RR and ABD. Request a new G-90 if the ABD year has changed. If the ABD is not impacted by the change in the DLW-RR, correct the DLW-RR on PREH.
- c. Case paid final, DRR change - Correct the DRR on PREH. Since the G-88A.1 listings only include employees who did not need their lag for eligibility, deemed railroad service months required for eligibility should not be an issue. The DRR change does not impact final payment.

However, if deemed railroad service months were included in the initial award due to special handling, request the Employer Service and Training Center to recompute the number of deemed railroad service months considering the corrected DRR. Refer the case to your supervisor if it appears the employee is overpaid or no longer eligible. Otherwise, correct the DRR on PREH.

6. Disposition of Listings

Only One Claim Number - If only one claim number on the same page of the listing has a correction, mark the claim number on the top and have that page of the listing imaged.

Multiple Claim Numbers - If more than one claim number on the same page of the listing has a correction, highlight the claim numbers and on the imaging request slip indicate that multiple accounts are affected.

C. Form G-88A.2

Notice of Retirement and Request for Verification of Service Needed for Eligibility - This form is available on RRAILS.

1. Purpose of Form

RRAILS Form G-88A.2 is sent by the RRB field office to the employee's last railroad employer(s) when lag service is needed to qualify for an annuity:

- a. 120 months for regular age and service or total and permanent disability; or,
- b. 240 months for occupational disability; or,
- c. 360 months for employee and spouse 60/30 eligibility; or,
- d. 360 months for the spouse of a disabled employee to qualify under the 60/30 provisions. The employee may have enough service to qualify for an disability annuity, but the lag service may need to be developed to qualify the spouse under the 60/30 provisions.

Lag service should be developed, even if there is sufficient claimed military service that could establish eligibility for an annuity. The military service might be used as wages to vest the employee for a vested dual benefit.

NOTE: The RRB field office will not release a Form G-88A.2 for service information to establish 25 years for a supplemental annuity. The regular annuity application will process to final payment. Prior to 2006 if lag service could establish eligibility for a supplemental annuity, a referral was created when lag was added in the mechanical RAIL mass adjustment. Beginning in 2006, if lag service makes the employee eligible for a supplemental annuity, RESCUE will process the initial supplemental annuity award if the employee is old enough at the time of the RESCUE run. If PREH does not contain information about the whether the employee is entitled to a RR pension, RESCUE will issue a referral to STAR (RUE 40). Otherwise RESCUE will update the service months in PREH, and MAP will issue a referral when the employee attains the required age to receive a supplemental annuity.

2. RRB Completion Items For Form G-88A.2 - The RRB is to complete the following items before releasing the Form G-88A.2 to the railroad:

Item 1, Social Security Number

Enter the employee's social security number.

Item 2, Name

Enter the employee's name.

Item 3, Date Released

Enter the date the Form G-88A.2 is released to the railroad. The Form G-88A.2 should not be released before the month in which the employee will cease railroad employment. RRB field offices should also enter the date the Form G-88A.2 was released (or will be released) on the Form G-230 that is transmitted with the annuity application.

Item 4, BA Number

Be sure to enter the BA number of the employee's last or, if applicable, next to last railroad employer.

Item 5, Railroad Name and Address

Enter the name and the address of the railroad retirement Compensation Contact Official (Category C, Subcategory 100) in the Employer Data Maintenance (EDM) Contact Official database who corresponds to the BA number entered in item 4. However, if the railroad has merged with another railroad, enter the name and address of the railroad contact official for the successor railroad.

The preferred method of sending the Form G-88A.2 to the railroad is by fax. If the field office sent the form by fax to the railroad, they should include the fax number in this item.

Item 6, Payroll Number

Enter the payroll number that the employee entered on his annuity application. For an employee of the Canadian National Railway, enter the SRB (staff record bureau) or PIN (personal identification number) number.

Item 7, Job Title

Enter the job title that the employee entered on his annuity application.

Item 8, Work Location

Enter the work location that the employee entered on his annuity application.

Item 9, Department or Division

Enter the department or division that the employee entered on his annuity application. Exception - If the employee was a labor organization official and Form G-88A.2 is being released to the labor organization, enter the Local Lodge affiliation.

Item 10, RRB Filing Date

Enter the filing date of the employee's annuity application.

Item 11, Date Last Worked

Enter the later of the employee's claimed date last worked for the railroad or the employee's claimed date last carried on the payroll due to pay for time lost, injury settlement, etc. When releasing a Form G-88A.2 for a Canadian citizen or permanent resident who performed service for a U.S. employer, enter the last day the employee performed creditable service in the U.S.

Item 12, Date Rights Relinquished

The entries for this item depend on the type of annuity application.

- a. For disability applications, enter "Disability" in Item 12, unless the applicant actually relinquished rights before filing the application.
- b. In age and service cases, enter the date the employee claimed as the date relinquished rights, or date will relinquish rights, to railroad employment. However, leave Item 12 blank, with a note in Remarks, if a discharged employee is in the process of asserting a claim before the National Railroad Adjustment Board for reinstatement with pay for time lost.

3. Release to Railroad

When an application is filed in advance of the annuity beginning date (up to 90 days) and a claimed date last worked after the filing date is involved, a Form G-88A.2 will be completed and placed in a pending file in the field office. The forms will not be released by the RRB field office until the month in which the employee ceases railroad employment.

The preferred method of release to the railroad is by faxing the forms to the fax number in item 5 of Form G-88A.2. For these cases, the retirement annuity cannot be paid until the railroad contact official returns these forms to the RRB.

4. Railroad Completion Items

The railroad contact official will complete item 13 of Form G-88A.2 only if a correction is needed for the date in item 11. The railroad contact official is always to complete item 14 of Form G-88A.2, indicating the employee's actual railroad service months in the lag period, and is always to complete item 16, with the Certification data.

The railroad returns the Form G-88A.2 to the RRB by faxing (or mailing) the form to the Retirement Benefits Division - RIS at (312)751-7192. This return address is preprinted on the form.

5. Processing Returned G-88A.2 Forms

RASI will set a 958 call-up pending receipt of the G-88A.2

RIS personnel should submit a 958 to enter the actual railroad service months verified on Form G-88A.2 into RASI as soon as possible. If the railroad changes either the date last worked - railroad (DLW-RR) or date relinquished rights (DRR) on a Form G-88A.2, enter the correct date(s) into REQUEST and RASI.. For a DLW-RR, the examiner should submit a 996 correcting EEDLWRR. For a DRR change, the examiner should correct EEDRRLST. Usually a DLW-RR or DRR of the second to last railroad employer does not have to be submitted to RASI, since it will not impact the ABD.

Note - In January through April of each year, RIS should check Form G-88A.2 to make sure that the preceding year's lag data has also been included. This procedure is discontinued around May 1 each year, after the preceding year's earnings are posted and RASI recycles cases pending lag through SEARCH.

If the lag data for the preceding year is needed for entitlement and not on the EDM and the Form G-88A.2 was completed incorrectly; or, if additional information is needed, send an E-Mail message to Michael Wietcha, in the Employer Service and Training Center of Assessment and Training to obtain the information from the railroad. Indicate the problem or the additional information needed.

When the 958 input is entered into RASI, the lag service months will be added to the service months already on record and RASI will determine if sufficient service has been established for eligibility. If so, RASI will continue its processing (usually by requesting TRIC). If not, RASI will issue a referral for the examiner to determine if deemed service months can be credited. Refer to RCM 9.3.15(E), under the referral "Insufficient Service Months for Annuity Type Code, Consider Deeming."

If the AA-1 shows two lag employers, and lag service is required for eligibility, RASI will produce a referral message: "TWO LAG EMPLOYERS INDICATED." When both G-88A.2's have been received, submit the data for both on one 958. If the employee had two employers in the lag period, and two G-88A.2's were released for service to establish annuity eligibility, RASI will reject 958 input which does not indicate two BA numbers.

6. Controlling for Return of Form G-88A.2

If the lag service is needed for entitlement, the case cannot be paid until the Form G-88A.2 is returned. A Form G-88A.2 tracer referral is generated by RASI 45 days after the application filing date. Trace any outstanding Form G-88A.2 according to RCM 8.1, Appendix D.

7. Disposition of Form G-88A.2

Mark the claim number on the top of the Form G-88A.2 and have the form imaged.

TYPE CODE 958 - LAG SERVICE - DATA ENTRY INSTRUCTIONS - This screen is used to clear the call-up on RASI for cases pending type code 958. If the DLW-RR has changed since the application was transmitted to RASI, a 996 should have been submitted to correct the EEDLWRR on REQUEST before completing this code 958. The lag service will not be displayed on the EDM until the year-end earnings reports are received from the railroad.

These are cases where railroad lag service is required for eligibility. This screen can be used to submit data for one or two lag employers. RASI will not produce a TRIC request until all required lag data has been entered.

Item 1 (EE SSN)

Enter the employee's social security number.

Item 2 (Code Name)

Enter the employee's code name. (First initial and first four letters of surname.)

Items 3-5 (BA NO, DLW, DRR)

Always complete using the corresponding items on the Form G-88A.2. The item 3 (BA NO.), item 4 (DLW) and item 5 (DRR) should always refer to the last chronological railroad employer, if there are two lag employers, no matter how they are listed on the AA-1.

Item 5 may be omitted when the employee is a disability annuity applicant.

Items 6-8 (Next-to-Last BA NO, DLW, DRR)

The item 6 (next-to-last BA NO), item 7 (next-to-last DLW) and item 8 (next-to-last DRR) should be complete using the corresponding items on the second Form G-88A.2 when there are two lag employers listed on the AA-1. Otherwise, leave these items blank.

Item 9 (Current Lag Year)

Enter the four digits of the year of the DLW shown in item 4.

Item 10 (Current Year Actual Service Months)

Enter the number of actual creditable railroad service months for the year entered in item 9.

One-Employer Cases - If item 14 on the G-88A.2 indicates actual service months for the "Current Year," enter the total actual service months for that year in this item .

Two-Employer Cases - Determine the number of actual service months which can be credited in the current lag year for each Form G-88A.2. A month in which the employee worked for both employers is only one creditable railroad service month. Enter the net number of creditable railroad service months.

Example 1:

The Form G-88A.2 for the last employer shows the DLW-RR as 10-31-2000, and the employee worked in all months through the DLW-RR. The Form G-88A.2 for the next-to-last employer shows the DLW-RR as 7-5-2000, and the employee worked in all months through that DLW-RR. The net amount of actual service months is 10.

Example 2:

The Form G-88A.2 for the last employer shows the DLW-RR as 12-15-2000, and the employee worked only in the months July - December 2000. The Form G-88A.2 for the next-to-last employer shows the DLW-RR as 7-5-2000, and the employee worked only in the months Mar - July. The net amount of actual service months is 10.

Item 11 (Current Year Deemed Service Months)

If deemed months are not necessary to establish eligibility, leave this item blank. Otherwise, when RASI rejects the 978 with the message: "G-88A.2 - INSUFFICIENT SERVICE MONTHS FOR ANNUITY TYPE CODE - CONSIDER DEEMING, see the instructions for that reject message in RCM 9.3.15(E), 958 Input Rejects.

Item 12 (Prior Lag Year)

Enter the four digits of the prior lag year. If none, leave this item blank.

Item 13 (Prior Year Actual Service Months)

If item 12 is completed, use the instructions in item 10, enter the net number of actual creditable railroad service months creditable for the prior lag year.

Item 14 (Prior Year Deemed Months)

See the instructions in RCM 9.3.15(E), 958 Input Rejects.

Item 15 (Exam Number)

Enter your three digit examiner number.

9.2.11 Proofs - Type Codes 900-6

A. General

This screen is required when an application is processed without a required proof attached, or when there is a discrepancy regarding a proof. The following type codes indicate the type of proof outstanding, although all proofs enter RASI as 900.

900 - Employee proof of age (items 1-3, 15)

901 - Spouse proof of age (items 4-5, 15)

902 - Child proof of age/relationship (items 1, 6-7, 15)

904 - Spouse proof of marriage (items 1, 8, 15)

906 - Employee - proof of military service (items 1, 9-15)*

*When proof of military service is still outstanding but not required for eligibility, and processing must be expedited, the RIS examiner must notify the manager or senior examiner. The manager or senior examiner will clear the military service call up and enter the claim number on STAR (RIS-MS). The examiner will continue to trace with the field office for proof of military service. If the proof of military service is abandoned by the field office, close out STAR and enter this information in remarks.

As many as all five types of proofs can be entered on the same screen. However, a separate screen must be completed for each period of military service when there are multiple periods, or for each child, when there is more than one.

B. Data Entry Instructions

Item	Entry
1	Usual.
2	Enter DOB established for employee.
3	Enter weight from G-91 from proof which establishes employee's DOB.
4	Enter DOB established for spouse.
5	Enter weight from G-91 for proof which establishes spouse's DOB.

6	Enter DOB established for child.
7	Enter weight from G-91 for proof which establishes child's DOB.
8	Enter DOM established for spouse.
9	Enter serial number shown on proof of military service (for the period involved, if multiple periods are claimed). Space out unused positions, if necessary. Do not use leading zeroes. This may be omitted, if not known.
10	Enter date <u>active duty</u> began.
11	Enter date <u>active duty</u> ended.
12	If multiple periods are involved, enter "1." If not, leave blank.
13	Enter "1" for enlisted, re-enlisted, commissioned. Enter "2" for inducted, called from inactive duty.
14	Enter "1" for "honorable." Enter "2" for "other."
15	Usual.
	Press "ENTER."

9.2.12 DUMP - Type Code 991

A. General

This screen is used to terminate RASI processing when mechanical handling is no longer advantageous. It is also used when an application is cancelled or denied and payment (partial or final) has already been issued. The screen is also used to remove a case from the RASI Master file and allow it to be re-entered with corrections.

B. Data Entry Instructions

Item	Entry
1	Usual.

2	Complete this item as follows:
	<ul style="list-style-type: none"> • Enter the code "141" to dump the employee and spouse (if any) from RASI for manual handling. A record of the dumped cases will remain on the RASI Master and REQUEST for about 90 days. This code should only be used to dump cases which <u>will not</u> be re-entered into the RASI system. • Enter code "142" to dump spouse-only cases for manual handling. A record of the dumped case will remain on the RASI Master and REQUEST for about 90 days. This code should only be used to dump spouse only cases which will not be re-entered into the RASI system. <p>NOTE: Do not use the above codes if you want to re-transmit a case to RASI.</p> <p>If you have been requested to dump a case which will be re-transmitted to RASI:</p> <ul style="list-style-type: none"> • Enter code "147" (spouse only). This code results in the <i>immediate removal</i> of the case from the RASI Master and REQUEST. • Enter code "149" employee (and spouse, if any). This code results in the <i>immediate removal</i> of the case from the RASI Master and REQUEST. • Enter code "148" to dump an employee SUP ONLY case from RASI for manual handling. A record of the dumped case will remain on the RASI Master and REQUEST about 90 days.

3	Enter first initial and first four letters of surname of employee if item 2 is "1" or "9," or spouse if item 2 is "2" or "7." (Leave blank if item 2 is "8." Space out the underscores.)								
4	Enter six-digit claim number, if applicable.								
5	<p>Enter the code number which corresponds to the appropriate reason for dump as shown on the form. Code numbers "1", "2", "4", and "5" will produce a disposition record which will remove the case from the pending load. If any other code is used as a reason for dump, the case will remain on the pending load until it has been coded as a disposition.</p> <p style="text-align: center;">DUMP REASONS</p> <table style="width: 100%;"> <tr> <td>1 – INCORRECT SSN</td> <td>5 – APP CANCELLED</td> </tr> <tr> <td>2 – DEATH</td> <td>6 – MANUAL PARTIAL</td> </tr> <tr> <td>3 – OP COULD OCCUR</td> <td>7 – OTHER</td> </tr> <tr> <td>4 – CLAIM ABANDONED</td> <td></td> </tr> </table>	1 – INCORRECT SSN	5 – APP CANCELLED	2 – DEATH	6 – MANUAL PARTIAL	3 – OP COULD OCCUR	7 – OTHER	4 – CLAIM ABANDONED	
1 – INCORRECT SSN	5 – APP CANCELLED								
2 – DEATH	6 – MANUAL PARTIAL								
3 – OP COULD OCCUR	7 – OTHER								
4 – CLAIM ABANDONED									
	Press "ENTER."								

9.2.13 IMPACT or SPAR – Type Code 944

A. General

This screen can be used to enter either an IMPACT rate for an employee or a SPAR rate for a spouse applicant, or to change an IMPACT or SPAR which has not yet been paid.

1. IMPACT (Initial Monthly Partial Certification in Tiers)
 - a. Eligibility Requirement For IMPACT – The field representative usually determines which employee applicants will be paid the IMPACT rate. If the field representative has reason to doubt that the employee is eligible for an annuity (s)he will not enter an IMPACT rate on the G-230.

RASI will pay an IMPACT rate in disability cases only after receiving a G-325 granting a disability rating. In cases granted an occupational disability rating, the establishment of a C/C and either at least 240 months of service or 60 years of age is also required before an IMPACT rate will be paid.

- b. Amount of Partial Rate – The field representative will compute the partial rate based in the information furnished on the Microfiche of Annuity, Residual and Compensation (MARC) file. The partial rate computed will be the same rate that is normally furnished employees who request an annuity estimate. A SUP ANN will not be paid in the partial certification.

The partial rates computed by the field will be entered by tiers, on the G-230 screen.

The breakdown of the IMPACT rate into tier components is required for taxation purposes. Each tier component must be entered as a dollar amount only and must not exceed the following maximums:

Tier 1 - \$1000

Tier 2 - \$800

Windfall - \$500

- c. Beginning Date of Payment – All beginning dates for payment of partial rates will be set for the first day of the month.

After the partial rate is entered, RASI will establish an assumed ABD and begin paying full age cases as follows:

Filing Month After DLW (RR and LPS) Month – The ABD for the partial rate will be the first day of the month of the application filing date.

Example: Employee last worked in RR service on 3-15-91. He filed an application on 4-10-91. RASI will establish 4-1-91 as his ABD for the partial rate and issue a check on 5-1-91 as payment for April.

Filing Month Same as DLW (RR or LPS) Month – The ABD for the partial rate will be the first day of the month following the filing month.

Example: Employee last worked in RR service on 3-10-91. He filed an application on 3-14-91. RASI will establish 4-1-91 as his ABD for the partial rate and issue a check on 5-1-91 for the month of April.

The ABD for a reduced age case will be the first day of the first full month the employee is age 62.

The ABD for a disability annuitant will be the first day of the sixth month following the month of the disability onset date. NOTE: If the employee has designated an ABD on the application, RASI will use the late of the two.

Only current month accruals will be paid. If the established ABD would result in more than one month's accrual being due, RASI will set the partial ABD so that only one month's accrual will be paid.

EXCEPTION: If RUIA clearance is not received by the cut-off date of the current month, the case will be paid the following voucher month, which would result in more than one month's accrual being paid.

When a case undergoing partial certification becomes ready for final payment, the final ABD will be used instead of the assumed ABD. In some cases, however, they may be the same date.

- d. RUIA Clearance – All cases will be cleared with RUIA before payment is made. The assumed ABD will be the ABD furnished RUIA.
- e. Award Forms and Notifications

Award Form – No Form G-354R will be produced for a RASI case in which a partial rate has been paid. The partial rate date is available on REQUEST Screen 11.

Award Notification – RL-20e and C.P. 400 will be used as the award notification for the partial certifications.

- f. Examiner's Entry of IMPACT Rate

IMPACT rates are generally entered in the G-230 by field personnel. In cases where a point of eligibility is questionable, however, the field may not enter the IMPACT rate, or RASI may zero out the IMPACT rate due to a manual review code or some special situation.

Once all questions are resolved, the examiner may enter the IMPACT rate by completing a 911. IMPACT rate should be entered whenever possible, especially if the claim is approaching 120 days old.

RASI will produce a referral message for every case in which no IMPACT data was received from the G-230, and the case has been on the system for 30 days.

Examiners may enter an IMPACT rate in a disability case prior to the case being rated, if the eligibility requirements are met; however, payment will not be made until the G-325 is processed. If an occupational disability has been granted, a C/C and either at least 240

service months or 60 years of age must be established before RASI will pay an IMPACT rate.

Use of the MARC – In general, the MARC estimate may be used as an IMPACT rate. However, many considerations may cause the MARC estimate to be altered:

- If there is a DOB discrepancy between the MARC and the AA-1, subtract \$30 from PIA 1 for each discrepant year, regardless of whether the employee is younger or older. Subtract an additional \$100 if the MARC year of birth is before 1917, but the employee is actually born in or after 1917.
- Check the VDB date of entitlement before using the MARC estimate. Exclude the VDB if it is not yet due or there is any doubt about vesting. Cut back the VDB if it is being paid in a VDB cutback period.
- For reduced age cases, be sure to consider age reductions. This is not done in the MARC estimate.
- Reduce the Tier 1 for SS entitlement. The rate shown on the MARC does not reflect the reduction for SS benefits.
- Subtract the amount of the social security benefit if the amount is known. Use the rate shown on the SSA award letter, DATA-Q or a G-90. If the employee has SS-covered wages after the last year SSA earnings are shown as posted on the MARC, increase the SS benefit by \$30 for each unposted year.

If the amount of the SS benefit is unknown, assume it equals the gross Tier 1 and do not include a Tier 1 in the IMPACT.

NOTE: An incorrect month or year of birth could also affect the employee's eligibility for a reduced 60/30 annuity, and the amount of the Tier 1 reduction. If the employee is applying for a 60/30 annuity to begin when he is less than 62, be sure to consider the Tier 1 age reduction.

2. SPAR (Spouse Partial Annuity Rate) – In cases in which the field representative does not enter a SPAR rate on the G-230, examiners may make the decision as to when to pay a SPAR rate. When deciding to pay a partial rate, consider such factors as:

- Age of AA-3 application;
- Amount of information in file to pay case;

- Reason field did not initiate SPAR payment;
- When case is expected to pay final.

Do not pay a partial rate if:

- Excess earnings are indicated; or
 - Employee is being paid 100% or 110% O/M rate; or
 - The employee and spouse are not living together and there is no G-346 in the file.
 - The spouse is receiving SS benefits from the Board and is subject to Medicare premium deductions, and the SPAR rate is less than the amount of the Medicare premium.
 - The spouse is not a citizen or legal resident of the United States, or is not a legal resident of Canada who has claimed exemption from non-resident alien tax withholding under the existing U.S. – Canadian treaty. (Non-resident alien tax withholding and account provisions preclude mechanical payment in these situations.) However, if a spouse living outside the United States claims legal U.S. residence, or is a legal resident of Canada, the field should have secured Form RRB-1001 and the Remarks section of the G-230 should be noted “U.S. – Canadian Tax Treaty Exemption Applies.” In that case a SPAR may be paid.
 - The spouse is filing based upon a minor or disabled child and the eligibility determination has not yet been made.
- a. Eligibility Requirements For Payment of Partial Rate to Spouse – Do not request a partial payment of a spouse unless the eligibility and entitlement requirements outlined in RCM 1.3 have been met. Also, the required proofs must be in file.
- NOTE: Do not request a SPAR payment for a case in which the employee is not in pay status, unless an IMPACT is being prepared as well. In that case, RASI will pay the IMPACT first, then the SPAR will be paid in the next run.
- b. Amount of Partial Rate – Examiners are responsible for computing the SPAR estimate if the district office has not already provided a SPAR rate on the G-230. The SPAR rate may consist of Tier 1 plus Tier 2, or either of Tier 1 or Tier 2 alone. The total SPAR rate may not exceed \$999.

- TO COMPUTE THE SPAR TIER 1 RATE
- Multiply the employee's PIA 1 (excluding any DRC's) by 50%;
- Reduce for spouse's age, PSP and/or SS benefit payable;
- Drop cents;
- Do not exceed \$600.

Exceptions:

1. If the employee is entitled to a reduced 60/30 annuity:

Multiply the employee's ABD Tier 1 (the age – reduced PIA 1) by 50%;

Reduce for other benefits as required;

Drop cents;

Do not exceed \$600.

NOTE: If the employee and spouse are both 62 or older, and employee's PIA 1 has been recalculated, compute as shown in previous section.

2. When PSP or SS benefit amount are unknown, do not pay SPAR Tier 1.
3. When employee and spouse are filing together for dual annuities, do not pay SPAR Tier 1.
4. When a spouse filing alone has an employee annuity in force, reduce the SPAR Tier 1 by the amount of the employee annuity gross Tier 1.
5. When the employee is entitled to a noncovered service pension, the SPAR Tier 1 must reflect the reduction in the employee's PIA 1.

TO COMPUTE THE SPAR TIER 2 RATE

Employee and Spouse Filing Together:

- Multiply the IMPACT Tier 2 by 45%; (If spouse annuity is subject to age reduction, multiply the IMPACT Tier 2 by 30%)

- If the spouse is continuing LPS, reduce the SPAR Tier 2 by half;
- Drop cents;
- Do not exceed \$399.

NOTE: If the employee is 65 or older in the ABD year, or did not work for the railroad in the ABD year, do not pay the SPAR Tier 2.

Spouse Filing Alone:

- Multiply the employee's Tier 2 by 30%;
- If SPAR Tier 1 was reduced for dual entitlement, restore reduction amount or net Tier 1 rate, whichever is less.
- If the employee or spouse is continuing in LPS, reduce the SPAR Tier 2 by half;
- Drop cents;
- Do not exceed \$399.

NOTE: If the employee's ward states "SPOUSE INVOKES MAX", do not pay the SPAR Tier 2.

The employee tier data necessary to compute spouse partial rate should be available from the claim folder. Other sources to sue when the data is not available from the folder are the MARC and the BIC. However, when using the MARC file, compare the employee's verified DOB with that shown on the MARC. If the employee is younger than the date on the MARC, do not use it to pay the SPAR as PIA 1 will be overstated.

- c. Beginning Date of Payment – RASI will compute all SPAR ABD's. If RASI cannot establish an ABD, it will produce the referral message "UNABLE TO SET SPOUSE'S ADB: SUBMIT SPAR FORCE 996". Prepare a 996 screen coded as indicated in RCM 9.2 Exhibit 9.
- d. Special Situation – Some spouse cases pending on RASI will not pay a partial when the employee is also on RASI and pending final payment. If the spouse's TRIC clearance is received before the employee pays final, RASI puts the spouse in "final mode" and will not pay a SPAR. The spouse will pend "TRACE" on REQUEST until the employee is processed and then the spouse will pay final. This will happen even if a SPAR was entered on the G-230 or if the examiner has entered a 911 for a SPAR.

The examiner can, however, take the spouse out of “final mode” and make RASI go through the evaluation process again, permitting payment of a SPAR. This is done by entering a miscellaneous tickler in the call-up table with a 996. Completion of the 996 to set the call-up is shown in RCM 9.2 Exhibit 10.

If there is already a SPAR in the record from the G-230, RASI will pay it. If no SPAR is in the record, the examiner can enter a 911. If the 911 is required, it can be submitted at the same time as the 996.

In either situation, the examiner must also enter another 996, a DUMMY, to remove the miscellaneous correction created by the first 996. Completion of the 996 to remove the call-up is shown in RCM 9.2 Exhibit 12. The second 996 can be submitted 2 or 3 working days after the first one. RASI will not pay the spouse final until the call-up is removed.

e. Award forms and Notification

Award Form – No Form G-355R will be produced for a RASI case in which the partial rate has been paid to the spouse. The partial rate data is available on REQUEST Screen 21.

Award Notification – An RL-20e and CP-400 will be used as the award notification for the partial certification.

B. Data Entry Instructions

Item	Entry
1	Usual
2	Enter “1” for an employee, or “2” for a spouse.
3	Enter the first initial and first four letters of the surname for the payee in item 2.
4	Usual (To enter SPAR data, go to item 11.)
5	Enter the IMPACT Tier 1 currently in the record. If none, leave blank.
6	Enter new IMPACT Tier 1. The last digit should be entered in the last space. Use leading zeroes if necessary. Never enter more than the current maximum of \$1000. If Tier 1 is zero, leave blank.

7	Enter the IMPACT Tier 2 currently in the record. If none leave blank.
8	Enter new IMPACT Tier 2. The last digit should be entered in the last space. Use leading zeroes if necessary. Never enter more than the current maximum of \$800. If Tier 2 is zero, leave blank.
9	Enter the IMPACT VDB currently in the record. If none leave blank.
10	Enter new IMPACT VDB. The last digit should be entered in the last space. Use leading zeroes if necessary. Never enter more than the current maximum of \$500. If VDB is zero, leave blank. Press Enter.
11	Enter the SPAR Tier 1 currently in the record. If none, leave blank. The last digit should be entered in the last space. Us leading zeroes of necessary.
12	Enter new SPAR Tier 1. The last digit should be entered in the last space. Use leading zeroes if necessary. Never enter more than the current maximum of \$600. If Tie 1 is zero, leave blank.
13	Enter the SPAR Tier 2 currently in the record. If none, leave blank. The last digit should be entered in the last space. Us leading zeroes of necessary.
14	<p>Enter new SPAR Tier 2. The last digit should be entered in the last space. Use leading zeroes if necessary. Never enter more than the current maximum of \$399. If Tie 1 is zero, leave blank.</p> <p>The total of items 12 and 14 may not exceed \$999.</p> <p>Press ENTER.</p>

9.2.14 Name - Address Change - Type Code 997

A. General

This screen is used to correct the name and/or address or to establish or discharge a representative payee for an employee or spouse. If a partial award has been made, FAST/COA must be used in addition to the 997.

B. Data Entry Instructions

Item	Entry
1. EE SSN	Usual.
2. Rep Payee Code	<p>"0" - No rep payee involvement. This action is for address-only change.</p> <p>"1" - This action is to name a rep payee. It is also used to change to a rep-payee who is Court Appointed.</p> <p>"2" - This action is to name a rep payee or to change to a rep-payee who is Board (RRB)Appointed.</p> <p>"3" - This action is to name a rep payee or to change to a rep-payee who is a Parent-For-Child rep payee.</p> <p>The following codes are expected to be operational in calendar year 2016.</p> <p>"4" - This action is to name a rep payee or to change to a rep-payee who is a High Risk-Court Appointed rep payee with custody of the annuitant.</p> <p>"5" - This action is to name a rep payee or to change to a rep-payee who is a High Risk-Board Appointed rep payee with custody of the annuitant.</p> <p>"6" - This action is to name a rep payee or to change to a rep-payee who is a High Risk-Court Appointed rep payee without custody of the annuitant.</p> <p>"7" - This action is to name a rep payee or to change to a rep-payee who is a High Risk-Board Appointed rep payee without custody of the annuitant.</p> <p>"8" This action is to name a rep payee or to change to a rep-payee who is a Parent-For-Child rep payee without custody of the child, but who retains responsibility for making decisions regarding the child.</p>
3. Code Name	<p>For employee, or if the change involves an employee and spouse, enter the employee's code name as currently shown on REQUEST screen 11.</p> <p>For spouse only changes, enter the spouse's code name as currently shown on REQUEST screen 21.</p>

4. Payee Code	"0" Employee only change. "1" Spouse only change. "2" Employee and spouse address change only.
5. Name & Add. Code	"7" Address only change. "8" Name and address change; <i>or</i> employee or spouse name change and a rep payee is involved. "9" Change of employee or spouse name, no rep payee involved. Entry of a rep-payee for the employee or spouse. Discharge of a rep-payee.
6. Exam No.	

Name - Address Change

Several rules must be considered when completing the name and/or address:

- If an address consists of only one line, the city and state must be entered on separate lines.
- Always leave a space in the first position of the first line of the address to indicate the location of the group mark when the data is passed to RASI.
- In a two line name, RASI will accept a single initial as one line.
- RASI will not accept numeric characters in a name entry.
- Only three items may be part of the name entry: first and middle name or initials and surname. If a fourth item is entered, RASI will reject the 997. However, RASI will not reject a 997 for the suffixes "II", "III", "MD," "JR," or "SR," if they are shown on line 1.
- When a representative payee is part of a name and address entry, the word "FOR" must be written at the beginning of the second or third name line, (followed by a blank space) and must be followed by the applicant's name. NOTE: RASI will not accept the suffixes listed above if entered on lines 2 or 3.
- When entering or changing a representative payee only, enter only the payee's name. Do not add "FOR" and the annuitant's name.
- Surnames with two words should be written as one name, e.g., STJOHN.

- A name and address entry should never exceed five lines. Before making a name or address change, check REQUEST Screen 11(ee) or 21(sp). If there is already a two line name, RASI will not accept a four line address. Likewise, a two-line name cannot be added unless the address is contained on two or three lines.
- If a representative payee is involved and it is necessary to change the annuitant's name, the full name and address must be entered in item 7, i.e., the representative payee, the annuitant's name (preceded by "FOR") and the complete address.

The following chart represents the most common scenarios regarding a name and address change. It is an aid in choosing the correct coding entries for items 2, 4, and 5 as well as the contents of the name-address area. Items 1 (EE SSN), 3 (code name) and 6 (exam #) should be completed as usual in all cases. Press enter after completing all required entries to process.

Type of Action:

	Item 2 Rep Payee Code	Item 4 Payee Code	<u>Item 5</u> Name & Address Code	Item 7 Name, Address & Rep Payee Lines
1. Change of employee's name; no rep payee involved	0	0	9	Enter the employee's name on the first line.
2. Change of employee's address; no rep payee involved	0	0	7	Space out first position of first line, then begin address.
3. Change of employee's name and address; no rep payee involved	0	0	8	Enter EE's name. Space out first position of next line, then begin address.
4. Change of spouse's name; no rep payee involved.	0	1	9	Enter spouse's name on first line.

5. Change of spouse's address; no rep payee involved	0	1	7	Space out first position of first line, then begin address.
6. Change of spouse's name and address; no rep payee involved	0	1	8	Enter MA's name. Space out first position of next line, then begin address
7. Change of employee and spouse address; no rep payee involved	0	2	7	Space out first position of first line, then begin address.
8. Entering rep payee for the EE	1-Court Appt. 2-Board Appt. 4- <u>High Risk (Court Appt non-3rd Party Custodian)</u> 5- <u>High Risk (RRB Appt non-3rd Party Custodian)</u> 6- <u>High Risk (Court Appt 3rd Party Custodian)</u> 7- <u>High Risk (RRB Appt 3rd</u>	0	9	Enter Rep payee's name only.

	<u>Party Custodian</u> 1			
9. Entering rep payee for the spouse	1-Court Appt. 2-Board Appt.4- <u>High Risk (Court Appt non-3rd Party Custodian)</u> 5- <u>High Risk (RRB Appt non-3rd Party Custodian)</u> 6- <u>High Risk (Court Appt 3rd Party Custodian)</u> 7- <u>High Risk (RRB Appt 3rd Party Custodian)</u>	1	9	Enter rep payee's name only
10. Change of EE's name. Rep payee involvement	1-Court Appt. 2-Board Appt. 4- <u>High Risk (Court</u>	0	8	Enter rep payee's name, followed by "FOR" and employee's name

	<u>Appt non-3rd Party Custodian)</u> <u>5- High Risk (RRB Appt non-3rd Party Custodian)</u> <u>6-High Risk (Court Appt 3rd Party Custodian)</u> <u>7- High Risk (RRB Appt 3rd Party Custodian)</u>			
11. Change of EE's address. Rep payee involvement	0	0	7	Space out first position of first line, then begin address.
12. Change of EE's name and address. Rep payee involvement.	1-Court Appt. 2-Board Appt. <u>4-High Risk (Court Appt non-3rd Party Custodian)</u> <u>5- High Risk (RRB Appt non-3rd Party</u>	0	8	Enter rep payee's name; followed by "FOR" and EE's complete name and address

	<u>Custodian)</u> <u>6-High Risk (Court Appt 3rd Party Custodian)</u> <u>7- High Risk (RRB Appt 3rd Party Custodian)</u>			
13. Change of MA's name. Rep payee involvement	1-Court Appt. 2-Board Appt. <u>4-High Risk (Court Appt non-3rd Party Custodian)</u> <u>5- High Risk (RRB Appt non-3rd Party Custodian)</u> <u>6-High Risk (Court Appt 3rd Party Custodian)</u> <u>7- High Risk (RRB Appt 3rd Party</u>	1	8	Enter rep payee's name followed by "FOR" and spouse's name

	<u>Custodian</u>			
14. Change of spouse's address. Rep payee involvement	0	1	7	Space out first position of first line, then begin address.
15. Change of MA name and address. Rep payee involvement	1-Court Appt. 2-Board Appt. 4- <u>High Risk (Court Appt non-3rd Party Custodian)</u> 5- <u>High Risk (RRB Appt non-3rd Party Custodian)</u> 6- <u>High Risk (Court Appt 3rd Party Custodian)</u> 7- <u>High Risk (RRB Appt 3rd Party Custodian)</u>	1	8	Enter rep payee's name; followed by "FOR" and MA's complete name and address
16. Change of EE and MA address. Rep	0	2	7	Space out first position of first line, then begin address.

payee involvement for both				
17. Change of EE and MA address. Rep payee involvement for one .	0	2	7	Space out first position of first line, then begin address
18. Discharging rep payee	5	0 – EE 1 – MA	9	
19. Discharging rep payee and making address change for EE	5	0	8	Space out first position of first line, then begin address.
20. Discharging rep payee and making address change for spouse	5	1	8	Space out first position of first line, then begin address.

9.2.15 Miscellaneous Correction Or Change - Type Code 996

A. General

This screen is used to add or change information in the RASI master file. A list of all fields is available in RAC; however, fields for common use are described in the specific referrals for examiner handling. A short list is provided in RCM 9.3.12 of general data fields. Various examples are shown in Exhibits 1 - 12.

NOTE: When changing a date, always enter all four digits of the year in CCYRMODE order.

B. Data Entry Instructions

Item	Entry
1	Usual.
2	Enter "1" for employee; "2" for spouse.

3	Enter the first initial and the first four letters of the surname of the payee in item 2.
4	Usual.
5	" <u>Present Contents</u> " - Starting in the first position, enter the current contents of the RASI field that is to be changed. Space out any remaining positions.
6	" <u>Changed Contents</u> " - Starting in the first position, enter the new contents of the field that is being changed. Space out any unused positions.
7	<u>Field Name</u> - Starting in the first position, enter the name of the field being changed. The name cannot be longer than 18 characters. Space out any unused positions.
9	<u>Inquiry Code</u> - The 996 can be used to query the RASI master file to determine its current contents on any field. Enter an "X" in this item and enter the name of the field in item 7. RASI will print the contents of the requested field on an 805 referral. This procedure is useful for determining the contents of fields not shown on REQUEST.
	Press ENTER.

9.2.16 Man Op Change - Type Code 995

A. General

Under certain circumstances, a man op code is set to prevent final payment, although all factors of adjudication have been completed. The man op code can be set at filing when the contact representative codes the manual review item, or it can be set when the application data contains conditions which require review by an examiner. These conditions are identified on the HSL referral which notes the setting of the man op code.

A 995 can also be used to set a man op code when there is a need to delay payment. In this instance, another 995 will be required to remove the man op.

B. Data Entry Instructions

Item	Entry
1	Usual.

2	"1" For employee.
	"2" For spouse.
	"3" For employee and spouse.
3	Enter first initial and first four letters of surname for payee in item 2.
4	"0" To remove man op.
	"2" To set man op.
5	Usual.
	Press ENTER.

9.2.17 Search Clearance - Type Code 946

A. General

A 946 can be used to override an incorrect employee name in DCC's records. When a 946 call-up exists, first determine whether the name on RASI is correct, and whether the SSN being used is correct. If so, entering a SEARCH clearance form will permit the release of the employment record data and allow the case to continue processing.

If the name on RASI is not correct, it must be changed with a 997. If the SSN is not correct dump the case and forward the correct data to BFS for re-entry.

B. Data Entry Instructions

Item	Entry
1	Enter first five letters of surname.
2	Usual.
3	Usual.
4	"13" Age and service claim.
	"15" Disability claim.
	"16" Medicare claim.

5	Enter two digits of month and four digits of year of birth.
6	"1" Application filed January - March.
	"2" Filed April - June.
	"3" Filed July - September.
	"4" Filed October - December and four digits of year of filing.
7	Enter two digits of month and four digits of year of claimed (or verified) date last worked for RR.
	Press ENTER.

9.3.1 RASI Referrals

If RASI will not accept an employee or spouse application or a supporting document because of coding errors, omissions, etc., it produces a RASI input reject message. These referral messages are printed in an HSL listing following each RASI run. The listing, under the main heading "RASI REPORTS," is entitled "RASI 805 REJ REF REPORT." The reject messages describe the missing or invalid data.

If the application is accepted, RASI may produce additional referral messages on line. These referrals are preceded by three-digit numbers which refer to RCA's numerical listing of all the messages. These messages, also accessed through HSL, appear under the main heading "RASI REPORTS," entitled "RASI G354A REPORTS".

In some cases, the reason for referral is technical and involves some discrepancy encountered within RASI. If the reason for the referral is not apparent, refer it to P/P&S-RAC through your supervisor.

9.3.2 Retirement Application Rejects

Correction And Rekeying Of Application Rejects

- A. General - Application rejects are referred to PES personnel, who then request the claim folders from the adjudication units. If there is no indication that an employee application should be handled manually, PES will have the application corrected and rekeyed by BFS - Program Services Section. The case will be returned to the appropriate adjudication unit.

Because RASI edits are considered in the IC system, the CR is instructed to explain any overriding of IC edits which will cause an application to reject from RASI. BFS will develop missing information and rekey applications if necessary when RASI rejects applications processed through IC.

If the case requires manual handling, PES forwards it to the appropriate unit.

- B. Employee-Spouse Case - If the employee and spouse applications are submitted simultaneously, a coding error on one application usually rejects only that application. The other application remains on RASI. However, RASI will not begin to process a spouse application until a rejected employee application has been corrected and rekeyed. The message "Spouse Only - No Matching Research Record" will be produced.
- C. Rekeying Forms - If an application is not shown on REQUEST or the G-425 status list, send the case to PES to see if there is an input reject for the case.

When an application rejects, related forms (e.g., G-91) that were keyed remain on the tape record for 36 runs. Therefore, it is not necessary to have related forms rekeyed if the corrected application will be rekeyed shortly after the date it is rejected.

9.3.3 Application Control

Listings and control cards for all applications pending 60, 90, 120 and more than 149 days are printed at the end of each month. The listings and the cards are forwarded to the modules for action to expedite payment in these cases.

9.3.10 Employee And Spouse Type Of Record And Call-Up Codes

A. Type of Record Codes - RASI has a code for each type of case it receives:

Code	Type of Record
100	Employee Application - Full Age
101	Employee Application - For HIB-SMIB Benefits
103	Spouse Application For HIB-SMIB Benefits
200	Employee Application - 60/30 Case
300	Employee Application - Reduced Age
500	Employee Application - Occupational Disability, Less than age 60, 20 years of service
600	Employee Application - Occupational Disability, Age 60, 10 years of service
700	Employee Application - Total and Permanent Disability
800	Spouse Application - Full Age
801	Spouse Application - Reduced Age
802	Spouse Application Based on Child
803	Spouse Application Based on 60/30 Employee

B. Call-Up Table Codes - The call-up codes are based on the columns checked on the G-230 and on the proofs required for the type of application filed. RASI sets the call-up date for each pending document. These codes are displayed on Screens 11 (ee) and 21 (sp) on REQUEST. The following codes identify the various types of data required by RASI:

Code	Type of Record
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150	Supp Ann-Post-Adjudication Award
900	POA - Employee
901	POA - Spouse
902	POA - Relationship - Child
904	Proof of Marriage
906	Proof of Military Service
932	Employee Data From Spouse Research Record
933	Miscellaneous Data For Spouse
939	CHICO Inquiry *
945	RUIA Clearance
946	DCC SEARCH Request

* If applicant has filed for social security benefits, but TRIC indicates no MBR, RASI will check CHICO to determine if RRB is paying an SS benefit.

Code	Type of Record
947	Current Connection Determination
948	Compensation Transfer
949	Research Data Required for SAARA
950	Employee SSA Data
951	Spouse SSA Data
953	Dual Spouse Data
954	SUP ANN Data
957	Public Service Pension
958	Lag Service Months
960	Employee TRIC Reply

961	Spouse TRIC Reply
970	G-325 Information
991	Dump
995	Manual OP Code
996	Miscellaneous Correction
997	Name or Address Change or Rep Payee
998	P/S or Total Additional Service for MPS Case

- C. The following table shows the length of the call-up RASI has set for the particular type of information that is pending. The codes are as follows:

Code	G-230 Indication	Call-Up Period
(Not shown on REQUEST)		
2	Checked "Att."	10-day call-up. Changes to Code 7 on trace.
3	Checked "Prev. Sub."	10-day call-up. Changes to Code 7 on trace
4	Checked "To Be Sub."	60-day call-up. Changes to Code 5 on trace.
5	60-day call-up.	Repeats on trace.
7	Checked "Att."	or 10-day call-up for "Prev. Sub." At least 945, 946, 995 or 997. 10 days elapsed 60 days for all others.

EXCEPTIONS TO ABOVE

TRIC REQUEST	(960) - 60 day call-up
EE INFO FOR SP	(932) - 30 day call-up
G-88A.2 REQUEST	(958) - 45 day call-up
PUBLIC SERVICE PENSION	(957) - 15 day call-up

The remaining digits in the call-up table represent the call-up date written in year, month, day order. (Sample referrals are at the end of this chapter.) For instance, 1-5-94 would appear as 940105.

9.3.11 Employee And Spouse Status Word Coding

- A. Status Words - Employee (SWE) - The employee status words are found on REQUEST Screen 12. Each code indicates the current status of the particular data required for RASI to adjudicate a claim. RAPT has a copy of RASI's master layout record. Consult with a supervisor before making any word changes involving these status words. (A mnemonic code is shown for each status word.) There are four lines of status words for the employee and three lines for the spouse.

LINE 1 POSITION 1 - EE AGE (SWEAGE)

Code	Meaning
1	Age - OK
3	Claimed DOB Accepted, Not Verified
4	Verification Required
8	Age Not Verified

LINE 1 POSITION 2 - EE SERVICE (SWESERV)

1	Sufficient Service Established
2	Verification of 120 Months Required
3	Verification of 240 Months Required
4	Verification of 360 Months Required
5	Insufficient Service
6	Verification of 120 Months Required
7	Verification of 240 Months Required
8	Verification of 360 Months Required

LINE 1 POSITION 3 - EE LAST WORKED IN RR (SWEDLWRR)

1	Verified
4	Verification Required

LINE 1 POSITION 4 - EE DATE RTS REL RR (SWEDRRRR)

Code	Meaning
0	Does not Apply
1	Verified
4	Verification Required
5	G-88 Certification Required - Lag Received

LINE 1 POSITION 5 - EE LAST EMPLOYMENT (SWELSTEMPMT)

1	Last Worked For RR Employer
2	Last Worked Outside - One RR Employer
3	DLW Outside Same As RR - One RR Employer
4	Two RR Employers - No Outside Employment
5	DLW Outside - Two RR Employers
6	DLW Outside Same As RR - Two RR Employers

LINE 1 POSITION 6 - EE LAST WORKED OUTSIDE (SWEDLWOUT)

0	Does Not Apply
1	Verified
2	Claimed DLW Accepted
4	Verification Required

LINE 1 POSITION 7 - EE DATE REL RTS OUTSIDE (SWEDRRROUT)

0	Does Not Apply
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1	Verified
2	Claimed DRR Accepted

LINE 1 POSITION 8 - EE BEGINNING DATE (SWEBEGDTE)

Code	Meaning
1	Requested
4	Required

LINE 1 POSITION 9 - EE PRIOR SERVICE (SWEPRSERV)

0	Does Not Apply
1	Verified
5	Verification Required
6	P/S Received - Lag Outstanding

LINE 1 POSITION 10 - EE MILITARY SERVICE (SWEMILSERV)

0	Does Not Apply
1	M/S Creditable - Needed For Eligibility
2	Claim For M/S Abandoned
3	EE Vested For VDB if M/S Used As Wages
4	EE Not Vested For VDB If M/S Used As Comp
5	Proof Received - M/S Claimed
6	Proof of M/S Required
7	M/S Creditable - Needed For Regular Annuity Eligibility - Ended Before 7-63
8	M/S Creditable - Needed For Regular Annuity Eligibility - Ended After 6-63

9	Claim Dumped Because of Other Federal Benefits
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LINE 2 POSITION 1 - EE DISABILITY (SWEDISBLTY)

Code	Meaning
0	Does Not Apply
1	Grant
2	Denial
3	Decision Outstanding

LINE 2 POSITION 2 - EE CURRENT CONNECTION (SWECURCON)

0	Does Not Apply
1	C/C - Yes
2	C/C - No
3	C/C No for Retirement, But Yes for Survivor
4	Determination Required

LINE 2 POSITION 3 - EE DUMP REASON (SWEDUMPRSN)

0	Does Not Apply
1	Incorrect SSA Number
2	Notice of Death
3	Overpayment Could Occur
4	Claim Abandoned
5	Application Cancelled
6	Manual Partial Award
7	Other - Including 950 Dump

8	Computer-Generated Dump
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LINE 2 POSITION 4 - EE RR 4 (SWERR4)

Code	Meaning
0	Does Not Apply
1	Entitled
2	Not Entitled
4	Verification Required
9	Dumped By 950 Code 9

LINE 2 POSITION 5 - EE ALLEGED SSA FILING (SWEALGSSAFIL)

0	No Answer
1	Filed Under Own Account Number
2	No Filing Alleged
3	Filed Under Other Account Number

LINE 2 POSITION 6 - EE RUIA CLEARANCE (SWEBUSICLR)

1	Received - No Record
2	Requested - Computed Final
3	Requested - Computed Partial
4	Required
5	Case Computed Final (Received)
6	Case Computed Partial (Received)
7	Pre-Clearance Requested
8	G-301

LINE 2 POSITION 7 - EE RED CAP (SWEREDCAP)

0	Does Not Apply
2	Determination Required
3	Compensation Transfer - Determination Required
5	Both Required

LINE 2 POSITION 8 - EE SMIB OPTION (SWESMIBOPT)

Code	Meaning
0	Does Not Apply
1	First Enrollment
2	No Response
3	No Election
4	First Termination
5	Second Enrollment (Yes)
6	Second Termination (No)
7	SSA Jurisdiction
8	State Buy-In
9	Dual Annuitant

LINE 2 POSITION 9 - EE HIB (SWEHIB)

0	Pending
1	Eligible
6	Not Eligible (Denied)
7	EE Not Eligible - Spouse May Be

LINE 2 POSITION 10 - HIB-SMIB (SWEHIBSMIB)

0	Does Not Apply
1	Clearance Sent
4	Initial Clearance Required
5	None Required

LINE 3 POSITION 1 - EE SUP ANN (SWESUPPANN)

Code	Meaning
0	Does Not Apply
1	Final Certification
2	Partial Certification
3	Recertification
4	In Force - Final
5	In Force - Partial
6	Not Eligible
7	Pending SUP Pension Information From Employer and/or Closing Date Information From Examiner
8	SUP Pension Information Received
9	SUP Annuity Not Payable - Zero Balance

LINE 3 POSITION 2 - EE SUP PENSION (SWESUPPPENS)

0	Does Not Apply
1	Closing Date Involved - Eligible
2	No Pension
3	G-88p Required
5	G-88p and Closing Date Eligibility Determination Required

7	Closing Date Eligibility Determination Only Required
8	Closing Date Involved - Not Eligible
9	Handle SUP Annuity Manually

LINE 3 POSITION 3 - EE SMIB DATE (SWESMIBDTE)

Code	Meaning
0	Not Applicable or Actual Date Furnished
1	Assumed Date Furnished (Used For Code 8 Transfer - G-354e)

LINE 3 POSITION 4 - EE TRIC REQUEST (SWETRICREQ)

0	All Replies Received or No Request Sent
1	Own SSA Number
4	Alleged SSA Claim Under 3rd Person's Number
5	Additive Combination of Above
8	950 Released To Examiner
9	No Request Received

LINE 3 POSITION 5 - EE SPOUSE (SWESPOUSE)

0	Does Not Apply
1	Yes - No Spouse Application In File
2	Spouse Dumped - EE Still Active
3	Spouse Attached To Pending EE
4	Spouse Attached To Dummy
5	Dummy EE Required

LINE 3 POSITION 6 - MARRIAGE (SWEMARR)

1	Single
2	Married
3	Widowed
4	Divorced

LINE 3 POSITION 7 - EE - SEX (SWESEX)

Code	Meaning
1	Male
2	Female

LINE 3 POSITION 8 - EE MAN OP CODE (SWEMANOP)

0	OK For Award
2	No Award - Manual Examination Required

LINE 3 POSITION 9 - EE RUIA CHANGE CODE (SWEBUSICHNG)

0	Does Not Apply
3	Record Changed While RUIA Out - Cancel RUIA and Recompute

LINE 3 POSITION 10 - EE CERTIFICATION (SWECERTIF)

0	Still Pending
1	Final Certification
2	Partial Certification
3	Recertification
4	In Force Final
5	In Force Partial
6	Denial

LINE 4 POSITION 1 - EE REP PAYEE (SWEREPAYEE)

Code	Meaning
0	None
1	Court-appointed
2	Board-appointed
4	Not Named
5	Discharged

LINE 4 POSITION 2 - EE OVERALL MINIMUM (SWEOVRMIN)

0	Not Tested
1	Does Not Apply
2	Payable
3	May Apply
4	May Apply - Children
5	May Apply - Self-Employment
6	May Apply - Insured Status
7	May Apply - Spouse Over 62
8	O/M Payable - Children To Be Included
9	May Apply For Several Reasons

LINE 4 POSITION 3 - EE FELONY (SWEFELONY)

0	Does Not Apply
1	OK, Continue Processing
2	Examiner Requested Dump

4	Verification Required
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LINE 4 POSITION 4 - EE LAG (SWELAG)

Code	Meaning
0	No Lag
1	Lag Verified
2	Verification Of Lag For Last Employer Required
3	Verification Of Lag For Next To Last Employer Required
4	Verification Of Lag For Last Two Employers Required

LINE 4 POSITION 5 - EE WINDFALL (SWEWINDFALL)

0	Does Not Apply
1	Insured As of 12-31-74
2	Insured As Of Last Year Worked
3	Not Vested
4	Possible Vesting On Another's Wages
5	Assumed Not Vested as of 12-31-1974
6	Assumed Not Vested as of Year Last Worked

LINE 4 POSITION 6 - EE 20-40 TEST (SWE2040TEST)

0	Not Required
1	Undetermined
2	Yes
3	No
4	Determination Required

LINE 4 POSITION 7 - EE PRIOR MILITARY SERVICE (SWEPRMS)

0	Does Not Apply
2	Claimed M/S Not Creditable
3	M/S Claimed But 30 Years of Service Without M/S
4	Prior M/S Claimed
5	Claim For Prior M/S Abandoned
9	Claim Dumped Via 998

LINE 4 POSITION 8 - EE WINDFALL WAIVER (SWEFWAIVER)

0	Does Not Apply
1	Waive Windfall
2	Do Not Waive Windfall
4	Answer To Windfall Waiver Required

- B. Status Words Spouse - The spouse status words are located on REQUEST Screen 22.

LINE 1 POSITION 1 - SP AGE (SWSAGE)

Code	Meaning
0	Does Not Apply
1	OK
4	Verification Required

LINE 1 POSITION 2 - SP PROOF OF MARRIAGE (SWSPRFMARR)

0	Does Not Apply
1	OK
4	Verification Required

LINE 1 POSITION 3 - SP FELONY (SWSFELONY)

0	Does Not Apply
1	OK, Continue Processing
2	Examiner Reply To Dump
4	Verification Required

LINE 1 POSITION 4 - SP INSURED STATUS (SWSINSTAT)

Code	Meaning
0	Does Not Apply
1	Entitled
2	Not Entitled
4	Verification Required
9	951 Dump

LINE 1 POSITION 5 - SP REPRESENTATIVE PAYEE (SWSREPAYEE)

0	Does Not Apply
1	Court-appointed
2	Board-appointed
4	Required
5	Discharged

LINE 1 POSITION 6 - SP AGE - RELATIONSHIP OF CHILD (SWSAGERELCHILD)

0	Does Not Apply
1	OK
3	Proof of Relationship Required - Age OK

4	Proof of Age - Proof of Relationship Required
---	---

LINE 1 POSITION 7 - SP DISABLED CHILD (SWSDISCHILD)

0	Does Not Apply
1	Child Disabled
2	Child Not Disabled
3	Not Required for Souse Eligibility
4	Disability Determination Required

LINE 1 POSITION 8 - SP CHILD QUALIFICATION (SWSCHILDQUAL)

Code	Meaning
0	Does Not Apply
1	Child Qualifies Spouse
2	Child Does Not Qualify Spouse
4	Determination Required

LINE 1 POSITION 9 - SP PREVIOUS MARRIAGE (SWSPRVMARR)

0	Does Not Apply
1	Reconciled
2	Not Reconciled
4	Reconciliation Required

LINE 1 POSITION 10 - SP MANUAL OP CODE (SWSMANOP)

0	OK For Award
2	No Award - Manual Examination Required

LINE 2 POSITION 1 - SP CERTIFICATION (SWSCERTIF)

0	None
1	Final Certification
2	Partial Certification
3	Recertification
4	In Force - Final
5	In Force - Partial
6	Denial

LINE 2 POSITION 2 -SP DUMP REASON (SWSDUMPRSN)

Code	Meaning
0	Does Not Apply
1	Incorrect SSA Number
2	Notice of Death
3	Overpayment May Occur
4	Claim Abandoned
5	Application Cancelled
6	Manual Partial Award
7	Other Including 951 Dump
8	Computer Dump
9	Requested - Reason Unknown

LINE 2 POSITION 3 - SP SMIB OPTION (SWSSMIBOPT)

0	Does Not Apply
1	1st Enrollment

2	No Response
3	No Election
4	1st Termination
5	2nd Enrollment (Yes)
6	2nd Termination (No)
7	SSA Jurisdiction
8	State Buy-In
9	Dual Annuitant

LINE 2 POSITION 4 - SP HIB (SWSHIB)

0	Does Not Apply
1	Eligible
4	HI - Record Created
6	Denied

LINE 2 POSITION 5 - SP HIB SMIB (SWSHIBSMIB)

Code	Meaning
0	Does Not Apply
1	Clearance Received - RRB Jurisdiction
3	Additional Clearance Required
4	Initial Clearance Required
5	None Required
6	Jurisdiction Not Determined

LINE 2 POSITION 6 - SP HIB DATE (SWSHIBDTE)

Code	
0	Does Not Apply
1	Spouse HIB Effective Date Set As Employee Date Attained Age 62

LINE 2 POSITION 7 - SP SMIB DATE (SWSSMIBDTE)

Code	
0	Does Not Apply
1	Assumed Date Furnished (Used For Code 8 Transfer - G-355e)

LINE 2 POSITION 8 - SP TRIC REQUEST (SWSTRICREQ)

Code	
0	Does Not Apply Or All Replies Received
1	Own SSA Number
2	Spouse Request Under Wage Earner's Number
4	Alleged SSA Claim Number 3rd Person's Number
3,5,7	Additive Combination of Above
8	951 Released To Examiner

LINE 2 POSITION 9 - SP ALLEGED SSA FILING (SWSALGSSAFIL)

Code	Meaning
0	Not Answered
1	Filed Under Own Account Number
2	No Filing
3	Filed Under Other Account Number

LINE 2 POSITION 10 - SP DATE OF MARRIAGE (SWSDOM)

0	Does Not Apply
1	Date of Marriage Applies
2	First Anniversary Applies
4	Determination Required

LINE 3 POSITION 1 - SP WINDFALL (SWSWINDFALL)

0	Does Not Apply
1	Insured As of 12-31-74
2	Insured As Of Last Year Worked
3	Not Vested
4	Vested On Another's Wages
5	Spouse Withheld
6	Vested On Another - EE Withheld

LINE 3 POSITION 2 - SP HIB-SMIB QUALIFICATION (SWSHIQUAL)

0	Does Not Apply
1	Employee Qualifies Spouse For HIB-SMIB
2	Employee Does Not Qualify Spouse For HIB-SMIB
4	Determination Required

LINE 3 POSITION 3 - SP WINDFALL WAIVER (SWSFWAIVER)

Code	Meaning
0	Does Not Apply
1	Waive Windfall
2	Do Not Waive Windfall

4	Answer To Windfall Waiver Required
---	------------------------------------

LINE 3 POSITION 4 - SP DIVORCED WIFE (SWSDIVRCEWIFE)

0	Does Not Apply
1	Divorced Wife Eligible
2	Divorced Wife Not Eligible

LINE 3 POSITION 5 - SP PUBLIC SERVICE PENSION (SWSPSP)

0	Does Not Apply
1	Entitled PSP (SSA Tax Not Ded't)
2	PSP Withheld
3	Examiner Requested Dump
4	Verification Required

9.3.12 Code Words On Alternate Request Screens 13,14 And 23 (Miscellaneous Data)

The following list includes an explanation of all the code words which can be found on REQUEST by pressing PF3.

A. Employee Miscellaneous Data

Mnemonic	Field Name
RECTYP	Record Type Code
DOEVER	Verified DOB
CODNME	Code Name
FILDTE	Filing Date (To change, use name and exam no) "EE996" and "ESA" for code
CALCABD	Calculated ABD
ENTPENDCDT	Date Entered Pending File

EEPDFINDTE	EE Paid Final Date
EEDESABD	EE Designated ABD
EEDLWRR	EE DLW Last RR Employer
EEDLWOUT (EELPSENDT1)	EE DLW Outside Employment
ESTDLWRR	Established DLW Railroad
TOTSUBSM	Total Subsequent Service Months
T2MSMOS	Tier II Military Service Months
GCYRMO	Grandfather Total Service
T2GRSPSMOS	Tier II Gross Prior Service Months
SUPABD	SUP Annuity ABD
EESANOFLD	EE SSA No. SSA App. Filed Under
EECLMSUF	EE SSA Claim Suffix
AWDRTPOPAR	Award Rate Paid on Partial
ABDPARTCRT	ABD of Partial Certification
VERLAGMOS	Months of Verified Lag
HIFILDTE	HI Filing Date
HIENTDTE	Date HI Record Entered
DISEFFDTE	Effective Date of Disability
TRICCODE	TRIC CODE
HICLRDTE	Date HI Clearance Created
RECOVBUSOC	Amount of BUSI Recovery On Original Cert.
CERTHRUDTE	DPA Cert. Through Date (Date of Last Service Month Currently Reported to DCC)
EERECURRT	EE Recurring Date

EEWDRECURRT	EE Work Deduction Recurring Rate
MSBEGDT1	M/S Beginning Date - Period 1
MSENDDET1	M/S Ending Date - Period 1
MSBEGDT2	M/S Beginning Date - Period 2
MSENDDET2	M/S Ending Date - Period 2
TYPCDLSTIT	Type Code Of Last Item Entered
LSTITMDTE	Date Last Item Entered
SPAMCD	Spouse PAM (Post Adjudication Module) Code
CREDPSMOS	Creditable Prior Service Months
EEOTHMSBEN	M/S Used For Other Benefits
FORM66AMC	Formula 66 AMC (IMPACT Rate)
RECOVBUSRT	Amount of BUSI Recovery on Recert
RESAMENDDT	Research Amendment Date
PAMCD	PAM Code
PAMSUPTICKDT EPAM SUP	Call-up Date
PAMTYPE	PAM Type Code
PAMSUPPDDTE	PAM SUP Paid Date

B. Spouse Miscellaneous Data

Mnemonic	Field Name
SPTYPECDE	Spouse Type Code
SPVERDOB	SP Verified DOB
SPDOMCLM	SP Claim DOB (When SPVERDOB Blank)
SPCODNME	SP Code Name

SPFILDTE	SP Filing Date (Requires "SP996" and "ESA")
SPABD	SP ABD
SPENTPEND	Date SP Application Entered Pending File
SPDESABD	Spouse Designated ABD
SPPDFINDTE	SP Paid Final Date
SPDLWRR	SP DLW In Railroad Employment
SPDOMARR	SP Date of Marriage
SPYCVERDOB	Spouse Youngest Child Verified DOB
SPMINCHLD	Spouse Minor Child
SPDISCHLD	Spouse Disabled Child
SPHICLRDTE	Spouse Date HI Clearance Created
SPHIFILDTE	Spouse HI Filing Date
SPHIENTDTE	Spouse Date HI Record Entered
SPTRICCCODE	Spouse TRIC Code
SPCLMSUF	Spouse SSA Claim Suffix
SPSSANO	Spouse SSA Number
SPSSACLMNO	Spouse SSA Claim Number
SPOCVERDOB	SP Oldest Child Verified DOB
SPPRTLABD	Spouse Partial ABD
SPPRTLAMT	Spouse Partial Amount
SPPRTLAWDDTE	Spouse Partial Award Date
SPTYPECDLSTIT	SP - Type Code Of Last Item Entered
SPLSTITMDTE	SP - Date Last Item Entered

9.3.13 Employee And Spouse Referral Messages

These messages are produced daily in the "RASI G-354A REF REPORTS" listing on HSL. Referrals are available for the ten most recent RASI runs. Messages are grouped as follows: Medicare, Age & Service, Disability, Dumps, Status Word Coding Errors. Within each group, numbers are in terminal digit order.

Except in cases where the referral message is self-explanatory, the appropriate action required follows each message. The messages are listed in alphabetical order for easy reference. Messages which begin with a number are listed alphabetically using the first letter of the first number. (Ex. - "953" would be listed under "N". Multiple numeric-series messages are listed in numeric order. Ex. - "950, 951, 953".)

- 045 ABD MONTH MORE THAN 24 MONTHS AFTER FILING DATE

RASI drops claim. Pay manually. Used for disability annuity applications - type code 500, 600 or 700.

- 076 ABD MORE THAN THREE MONTHS AFTER FILING DATE

RASI drops claim. Take appropriate action to deny annuity application.

- 038 ALL EVIDENCE IN - CHANGE MANUAL OP CODE TO ZERO

Examine REQUEST screens for accuracy of all information. Correct any inaccurate information. Prepare a 995 to clear man op.

- 216 APP CANCELLED - CHECK HI

RASI will drop application. Send folder to MPS for handling.

- 092 APPLICANT IS NOT EMPLOYEE'S SPOUSE****DENIAL****

A code 2 was entered in the "PM" box of the 933, causing RASI to drop case. Deny the annuity application.

- 521 BUSI INDICATES POSSIBLE GARNISHMENT - SPECIAL HANDLING REQ'D

The AA-1 indicates that the employee is not under an obligation to pay part of his/her annuity to a former spouse, but the BUSI pre-clearance indicates that a court order may be on file in that bureau. RASI will dump the case. The initial examiner will send the case to RPS-B2 with the note "BUSI indicates possible garnishment." Examiner will investigate and secure new BUSI clearance for payment. If it is found no garnishment is involved, RPS-B2 will forward case back to RIS for payment and new BUSI clearance will be secured.

- 308 BUSI RECOVERY EXCEEDS PARTIAL - CONVERTED TO INITIAL

This message is generated when the BUSI overpayment exceeds the partial accrual. RASI will zero-out the partial award and continue processing the case for final payment. No examiner action is required.

- 028 115 CASE CODED FOR MANUAL REVIEW

032 116 MANUAL OP CODED 2

023 017 IMPACT (SPAR) RATE ZEROED OUT

The G-230 is coded for manual handling. This referral gives the examiner an opportunity to review the case to determine if manual handling is necessary. If case can be processed mechanically, submit a 995 to change manual OP code to zero. If case should be handled manually, submit a 991 coded to dump case.

- 290 CASE DUMPED - DESIGNATED DECEMBER 31 ABD

60/30 employee age 60 or 61 in the ABD year has designated an ABD of December 31st. Because RASI would erroneously pay the Tier II COL increase based on January 1st of the next year, RASI will only pay the IMPACT rate, if any, and release a TRIC request.

Pay the case manually based on a December 31 ABD. The G-90 generated by RASI will have PIA's computed based on the ABD year as the eligibility year. Even though December 31 is the ABD, no accrual is payable until January 1 of the following year. Since December 31 is the ABD, do not pay the Tier II COL increase that would have been established as January 1 of the following year.

- 267 CASE DUMPED EE M/S REDUCTION OR M/S USED AS WAGES

This referral is produced in spouse-only cases if RASI receives a code from Research indicating that a military service reduction or military service used as wages was involved in the employee's annuity calculations. RASI will not calculate spouse annuity and will drop case.

- 247 CASE DUMPED - EE TIER II AMOUNT BEFORE VDB UPDATE NEEDED

RASI cannot compute the spouse's tier II because Research has already adjusted the employee's tier II for the vested dual benefit. Pay the spouse manually.

- 036 CASE DUMPED - WF PIA 7 IS ZERO-EE RR SERVICE PRIOR TO 1937

This message occurs in spouse-only cases when the employee's railroad service is all prior to 1937. Employee may have been erroneously paid as a conversion case. Since PIA 15 is based solely on railroad compensation through 1974, it should equal zero if there is no compensation after 1936.

Review employee computations. Recompute conversion rate using zero PIA's 15 and 7. The correct January 1, 1975 tier II amount should equal the December 1974 rate and the WF amount should equal zero.

Pay the spouse manually based on the corrected employee annuity computations.

- 067 CHILD NOT DISABLED - DENIAL

A Code 2 was entered in the "DIS" box of the 933, causing RASI to drop case. Deny the annuity application.

- 011 CHILD NOT ELIGIBLE - DENIAL

A Code 2 was entered in the "ELG" box of the 933, causing RASI to drop case. Deny the annuity application if spouse's eligibility is based solely on having a child in her care.

- 014 COMPENSATION REPORTED AFTER DLWCOMP LAST REPORTED (DATE)

This referral occurs when the SEARCH reply indicates that there are more than three service months after the DLW claimed on the RASI record, and either the last of the service months is within one year of the filing date, which could affect the ABD, or a 958 call up is in the record.

Investigate DLW claimed. If correct, request a dump of record and handle manually. If the DLW is incorrect, prepare a 996 to correct the DLW.

NOTE: If the SEARCH reply indicates less than 4 service months after the claimed DLW, RASI will accept the claimed DLW, but the compensation for those service months will be used in determining PIA's.

- 065 COMPUTER GENERATED DUMP

- 015 112 COMPUTER PROCESSING NOT FEASIBLE

RASI has dumped the case; handle manually.

- 375 299 CONSIDER ENTERING IMPACT (SPAR) DATA

This message will be produced when an application contains no partial rate information, the ABD has elapsed and the case is not pending final action.

Check "Remarks" on the G-230 to see if a reason was given for omitting a partial. Consider that, as well as the instructions given for IMPACT and SPAR rates in the 911 instructions in RCM 9.2, and enter a partial rate if possible.

NOTE: If the message is released for a spouse pending "Trace," meaning the employee is active as well, check to see if the employee is close to paying final before entering a partial rate. If the employee is pending final BUSI clearance, or a man op (995) which can be

cleared now, or 954, then entering a partial rate for the spouse will delay the spouse's final award. And the final award will be payable as soon as the employee's final award is processed.

- 057/126 DESIGNATED ABD INVALID

The ABD designated on the annuity application is an impossible date. If the application was keypunched correctly, develop for a correct designated ABD and prepare a 996.

- 191 DA RATED - WC/PD INVOLVED - (MISSING) SUBMIT 996 IMPACT NOW ZERO

This is a disability application for which RASI requires information regarding worker's compensation or public disability (MEGACAP) benefits. Item 124 (WC) or 125 (PD) of the AA-1 was either answered "yes" or was omitted. This message occurs after the rating on the G-325 has been received. Even if there is no benefit involved, RASI requires examiner input to clear the 996 call-up. Determine the effect of the benefit, if any, on the case (consult [RCM8.5](#)) and complete a 996 as follows:

WC Item	Entry
1-4	As usual.
5	"5"
6	"1" Offset is required and RASI must dump case. Pay final manually.) "2" (No benefit is in effect or no offset is required. RASI may continue processing.)
7	"EEWORKCOMPCD"
PD Item	Entry
1-4	As Usual
5	"5" Space out unused positions.
6	"1" (Offset is required and RASI must dump case. Pay final manually.) "2" (No benefit is in effect or no offset is required. RASI may continue processing.) Space out unused positions.
7	"EEPUBDISCD" Space out unused positions.

In either case, if no offset is required, re-enter the IMPACT rate if possible.

- 234/156 DOB AND SEX

230/152 NAME

231/153 NAME AND DOB

232/154 SEX

233/155 NAME AND SEX

235/157 NAME, DOB AND SEX DISCREPANCY ON G-90

Check G-90 for correct wage record and PIA's. If this information is not correct, dump case and handle manually. If all information is correct and discrepancies can be reconciled, submit 950 or 951.

- 278 DUAL ENTITLEMENT-CORRECT EMPLOYEE'S PREH RECORD

This referral is generated for either employee or spouse cases involving any dual annuitant. It alerts the examiner that PREH input is necessary when a spouse application is filed after the employee annuity is paid final. Entries need to be made on the employee

PREH record, screen 3200 (RHRRID) using the PREH correction system. The specific fields are DUAL-ANN-RED-TYP-CODE, OTHER-RRB-CLM-NO, OTH-BENF-TYP-CODE, AND OTH-BENF-AMT.

- 281 DUAL ENTITLEMENT-RR SERVICE BEFORE 1975

This referral is generated for either employee or spouse awards involving any dual annuitant. Determine if either employee has RR service prior to 1975. If yes, clear the 953 call-up and payment processing continues on RASI. RASI will then compute the tier two restored amount. If neither employee has RR service prior to 1975, drop from RASI and pay via p.c. award shell.

- 362 DUAL SPOUSE TAKEBACK DUMP

This message is generated in dual spouse cases with an ABD before 12-1-83 and an SS reduction effective 12-1-83. RASI is unable to compute the 12-83 takeback amount and so will dump these cases. Refer to RCM 8.8 for instructions on how to compute them manually.

- 198 EE ABD PIA 1 MISSING FOR RRA MAX TEST

RASI will generate this message in "spouse-only" cases where RASI is attempting to make the RRA Max test but the employee's PIA 1 information is missing. Examine the folder to determine the employee's PIA 1, excluding DRC's, as of the employee's ABD. Submit a

996 to enter this amount into RASI. Complete items 1 and 4 of the 996 as usual. Complete items 2-3 and 5-7 as explained below. In addition, enter the employee's ABD PIA 1, excluding DRC's, in the Remarks section of Form G-59 and forward it to Research.

Item	Entry
2	Enter "2".
3	Enter <u>spouse's</u> code name.
5	Enter "00000" (five zeroes) in the first <u>five</u> blocks. Space out the unused positions.
<u>AIME/TRANS PIA USED</u>	
6	Enter the PIA 1 amount, excluding DRC's, as of the ABD in the first <u>five</u> blocks. Enter only the dollar and dime amount. Use leading zeros if necessary. Space out the unused positions.
7	Enter "T1ABDPIA". Space out the unused positions.
<u>AMW PIA USED - NO M/S INVOLVED OR M/S USED AS WAGES</u>	
6	Enter the PIA 1 amount, excluding DRC's as of the ABD in the first <u>five</u> blocks. Enter only the dollar and dime amount. Use leading zeros if necessary. Space out the unused positions.
7	Enter "T1ABDPIA". Space out the unused positions.
<u>AMW PIA USED - M/S USED AS COMPENSATION</u>	
6	Enter the PIA 1 amount, excluding DRC's, as of the ABD in the first <u>five</u> blocks. Enter only the dollar and dime amount. Use leading zeros if necessary. Space out the unused positions.
7	Enter "T1MSABDPIA". Space out unused positions.

- 380 (381) EEDRRLST OR PRV MISSING. SUBMIT 996. (996 TRACED)

This message is printed when item 41 or 48 on the AA-1, the relinquishment of rights date for the employee's last or second-last railroad employer, is missing, and the application is for an age and service annuity. The case will not pay final until the date is submitted. This message will be traced every 45 days. Obtain the date through the district office and complete a 996 as follows: (Complete items 1-4 as usual. Space out unused positions.)

Item	Entry
5	"00000000" (eight zeroes)
6	Enter date in CCYRMODE order.
7	"EEDRRLST" or "EEDRRPRV."

Also instruct the district office to obtain Form G-88 certifying the date of relinquishment of rights. (See RCM 5.1.40.) Do not hold up payment for receipt of Form G-88.

- 366 EE FILING FOR 60/30, ITEM 26 MISSING ON AA-1
- 032 MANUAL OP SET

When this item has been left blank, RASI accepts the application and does not zero out the partial rate, but must make the following assumptions in order to continue processing.

1. If the applicant attains age 62 within three months of the filing date (or on or before), the ABD is set based on age 62. No Tier 1 reduction applies.
2. If the applicant does not attain age 62 within three months of the filing date (or on or before), the ABD is set based on age 60. The Tier 1 age reduction will apply.

(Other data such as designated ABD, DLW, etc., are still considered as usual.)

After this message has been produced, a 996 must be submitted to approve RASI's assumption, and a 995 must be submitted to remove the manual OP code and permit payment. If, as in the first case above, the ABD has been set based on age 62, and, is later than the earliest possible ABD, it is necessary to contact the district office to obtain the missing answer to item 26. Should the applicant choose not to use the later ABD, and opt instead for the earlier ABD despite the Tier 1 age reduction, the case cannot be paid on RASI. (See Note.)

- I. Complete the 996 as follows:

Item	Entry
1-4	As usual.
5	Always enter "0." Space out unused positions.
6	Always enter " <u>1</u> ." (See Note.) Space out unused positions.
7	Always enter "EEDSREDABD." Space out unused positions.

II.	Also complete a Form 995 to remove the manual OP code. (They may be submitted at the same time.)
-----	--

NOTE: A code "2" in item 6 will have no effect. If the applicant attains age 62 within three months of the filing date (or on or before), the ABD remains set based on age 62, whether acceptance of a reduced annuity is indicated or not. Likewise, if the applicant does not attain age 62 within three months of the filing date (or on or before), the ABD remains set based on age 60. To pay a case contrary to either determination requires manual handling.

- 409 EE REDUCED FOR NON-COVERED SVC PENSION - SPOUSE DUMPED FOR MANUAL HANDLING

130 COMPUTER GENERATED DUMP

This spouse-only has been dumped because the employee's annuity was paid with a reduction for a non-covered service pension, and the effective date of that reduction was later than the ABD. RASI cannot obtain the correctly reduced EE ABD PIA 1 to pay the spouse, so it must be handled manually.

- 314 EE RRA MAX MAY APPLY

RASI will issue this message in an employee-only case if preliminary testing indicates that the RRA MAX limitation may apply to the employee only. After verifying this by manually testing for the max, submit a 996. Code items 1-4 as usual. Complete items 5-7 as follows, and space out unused positions:

Item	Entry
5	Enter "4" in the first block.
6	If the RRA MAX applies, enter "1" in the first lock. This will generate a COMPUTE ONLY award, showing RRA MAX in the remarks section. Pay the ee manually.
If the RRA MAX does <u>not</u> apply, enter "2" in the first block. This will allow the award to pay without an RRA MAX reduction.	
7	Enter "EERRAMAXCD."

- 199 EE T1 MISSING FOR RRA MAX TEST

RASI will generate this message in "spouse-only" cases where RASI is attempting to make the RRA Max test but the employee's ABD gross tier one information is missing. Examine the folder to determine the employee's gross tier one, including any DRC's, as of the

employee's ABD, to enter this amount into RASI. Complete items 1 and 4 of the 996 as usual. Complete items 2-3 and 5-7 as follows:

Item	Entry
2	Enter "2".
3	Enter <u>Spouse's</u> code name.
5	Enter "000000" (six zeroes) in the first six blocks. Space out unused positions.
6	Enter the gross tier one amount, as of the ABD, in the first six blocks. Include dime and cent amounts. Use leading zeros if necessary. Space out unused positions.
7	<ul style="list-style-type: none"> • If an <u>AIME/TRANS PIA</u> was used, enter "T1ABDGRSAMT." • If an <u>AMW PIA</u> was used and <ul style="list-style-type: none"> • M/S was <u>not used</u> or was used as <u>wages</u>, enter "T1ABDGRSAMT." • M/S was used as <u>compensation</u>, enter "T1MSABDGRSAMT." Space out unused positions.

- 218 EMPLOYEE CALCULATION ERROR - SPECIAL HANDLING REQ'D

Notify P/P&S-RAC via e-mail.

- 403 EMPLOYEE FELONY CONVICTION INDICATED - SP MANUAL OP CODED 2

Use RCM 6.3.7, Prisoner Conviction Cases, to determine the effect of an offense punishable by imprisonment for more than 1 year on the annuity.

- 258 EMPLOYEE PAID FINAL (DATE) - CODED FOR IMMEDIATE DUMP
- 257 EMPLOYEE PREV DUMPED - CASE NOW CODED FOR IMMEDIATE DUMP

These referrals are produced when a 991 is submitted to dump a case which has already been paid (or dumped with a retention period), but an immediate dump has now been processed.

- 034 EMPLOYEE PREVIOUSLY FILED FOR RRB BENEFITS

Item 104 of AA-1 indicates that applicant previously filed for another RR Act benefit. Application has been accepted, but manual OP code has been entered to prevent payment. Obtain the claim file and document the claim file as explained in RCM Part 11, "Form G303 Instructions."

If no overpayment recovery is necessary from the employee annuity, change the manual OP code to zero.

- **009 EMPLOYEE'S RESEARCH RECORD NOT UPDATED WITH LATEST COL**

RASI will generate this message in "spouse only" cases where the employee's research record has not been updated with the latest COL increase. Dump the case and handle manually. If the employee annuity has not yet been handled for the latest COL, recertify the employee case to pay the COL increase.

- **317 EXCESS TAX REFUND PAYABLE**

An excess tax refund may be payable if the employee is not vested. If a tax refund is payable, use Form G-357 as explained in RCM 8.6 and RCM 5.13.

- **052/062 FED EMP IN LAST (NEXT-TO-LAST) NON-RR WORK IS MISSING - 996 REQUIRED**

- Item 60 (65) of Form AA-1 has been keyed incorrectly or left blank. Obtain the correct answer either from the AA-1 or by contacting the district office, and enter it into RASI as follows:

Item	Entry
1-4	Usual
5	"0" (zero). Space out unused positions.
6	"1" (YES), or "2" (NO) Space out unused positions.
7	"EEFEDEMPAFTDLW" (item 60) "EEFEDEMP2" (item 65). Space out unused positions.

- **363 406 FELONY INVOLVED - CASE DUMPED**

The examiner has indicated to RASI on a 996 that there is a felony involved which will affect the payment of this case. See RCM 6.3.7, Prisoner Conviction Cases.

- 359 400 FELONY INVOLVED - SUBMIT 996 - IMPACT (SPAR) NOW ZERO

The applicant has answered "yes" to item 19 on the AA-1 or AA-3, the question regarding felony. Use RCM 6.3.7, Prisoner Conviction Cases, to determine the effect of the prisoner conviction on the annuity. When this determination is complete, submit a 996 as follows:

Item	Entry
1-4	Usual
5	"0" (zero). Space out unused positions.
6	"1" (Clear call-up and continue processing.) or "2" (Dump case.) Space out unused positions.
7	"EEFELONY" or "SPFELONY." Space out unused positions.

If processing can continue, consider re-entry of the partial rate.

- 211 G-88A.2 REQUIRED - TRACE

For non-advance file cases, this message will be released 45 days after the date the case entered RASI. For advance file cases, it will be released 45 days from the employee's date last worked for the railroad.

If the G-88A.2 is still outstanding and lag service is required for eligibility (see G-88A.2 instructions in RCM 9.2.10), trace as usual with Form G-234 through the district office in the railroad's area. The address of the railroad to which the G-88A.2 was mailed is shown on the G-230.

If the G-88A.2 is in file, submit the data to RASI to clear the 958 call-up.

If lag service is not needed to establish eligibility, notify P/P&S-RAC via e-mail message that the 958 call-up should be removed.

NOTE: If an application becomes delayed pending the receipt of the G-88A.2 and the employee has military service which may be sufficient to establish eligibility, message #212 - "Consider M/S Use," will also be printed. If it appears the military service may establish eligibility without the lag service, notify P/P&S-RAC via e-mail message that the 958 call-up should be removed. Notate the file that if the military service does not establish eligibility the lag service data should be traced.

- 306 G-325 DIS EFF YR GREATER THAN TRIC ABD YEAR

In disability cases, RASI will release a TRIC request, before receiving Form G-325, based on an assumed ABD. If the G-325 indicates a disability effective year later than the assumed ABD, RASI will drop its original TRIC request and request a new TRIC reply based on the disability effective date. Once this new TRIC reply is received, RASI will continue to process the case. Consider paying IMPACT rate pending TRIC reply.

- 075 HANDLE SUP MANUALLY - ACTIVATED

Manually award or deny supplemental annuity.

- 022 IMPACT RATE INVALID - RATE NOW ZERO - 911 REQUIRED

The partial rate entered on Form G-230 is invalid. Determine the correct partial rate and enter it into RASI.

- 018 113 IMPOSSIBLE CODE IN RECORD

Send the claim number to P/P&S-RAC via e-mail message, indicating the reason for the referral.

- 048 121 INQUIRY PER EXAMINER

A 991 was submitted requesting a computer printout of an annuitant's record.

- 006 INSUFFICIENT SERVICE***DENIAL****

If employee has less than 120 months of service and no military service is involved, RASI will drop case. A mechanical match of employee's claim number with BCC's records indicates employee does not have sufficient subsequent service. If further service cannot be verified, deny annuity claim.

- 214 INTERNAL CODING ERROR - SPECIAL HANDLING REQ'D

Notify P/P&S-RAC via e-mail.

- 078 INVALID DATES FOR SETTLEMENT OR PAY FOR TIME LOST

Item 49 on the AA-1 is "YES," but 50 has been omitted or completed incorrectly. If the information is shown in documentation in file, enter the correct date on a 996 using the field name "EERR-SETTL-DATE." (Use spaces instead of hyphens.) Also correct the DLW and DRR if necessary. Otherwise, develop the information through the D/O. If item 49 should have been "NO," no further action is necessary. If the information is received after the case pays final and a settlement or pay for time lost is involved, the ABD can be no earlier than the last day of the period involved. If the ABD is affected, correct it and the DLW and DRR, if appropriate, and handle any overpayment as usual.

- 047 INVALID ENTRY FOR SETTLEMENT OR PAY FOR TIME LOST

Item 49 is blank or "NO," but 50 contains valid dates. Determine whether a settlement is involved by checking documentation in file or by contacting the D/O. If there is a settlement, complete a 996 as follows to change the answer to item 49 to "YES": (Space out unused positions.)

Item	Entry
1-4	Usual
5	"0" if blank (zero); "2" if "No."
6	"1" (Yes.)
7	"EERR-SETTLEMENT." Use a space instead of a hyphen, and space out unused positions at the end of the word.

If there is no settlement involved, and item 50 should have been blank, no further action is necessary. If the information is received after final payment, handle as for the previous referral.

- 377 LAG SERVICE NOT REQUIRED FOR ELIGIBILITY. 958 CODED ON G-230

RASI has determined that lag service is not required to establish eligibility, but the G-230 indicates that the D/O released a G-88A.2 for service information. RASI will not establish a 958 call-up, and will continue regular processing.

- 376 LAG SERVICE REQUIRED FOR ELIGIBILITY. NO 958 CODE ON G-230. RELEASE G-88A.2

RASI has determined that lag service is required to establish eligibility for a regular annuity, but the G-230 data indicates that the D/O did not release a G-88A.2 for service information. RASI will process the case as if the 958 code had been passed and pend for receipt of the G-88A.2 before releasing the TRIC request.

Prepare a G-88A.2 (or 2, if the employee has two lag employers) for release to the railroad employer(s) shown in item(s) 34 (and 40) of the AA-1. See RCM 9.2.10, G-88A.2 Instructions, if necessary.

If lag service is not required to establish eligibility for a regular annuity do not release a G-88A.2. Notify P/P&S-RAC via e-mail that the 958 call-up should be removed.

- 016 LEGAL PROCESS ISSUE – CONSIDER LEGAL PROCESS QUESTION – SUBMIT 996

This referral is generated when RASI first encounters a legal process case on the imaged file. The referral needs a response via a miscellaneous correction (996) in Keyprod. The screen needs to be completed as follows:

1. EE SSN
2. PAYEE CODE
3. CODE NAME – ee996 or sp996
4. EXAM NO – esa
5. PRESENT CONTENTS – I (lower case L)
6. CHANGED CONTENTS – If legal process is an issue and a partition or garnishment payment will be made, code this as Y. This will force RASI to dump the case and referral 030 is then generated.

If a legal process payment will not be made or if legal process is not an issue, the CHANGED CONTENTS should be coded as N. The partial payment is restored mechanically and RASI will continue processing.

7. FIELD NAME – legalprocess
- 030 LEGAL PROCESS APPLICABLE – MANUAL HANDLING REQ'D – CASE DUMPED

This referral is generated when referral 016 is answered Y. Pay the case manually on ROC

- 036 LEGAL PROCESS FOR INACTIVE MASTER FOUND

This referral is generated if RASI encounters a number on the legal process list and the RASI master is inactive (paid final or dumped). Please check the Imaging system or the file to see if legal process applies. Take action if necessary. This referral serves as an alert and does not need to be cleared if no action is necessary.

- 372 MARITAL STATUS MISSING OR INCORRECT - SUBMIT 996

Item 9 of AA-1 omitted or keyed incorrectly. If the correct information can be obtained while the case is still active, submit it on a 996. Complete 1-4 as usual. Complete 5-7 as follows:

Item	Entry
5	"0" (zero). Space out unused positions.
6	Enter "1" if EE is married. Enter "2" if EE is not. Space out unused positions.
7	"EEMARTSTAT." Space out unused positions.

RASI issues this referral only once, and does not control for a reply. If the information is received after the case has paid final, use a G-59 to submit it to Research.

- 005 MORE THAN 4 PERIODS OF M/S. CONSOLIDATE OR HANDLE MANUALLY

Neither RASI nor SEARCH can handle more than four separate periods of military service. When this message is released, a 996 call-up will be set and no TRIC request will be released until a change is made to the number of periods involved. A tracer message will be released every 30 days. Determine whether the M/S can be reduced to four or less periods, and, if it can, notify P/P&S-RAC via e-mail. Indicate the reason for the referral and give instructions for consolidation. P/P&S-RAC will make the necessary changes to permit release of the TRIC request. If the M/S cannot be consolidated to four or less periods, the case will require supervisor review.

- 088 M/S CREDITABLE AS COMP - NO M/S MOS - PAY MANUALLY

Because M/S months overlap with RR service months, only M/S compensation can be used in the computations. RASI will dump the case and examiner should pay manually.

- 319 M/S DISCHARGE - REVIEW

RASI generates the above referral and sets a man op code when an other than honorable discharge is indicated by the field. Review the service record submitted and determine M/S creditable as either wages or comp. Refer to RCM 5.4.33-34.

If M/S is creditable, clear the MAN OP CODE. If the entire period of M/S or any portion thereof is not creditable as either compensation or wages, determine how the G-90 is set to use M/S and allow the case to pay on RASI, or dump the case accordingly.

- 379 MS-INTERV-CODE MISSING OR INVALID

RASI has no AA-1 data regarding intervening earnings after M/S in the period 6/15/1948 - 12/15/50. This affects one or more codes used in the SEARCH request. Obtain the correct answer to item 29 of the AA-1. Prepare a 996 for each voluntary MS period overlapping the 1948-50 time period. Complete items 1-4 as usual, and items 5-7 as follows:

Item	Entry
5	"0"
6	"1" if EE had the earnings in question. "2" if EE did not.
7	"MS-INTERV-EARN1" if the earliest M/S period overlaps 6/15/48-12/15/50. (Use ending digits 2, 3 or 4 as appropriate for subsequent M/S periods.)

- 208 M/S REQUIRED FOR VDB ELIGIBILITY

RASI will drop case. The employee claimed more than one period of M/S or M/S extends beyond 12-56. See RCM 5.4.67A for complete instructions on handling this referral.

- 378 MS-V-48-50 MISSING OR INVALID

RASI has no data regarding voluntary M/S in the 1948-1950 period. Obtain the correct answer to item 28 of the AA-1. Submit a 996. Complete items 1-4 as usual, and items 5-7 as follows:

Item	Entry
5	"0" (zero)
6	"1" if EE had voluntary M/S in the period 6-15-48 to 12-15-50. "2" if EE did not.
7	"MS-V-48-50" Use spaces instead of hyphens. Space out unused positions.

- 094 137 NAME OR ADDRESS CHANGE REQUIRED

A previous referral requested a specific name or address change. This referral is a tracer, indicating that the change has not yet been made. (A common error to be corrected is failure to include a ZIP code address entry.) Prepare a 997 if a partial award has not been made. If a partial payment has been awarded, prepare a 997 and G-607.

- 206 143 NAME/ADDRESS CHANGE OR REP PAYEE REQUIRED

Submit a 997 to correct RASI; if a partial payment is in force, also correct CHICO.

- 049 NCSP MAY APPLY - CHECK YOC

This message is generated when the employee answers "Y" for Non-Covered Service Pension on the APPLE Recurring Annuities Screen.

RASI automatically sets a man-op code once the TRIC request is released. This allows payment of the IMPACT rate entered on the APPLE summary screen but prevents **final** payment. Examiner action to clear the man-op code is necessary to allow for final payment.

Secure the Employee's Creditable Service and Earnings Yearly Total Screen from EDMA. For each year of earnings on EDMA, determine if the employee can receive a year of

coverage (YOC). Refer to the instructions and chart in RCM 8.11, Appendix M to compute the YOC when determining the PIA reduction for an NCSP.

1. If the employee has at least 30 years of coverage (YOC), he/she is exempt from the modified benefit formula calculation required for NCSP cases. No further action is required and the man-op code may be cleared.
2. If the employee has less than 30 years of coverage YOC, follow the instructions indicated below:

If the YOC is less than 30, and the employee does not fit any of the exemptions listed in RCM 1.1.17, and the PSP has already been paid or is about to be paid (per RCM 1.1.18), dump the employee (and spouse if applicable) from RASI, calculate the NCSP reduction, and award the annuity on ROC. The information required to make these determinations is contained on Form G-209. Instructions for manual processing are in RCM 8.11.76.

- 411 933 REQUIRED FOR SPOUSE DIS

The AA-3 indicates that the spouse is filing based upon having the employee's disabled child in his/her care. Submit a 933 according to the instructions in RCM 9.2, after a disability determination has been made.

- 412 933 REQUIRED FOR SPOUSE PM

The AA-3 or AA-7 indicates that either the spouse or the employee has a previous marriage. Submit a 933 according to the instructions in RCM 9.2.

- 413 933 REQUIRED FOR SPOUSE DOM

The AA-3 or AA-7 indicates that the employee and spouse do not meet the one year marriage requirement as of the filing date. Submit a 933 according to the instructions in RCM 9.2.

- 414 933 REQUIRED FOR SPOUSE ELG

This will be printed with message 411 when the AA-3 indicates that the spouse is filing based upon having the employee's disabled child in his/her care. It will be printed alone when the AA-3 indicates that the spouse is filing based upon having the employee's minor child in his/her care. Submit a 933 according to the instructions in RCM 9.2, for "Retirement Applications."

- 415 933 REQUIRED FOR SPOUSE MEDICARE

This is printed in all AA-7 cases. Submit a 933 according to the instructions in RCM 9.2, for "Medicare Applications."

- 417 933 REQUIRED - TRACE

Previously requested 933 data is still outstanding. Check previous referrals in file, or REQUEST Screen 22 to see what spouse information is required. (One or more of these items - DIS, PM, DOM, ELG, will be coded "4.") Submit a 933 according to the correct item instructions in RCM 9.2.

- 383 947 REQUIRED - FED EMP AFTER DLW-RR

The AA-1 indicates that the employee last worked for a federal agency. Check FOM1 225.35B to see if the federal agency is one for which earnings do not break a C/C:

If it is, enter "1" according to the instructions in RCM 9.2 (C/C - Yes). After the case has paid final (or for manual final payment), it will be necessary to compute an indexed AMC.

If it is not, make a C/C test considering the earnings as usual. Then enter the results according to the instructions in RCM 9.2, and no further action is necessary.

- 500 947 REQUIRED FOR C/C

This is produced when a current connection cannot be determined mechanically. Submit a 947 according to the instructions in RCM 9.2.

- 385 947 REQUIRED - NO C/C ASSUMED

RASI will produce this message when it appears that the employee has broken his/her current connection with the railroad industry. Make a C/C test and enter the results according to the instructions in RCM 9.2.

- 384 947 REQUIRED - POSSIBLE CANADIAN EMP

This message is produced when the AA-1 indicates that the employee may be a Canadian in the service of a U.S. employer in Canada. Check the employee's address. If he/she resides in Canada, check the instructions in RCM 5.5.7 regarding these employees then make the C/C test and enter the results according to the instructions in RCM 9.2. If he/she does not reside in Canada, make the C/C test and enter the results as usual according to the instructions in RCM 9.2.

- 382 947 REQUIRED - POSSIBLE DEEMED C/C

It appears that the employee has broken his/her current connection with the railroad industry, but the AA-1 indicates that the employee may be eligible for a "Deemed C/C" for supplemental and survivor annuity purposes. Evaluate per instructions in FOM1 225.45, and enter the results according to the instructions in RCM 9.2.

- 502 947 REQUIRED - TRACE

A current connection determination was previously requested, and is still outstanding. Submit a 947 according to the instructions in RCM 9.2.

- 503 948 REQUIRED FOR R/C

Board records indicate possible Redcap service. Submit a 948 according to the instructions in RCM 9.2.

- 504 948 REQUIRED FOR TR

Item 80 of the G-90 contains "RCU," indicating that railroad compensation may be in use at SSA. Submit a 948 according to the instructions in RCM 9.2.

- 505 948 REQUIRED - TRACE

Information regarding possible R/C or TR involvement was previously requested, and is still outstanding. Check previous referrals in file, or REQUEST Screen 12 to determine which applies, and submit a 948 according to the instructions in RCM 9.2. (If "REDCAP" is coded as "2," RC applies; if coded "3," TR applies.)

- 040 060 950 (951) REQUIRED ABD

- 276 277 950 (951) TRACED ABD

RASI is requesting social security benefit data. This referral will be produced every 90 days until the benefit data has been submitted. See RCM 9.2 for instructions.

- 407 953 REQUIRED

This message was generated and a 953 call-up was set because the spouse indicated that (s)he previously filed an application with the RRB and the claim number of that application is not the employee's claim number. Submit a 953 as described in RCM 9.2.

- 408 953 TRACED

See instructions for "953 REQUIRED." This message will be produced every 30 days until the data has been received.

- 506 954 REQUIRED FOR PENSION - MS

or

- 508 954 REQUIRED FOR PENSION

Pension information is required before the supplemental annuity can be paid.

When the message includes "MS," the Tier 2 rate shown may not include military service. Check REQUEST Screen 11, and, if the Tier 2 rate shown differs, use that Tier 2 to complete the annuity rate information on Form G-88p.

When the pension information is available, submit a 954 according to the instructions in RCM 9.2.

- 507 954 REQUIRED FOR PENS CD - MS

or

- 509 954 REQUIRED FOR PENS CD

Pension and closing date information is required before the supplemental annuity can be paid. When the message includes "MS," the Tier 2 rate shown may not include military service. Check REQUEST Screen 11, and, if the Tier 2 rate shown differs, use that Tier 2 to complete the annuity rate information on Form G-88p.

If the pension information is available, submit a 954 according to the instructions in RCM 9.2.

- 510 954 REQUIRED FOR CD

Closing date information is required before the supplemental annuity rate can be paid. Submit a 954 according to the instructions in RCM 9.2.

- 511 954 REQUIRED - TRACE

Information required to pay the supplemental annuity was previously requested, and is still outstanding. Check previous referrals in file, or REQUEST Screen 12. (The status word SUP PENS will show "3" when only pension information is required; it will show "5" when both pension and CD information is required. Submit a 954 according to the instructions in RCM 9.2.

- 360 957 REQUIRED - PUBLIC SERVICE PENSION INDICATED - SPAR T1 NOW ZERO

RASI will generate this referral when item 104 of the AA-3 has been answered "Yes," or "G-208" is indicated on the G- 230. If a SPAR was entered, RASI will zero out Tier 1, but will pay Tier 2. Consult RCM 1.3 to determine the effect the public service pension will have on the annuity, then complete a 957 screen according to instructions in RCM 9.2.9.

The PSP reduction will be effective from the first day of the month if the month is within the accrual period for the RASI award or the ABD. The reduction will be the first reduction made in the spouse's gross Tier 1 amount. The amount of the reduction will be shown on the award form.

- 410 957 TRACED

See instructions for "957 Required - Public Service Pension Indicated." This message will be repeated every 30 days until the data has been received.

- 042 120 996 INPUT REQUIRED - CHECK PREVIOUS MSGS - EE (SP)

This is a tracer referral produced when information previously requested in a referral message is still outstanding. 996 input is required to provide the information and clear the 996 call-up.

Check the file for a G-805 notice of rejected input or a previously unanswered referral message to determine what is required. If neither of these is available, review the status words on REQUEST Screen 12 (22) or the application for areas which may have required development (Status Word SWE(S)FELONY still shows "4"; application indicates federal employment, workers comp/public disability benefits; data for spouse RRA MAX test outstanding, etc.).

If there is nothing in the file to explain the cause for the referral, send an inquiry via e-mail to P/P&S-RAC.

- **368 996 REQ - CHILD CARE ITEM (123) MISSING**

Submit a 996 to furnish the answer to the AA-1 question. Complete items 1-4 as usual. Complete items 5-7 as follows:

Item	Entry
5	Enter "0" (zero) in first block. Space out unused pos.
6	Enter "1" if answer is "Yes." Enter "2" if answer is "No." Space out unused pos.
7	Enter "EEDISCHLDLW." Space out unused pos.

- **261 996 REQ - FURN ANS TO CLAIM WITH OTHER AGENCY BASED ON M/S**

Submit a 996 to furnish RASI with the answer to item 30 of AA-1. Complete items 1-4 as usual. Complete items 5-7 as follows, spacing out unused positions:

Item	Entry
5	Enter "0" (zero) in the first block.
6	Enter "1" if the answer is "Yes." Enter "2" if the answer is "No."
7	Enter "EEOTHMSBEN."

- 370 996 REQ - PUBLIC DISABILITY ITEM 125 MISSING IMPACT NOW ZERO

Item 125 of the AA-1 is missing. When this has been omitted, RASI generates this referral and zeroes out the IMPACT rate. To prevent an overpayment, RASI assumes Public Disability is involved and also prints message #190, "WORKER'S COMP/PUBLIC DISABILITY DEVELOPMENT REQUIRED. IMPACT NOW ZERO." If P/D is involved, wait for message #191 to be printed after the rating data has been processed. Follow the instructions for that message. (#191 - DA RATED - WC/PD INVOLVED (MISSING). SUBMIT 996. IMPACT NOW ZERO.)

If P/D is not involved, complete a 996 as follows, spacing out unused positions. Complete items 1-4 as usual. Complete items 5-7 as follows:

Item	Entry
5	"1"
6	"2"
7	"EEPUBDISIND." Re-enter IMPACT on screen 911.

NOTE: When PD is not involved, it is not necessary to wait for the rating to enter this data.

- 369 996 REQ - WORKER'S COMP ITEM 124 MISSING. IMPACT NOW ZERO

Item 124 of the AA-1 is missing. RASI will generate this referral and zero out the IMPACT rate. To prevent an overpayment, RASI assumes Worker's Comp is involved and also prints message #190, "WORKER'S COMP/PUBLIC DISABILITY DEVELOPMENT REQUIRED. IMPACT NOW ZERO." If W/C is involved, wait for message #191 to be printed after the rating has been processed. Follow the instructions for that message (191- DA RATED - WC/PD INVOLVED (MISSING). SUBMIT 996. IMPACT NOW ZERO.)

If W/C is not involved, complete a 996 as follows, spacing out the unused positions. Complete items 1-4 as usual. Complete items 5-7 as follows:

Item	Entry
5	"1"
6	"2"
7	"EEWCIND"

Re-enter IMPACT on a 911 screen.

NOTE: When WC is not involved, it is not necessary to wait for the rating to enter this information.

- 512 998 REQUIRED FOR P/S

This message is released when the employee has claimed prior service on the AA-1. Submit a 998 according to the instructions in RCM 9.2, for "Retirement Applications."

- 513 998 REQUIRED FOR 120 MOS

This is released when an AA-6 has been filed, and Board records indicate that the employee has less than 120 service months on file. Submit a 998 according to the instructions in RCM 9.2, for "Medicare Applications."

- 514 998 REQUIRED FOR POA

This is released when the proof of age attached to an AA-6 has a weight less than 30. Submit a 998 according to the instructions in RCM 9.2, for "Medicare Applications."

- 515 998 REQUIRED - TRACE

Retirement Case - Prior service information which was previously requested is still outstanding. Submit a 998 according to the instructions in RCM 9.2 for "Retirement Applications. "

Medicare Case - POA or service information was previously requested, but is still outstanding. Check previous referrals in file to determine which is applicable, and submit a 998 according to the instructions in RCM 9.2, for "Medicare Applications."

- 104 NO CURRENT CONNECTION

- 105 NOT CURRENTLY ENTITLED TO SUP

This message occurs when RASI is processing a SUP case and has determined there is no current connection. RASI will deny the SUP and generate code paragraph 406A to inform the employee of the denial.

- 223 NO REL OF RTS INFO FOR EE. GET G-88

This referral message occurs in spouse-only cases in which the employee was awarded a disability annuity under the provisions of the 1974 Act, the filing date was 12-31-76 or earlier, there is no ROR on file and the ee is not age 65 on the spouse's ABD. Take action as outlined below, depending upon the revision date of the AA-1d on file.

1. Revision date of AA-1d is before 5-76

- a. Instruct F/O to obtain Form G-88 from the employee. (See RCM 5.1.40.)

NOTE: Effective with a revision date of 10-92 or later, the Form G-346, Employee Authorization, includes a statement authorizing the Board to relinquish his/her rights when the annuitant's spouse becomes entitled to an annuity. If such is the case, a Form G-88 is not required. Continue with processing as described in -d- below.

- b. Set a manual op code to hold the case from paying final until the G-88 is received.
- c. Remove manual op code when G-88 is received.
- d. An award message will be printed on the final award, saying to release an RL-13g.1 to the employee's last RR employer. If the spouse will not be paid final on RASI, the letter should be released when the G-88 is received.

2. Revision date of AA-1d is 5-76 or later, or revision date of G-346 is 10-92 or later.

For these cases, relinquishment of rights is automatic when the spouse becomes entitled to an annuity. No G-88 is required. An award message will be printed saying to release an RL-13g.1. Handle as described in #1-d, above.

NOTE: If the employee has submitted a signed statement to override the ROR clause on the AA-1d, handle the case as described in #1a-d, above.

- 026 NO SERVICE REPORTED AFTER 1936

RASI will not drop case. The cause of this referral is often an incorrect SS number. If this is the case, dump application, verify number, and resubmit case to RASI under correct number. If 120 months of service cannot be verified, deny annuity application.

- 003 NOT DISABLED - DENIAL

RASI will drop a case when a G-325 is coded "not disabled," and applicant is not eligible for an age and service annuity. Prepare denial letter.

- 354 NOT DISABLED - WILL PROCESS AS A&S ANNUITY - SUBMIT NEW IMPACT

If an EE filing for a D/A is denied, the case can convert to A&S processing based on the age and service information in file. (If the EE is ineligible for an A&S, or if the EE is entitled only to a reduced annuity, and has indicated on the AA-1 that this is not acceptable, the case will be dumped as usual.) If the DRR is missing, RASI will use the filing date in its place. If TRIC has been requested, a new TRIC request will follow the reply to the previous. Unpaid IMPACT data will be zeroed out. A review message will appear on the award form. Re-enter IMPACT rate on 911. Release a letter to the applicant stating that the disability application has been denied, but that (s)he will now be considered for an age and service annuity.

- 217 147 NOT ELIGIBLE FOR HIB - DENIAL

Deny AA-6 or AA-7.

- 200 NOTIFY RESEARCH - EMPLOYEE COMPUTATIONAL DATA MISSING 932 CALL UP

The absence of a G-90 date on a manual employee conversion award produces this message. Route this referral to Research with the folder. Research will secure correct G-90 tape to update record.

- 004 150 SUBMITTED SUPP PREVIOUSLY PAID (DATE) CASE DUMPED

150 data was submitted for a case in which the supp has already been paid.

- 207 183 PAM INDICATES SS BENEFIT - NO RECORD ON MBR

PAM has received a SSADTS transmission indicating SS entitlement, thereby triggering RASI to request social security benefit data even though the G-90 shows "NO MBR ON FILE."

The referral will be produced only once, however it will generate a 950/951 call-up which will not clear until the data is submitted.

- 226 148 PARTIAL RATE INDICATED ON G-90

TRIC shows that the SS benefit being paid is a partial rate. Determine the correct SS benefit rate and enter the data.

- 201 POA EMPLOYEE/ 202 SPOUSE/ 203 CHILD/ 204 PROOF OF MARR REQUIRED - NOT YET RECEIVED HQ

These proofs have not yet been entered into RASI. Secure proofs and submit a 900. These tracing referrals will be produced every 60 days until the proof is submitted. Note: If a spouse has filed on the basis of a disabled child, or if the spouse is entitled without a minor child in care, do not submit POA. Take action described in the instructions for the reject referral "CHILD DOB DOES NOT MATCH CLAIMED DOB" in RCM 9.3.14.

- 080 POSSIBLE AERO RECOMP - PAY SPOUSE MANUALLY

This referral messages is produced in spouse-only cases when the employee Research record has been updated with RECOMP PIA's and the spouse has an ABD prior to the updated year. Since RASI would calculate the spouse's annuity from her ABD, based on the RECOMP PIA's RASI will dump the case to avoid a possible overpayment.

- 209 163 POSSIBLE DUAL SOCIAL SECURITY

Two or more TRIC requests have been received, each with rate and date information and each for a different account number. Secure the correct social security reduction amount and submit the data.

- 096 POSSIBLE DUPLICATE EARNINGS - SPECIAL HANDLING REQ'D

This referral is produced in cases involving a BA number which has known reporting problems having wages posted to a problem year (see RCM 9.3, Appendix E, Duplicate Earnings Table for a current list of these BA numbers). For handling instructions, refer to RCM 9.14.110, POSSIBLE DUPLICATE EARNINGS BA 9999.

Item 18 of the AA-1 has been answered "Yes," indicating that there may be a court order in effect which could affect how the annuity should be paid. A manual op code has been set to prevent final payment, and, if an IMPACT was entered, it has been zeroed out. No partial payment should be made at this time.

When the G-90 is received, forward the case to the BCS for their action. If necessary, they will dump the case for manual payment. However, if their records indicate that no special action is required, i.e., there is no court order on file at the Board, they will return the case indicating so. Clear the man op code and allow the case to process as usual.

- 024 POSSIBLE RED CAP SERVICE

This referral is produced when a Code 1 is entered in the "RC" box on a 948 causing RASI to dump case.

- 051 POSSIBLE W/D - NO SPAR

To avoid possible overpayments, RASI will not pay a partial rate in cases where excess earnings are indicated.

- 229 151 POST-ENTITLEMENT ACTION REQUIRED

This referral indicates that SSA is taking some action to adjust benefit rates. Secure correct rate before submitting the data.

- 002 PROOF OF MS REQUIRED - ABANDONMENT WILL OCCUR IN 30 DAYS

This referral is produced 30 days after RASI initial call-up for proof of military service has expired.

- If military service is needed for ELIGIBILITY, this referral will be produced. If military service has not been entered 30 days later, the referral will be abandoned and RASI will process case without military service.
- If the military service has not been entered within 30 days, this referral will not be produced. RASI will process case without military service. Screen 12 of REQUEST will show: M/S – 2 CLAIM ABANDONED.

- 031 PROOF OF M/S SUBMITTED, M/S PREV ABANDONED

A 900 with proof of M/S was entered into RASI, but the information was rejected because it came in after the call-up for M/S was abandoned. RASI will process the case without M/S. Control the case to include after the award. If it is required for eligibility, dump the case and handle it manually.

- 021 RATED 2A4 NO C/C 307 CASE NEEDS TO BE RATED 2A5

If current connection determination is correct, send case to DPS to determine if a total and permanent disability rating is possible. RASI will set a 60-day call-up for receipt of a G-325 and continue this call-up until some disability rating is received. If a total and permanent disability rating is granted, RASI will continue to process case. If a total and permanent disability rating is denied, RASI will dump claim.

- 053 124 REPRESENTATIVE PAYEE NOT YET NAMED

There is an indication on the annuity application or on the G-325 that there is a representative payee involved in the case. Prepare a 997 to enter representative payee information into RASI.

If there is an input error or some other incorrect designation of representative payee prepare a 997 to discharge representative payee.

- 001 109 REQUESTED DUMP OF RECORD

A code 9 was entered in the "other benefits" item (#4) of the re-entry data screen causing RASI to drop case.

- 001 109 REQUESTED DUMP OF RECORD - APPLICATION CANCELLED (CLAIM ABANDONED) (INCORRECT SSA NUMBER) (MANUAL PARTIAL AWARD) (NOTICE OF DEATH) (OVERPAYMENT COULD OCCUR) (REASON UNKNOWN)

A 991 was submitted requesting dump of record for one of the above reasons.

- 001 REQUESTED DUMP OF SUPPLEMENTAL ANNUITY ONLY

A 991 was submitted requesting dump of the SUP ONLY.

- 079 SEARCH REPLY - NO MATCH ON ACCOUNT NUMBER

- 065 COMPUTER GENERATED DUMP

- 063 VERIFY THAT ACCOUNT NUMBER IS CORRECT

The social security number on the AA-1 does not match that in DCC's records. RASI will dump the case. Verify the account number. If the number in DCC's records is correct,

correct the AA-1 and have it re-entered. If DCC's number is incorrect, send case to DCC for handling.

- 055 125 SELF-EMPLOYMENT INDICATED - MANUAL OP CODED 2

032 116 MANUAL OP CODED 2

Applicant claims self-employment, and the field office has determined that BRB examiner review and determination is required. Investigate the nature of the employment. If the employment is determined to be self-employment, submit a 995 to change manual OP code to zero. Enter an IMPACT or SPAR rate if appropriate.

If the employment is determined to be LPE (e.g., business is incorporated), notify the applicant of the determination. Notify P/P&S-RAC via e-mail that the SE and LPE fields must be corrected, so that LPS work deductions are properly considered. After these changes are verified, (see REQUEST screen 14 or 23,) submit 995 to change the manual op code to zero. If desired, it is also possible to dump the case and include LPE work deductions in the manual award.

- 012 SPAR RATE INVALID - RATE NOW ZERO - 911 REQUIRED

The partial rate entered on Form G-230 is invalid. Determine the correct partial rate and enter it into RASI. Do not exceed the current Tier 1 and/or Tier 2 maximums.

- 219 SPOUSE CALCULATION ERROR - SPECIAL HANDLING REQ'D

Notify P/P&S-RAC via e-mail.

- 142 SPOUSE DUMPED WITH EMPLOYEE

This referral results from a 991 coded to dump both employee and spouse.

- 286 SPOUSE ONLY - EE PAID UNDER O/M - SPOUSE DUMPED

If the Research record indicates that the employee was paid under the O/M, RASI will not pay a spouse-only award.

- 182 SPOUSE ONLY - EE TIER TWO RECOMPUTED - SPOUSE DUMPED

RASI cannot calculate the spouse's annuity because Research records indicate the employee's tier two was recomputed due to service after his or her ABD. Pay the case manually.

- 033 SPOUSE ONLY - NO MATCHING RESEARCH RECORD

Spouse application has been entered into RASI, but Research does not yet have employee's record. Spouse will be held in RASI until it can be matched to employee's record. If it is necessary to expedite payment, dump the case and handle manually. This

message can also occur when the employee's application, submitted separately, has rejected.

- **260 SPOUSE PAID FINAL (DATE) - CODED FOR IMMEDIATE DUMP**

A dump request has been received which will remove the spouse from the RASI master file, regardless of the remaining retention period.

- **259 SPOUSE PREVIOUSLY DUMPED - CASE NOW CODED FOR IMMEDIATE DUMP**

This referral is produced when a 991 is submitted to dump case which has already been dumped from RASI with a retention period. The case will now be removed immediately.

- **069 SPOUSE PREVIOUSLY FILED FOR RRB BENEFITS**

Item 101 of AA-3 indicates that applicant previously filed for another RR Act benefit; e.g., a spouse is receiving a widow's benefit. Application has been accepted, but manual OP code has been entered to prevent payment. Obtain the claim file and document the claim file as explained in RCM Part 11, "Form G303 Instructions."

If no overpayment recovery is necessary from the spouse annuity, change the manual OP code to zero.

- **029 SPOUSE PREVIOUSLY TIERED; SPOUSE DUMPED*REX***

Research records show the spouse is in either final pay status or terminated pay status with the year and month of termination less than 12 months prior to the current filing date. Examiners should review this case and, if an annuity is payable, be sure that the ABD does not retroact to the period when the other annuity was being paid.

- **177 SPOUSE RRA MAX MAY APPLY**

RASI issues this message in a spouse case when the information currently available indicates that the RRA maximum applies. Manually test for the RRA maximum. Use the G-354.4 (PC) or ROC for folder documentation. Submit a 996 to enter the reduction amount for the tier II if the max applies, or to inform RASI there is no tier II reduction. The 996 can also be coded to produce a COMPUTE ONLY Award when the total RRA maximum reduction exceeds the spouse tier II.

The FAMC can be secured from Rate History Inquiry (PREH), screen 3300 (RHEE) AMC 6. If AMC 6 shows 0000.00, the folder must be requested. Once received, find the FAMC on the G-90, correct PREH using the on-line correction system and submit the 996.

Complete items 1 and 4 as usual. Complete items 2-3 and 5-7 as follows:

Item	Entry

2	Enter "2."
3	Enter <u>Spouse's</u> code name.
5	If entering the amount of reduction for tier II, leave this item blank. Otherwise, enter "4" in the first block. Space out unused positions.
6	<p>If entering the amount of the reduction for tier II, enter the dollar and cents amount in the first <u>six</u> blocks, using leading zeroes if necessary. For example, if the reduction amount is \$40.70, the entry would be "004070." RASI will reduce the spouse's tier II by the amount entered and pay the case final.</p> <p>If the RRA MAX does not apply, enter "2" in the first block. RASI will pay the case without a reduction.</p> <p>If the <u>total</u> RRA maximum reduction <u>exceeds</u> the spouse tier II, enter "1" in the first block. This code will generate a "COMP ONLY" G-355 showing "RRA MAX" in "REMARKS." It is necessary to pay the spouse and adjust the employee annuity manually to avoid employee overpayment.</p> <p>For each of these responses, space out the unused positions.</p>
7	If entering the amount of reduction for tier II, enter "RRAMAXRED." Otherwise, enter "SPRRAMAXCD." Space out unused positions.

- 287 SPOUSE SSA NO EQUAL TO ZEROES

This message is produced if the spouse's SSA number is omitted from the AA-3. RASI will set a manual OP code to prevent payment. Submit a 996 to change the manual OP code from 2 to zero (SWSMANOP); this will clear both the 996 call-up and the manual OP code. RASI will then continue processing the spouse award. However, without a spouse SSA number, RASI will not be able to make a TRIC AUX request; therefore, the spouse's wage record will not be considered in the annuity computations.

Do not request the field to secure the spouse's SSA number, as it will be submitted when received. If the SSA number is received before the case has paid final, enter it into RASI with a 996 (SPSSANO). If the number is received after the case has paid final, send it to Research on a G-59. Request a G-90 under the spouse's SSA number if there is any indication spouse has a wage record and make any necessary annuity adjustments.

- 066 SPOUSE SSA NO INVALID

068 SP MAN OP CODED 2

086 THIS CONDITION PROHIBITS RELEASE OF TRIC REQUEST

The spouse's SSA number, as entered on the AA-3, is an incomplete or impossible number. The correct SSA number is required for RASI to be able to secure a TRIC reply. Submit a 991 coded with a "7" to dump the AA-3 from RASI, then forward the case to PES for re-entry.

- 083 SPOUSE TOO YOUNG FOR BENEFIT CLAIMED

RASI will drop case. Examine the folder for correct data. If there is incorrect data and spouse could qualify for an annuity, pay case manually.

If EE has 360 SM on EDM, but his annuity was paid based on less than 360 SM on the ABD, do not deny the spouse application. See FOM1 207.12.6 for handling.

- 420 SPOUSE TRIC O/S 90 DAYS OR MORE

Refer case to your supervisor.

- 419 SPOUSE TRIC REPLY O/S 60 DAYS. REQUEST DATE ()

Release a G-60s to trace on the appropriate TRIC reply, using the instructions in RCM 9.1 for that form. If a partial rate can be paid and one was not previously entered, consider entering one now.

- 227 149 SSA BEN ON ANOTHER NUMBER CHECK FILE

The annuity application indicates the annuitant is claiming SS benefits under another person's SS number. If necessary, request an MBR for this other number to secure correct benefit data. Submit a 950 or 951 to enter it into RASI.

- 274 166 SSA ENT INDICATED BUT NO SS RATE

TRIC indicates entitlement, but shows no benefit rates. Secure correct rates and submit a 950/1.

- 295 169 SSA RATE DECREASE

296 170 INVESTIGATE POSSIBLE SSA WORK DEDUCTION

This message appears when the SSA MBR shows a decrease in rate in the award accrual period. When this referral message is shown, RASI will use the full SS benefit when making final payment.

A decrease in the SS benefit rate could be due to a change in entitlement (e.g., DIB adjusted to age reduced RIB because of recovery from disability) but more commonly is due to:

- Work deductions applied to the SS benefit; or
- Recovery of an SS benefit by partial withholding; or
- A worker's compensation offset in the SS benefit.

The following is a list of the situations which may cause this referral and the action to take when they are encountered.

1. SSA W/D's shown on RR-1a or SOLAR award in file. No action necessary.
2. SSA deferred O/P recovery. No action necessary.
3. SS benefit offset for Worker's Compensation. Recertify to use SS rate payable.
4. Rate decrease is because of an SS entitlement adjustment. Recertify to use the correct SSA rate.
5. No SS information in file - G-90 LAF Code is "C." Secure an MBR to determine why SS rate decreased and handle as shown above.

If there is no RR-1a or SOLAR award in file and LAF Code "E" is shown on the G-90, check POLO for SS payment activity and take appropriate action.

- 041 119 STATUS WORD CODING ERROR - SPECIAL HANDLING REQ'D

Notify P/P&S-RAC via e-mail.

- 058 127 STILL SELF-EMPLOYED INDICATED - MANUAL OP CODE 2

Investigate the self-employment to determine whether or not it is LPS. If self-employment is determined, prepare a 995 to change manual OP code to zero. If LPS is determined, notify the applicant of the determination. Dump the case and include LPS work deductions in the manual award.

- 309 SUBMIT 996 TO VERIFY PENSION BA NO

This referral may occur in both pension and non-pension cases whenever it appears that RASI has a missing or discrepant BA number. For instance, this message will be produced if the BA number shown on the annuity application does not agree with that shown on the 954 data or if RASI receives a 954 with a code 8 and the annuitant indicated (s)he was receiving a pension on the annuity application; or if the Research file does not contain the employee's BA number.

Submit a 996 to enter the correct pension BA number into master record using the field name "SUPBANO." Leave item 5 blank.

Note: In SUP attainment cases the RASI master does not contain the ee's code name because that is not a Research field. If the code name is not shown in the referral data, leave item 3 blank. Space out unused positions in items 6 and 7.

- **193 SUBMIT RESTORATION DATE**

RASI generates this message and sets a 996 call-up in dual spouse cases after the 953 call-up has been cleared. The 953 call-up is cleared when RASI receives the reduction amount for the spouse's own Tier 1 based on his/her own employee annuity. After receiving this reduction amount, RASI requests the Tier 2 restoration date.

When this date is received, RASI will use the earliest amount entered on the 953 as the restoration amount, and will apply the appropriate COL increase. Complete the 996 as follows, spacing out the unused positions:

Item	Entry
1-4	Usual
5	Enter "00000000" (eight zeroes)
6	Enter the restoration date in CCYRMODEA order.
7	Enter "SPT2RESTORED"

This referral will be traced every 30 days until the data is received.

- **265 SUBSEQUENT SERV INDICATED - DLW PRIOR TO 1937**

BDP's record indicates subsequent service but the annuity application shows a DLW prior to 1937. Investigate claimed DLW. If correct, submit a 996 to correct DLW. (EEDLWRR)

- **025 SUP ACTIVATED - EMPLOYEE DECEASED - CASE DUMPED**

This referral occurs when RASI receives a 150 to pay the SUP ANN but the regular annuity has been terminated. RASI will reject the 150.

This message is produced if the employee has 30 or more years of service and is age 60-64 or has 25 or more years of service and is age 65 or older and the case has been dumped for manual action. Review the file for supp entitlement and take the necessary action to pay or deny the supplemental annuity.

- **518 SUPP ACTIVATED - MANUAL ACTION REQUIRED**

This message is produced if the employee has 30 or more years of service and is age 60-64 or has 25 or more years of service and is age 65 or older and the case has been

dumped for manual action. Review the file for supp entitlement and take the necessary action to pay or deny the supp ann.

- 091 TAKE ACTION TO CLEAR 946 CALL-UP

The employee's application was filed at least three months ago, and the case is still pending "946 - SEARCH" for identification in our records. Follow the instructions for "Name Reconciliation Required." TRIC cannot be requested until this has cleared.

- 356 (357) TIER I (TIER II) RATE INVALID - 911 REQUIRED IMPACT NOW ZERO

Tier I (II) component on G-230 or 911, exceeds maximum or is otherwise incorrect. Submit correct 911. Show all three components of rate. If any one field is invalid, the others remain zero.

- 077 TRACE - TWO EMPLOYERS INDICATED

One or both G-88A.2's is still outstanding, and this case will not go out for TRIC clearance until it is received and submitted on a 958. Trace with the D/O in the railroad area.

- 520 TRIC O/S 90 DAYS OR MORE

Refer case to your supervisor.

- 084 TRIC REGENERATED: INITIAL TRIC REQUEST'S RECORD TYPE DIFFERENT FROM RECORD TYPE EVALUATED FINAL

This referral is produced when RASI regenerates a new TRIC request because of a change in the type of annuity after the initial TRIC request is evaluated. No examiner action is necessary.

- 519 TRIC REPLY O/S 60 DAYS. REQUEST DATE ()

Release a G-60a to trace on the TRIC reply, using the instructions in RCM 9.1 for that form. If a partial rate can be paid and one was not previously entered, consider entering one now.

- 263 TRIC REPLY - TERMINATED BENEFIT

TRIC shows that the SS benefit for the annuitant has been terminated. Review the file, secure the correct SS benefit information, and submit to RASI.

- 101/111 TRIC REQUEST REPLY EQUALS ALL "9's"

The current rate and/or current date equals all "9's." Any one of the five previous rate or date fields equals something other than all zeros or all "9's." Secure the correct SS benefit information and submit the data.

- 013 TRR DUAL SOC SEC BENEFIT

A TRIC reply was received by RASI with a "D" code indicating the annuitant has two SS benefits. RASI could not convert the case mechanically. Recertify the case to enter the correct SS rate and code into Research's record.

- 074 TWO LAG EMPLOYERS INDICATED

The AA-1 indicates two employers in the lag period and a 958 call-up has been established for lag service to establish eligibility. When both G-88A.2's are received, prepare a 958 to submit this information.

- 056 UNABLE TO SET SPOUSE ABD: SUBMIT SPARFORCE 996

This referral is produced when RASI is unable to determine the spouse's ABD when trying to pay a SPAR generated mechanically, by the examiner, or by the D/O. Pay the SPAR in these cases by submitting a 996 as shown in the instructions, RCM 9.2, Exhibit 9.

- 194 UPDATED 953 REQUIRED

This message will be generated in dual spouse cases when RASI has a date-break in the spouse annuity that is after the latest date break that was shown on the 953. For example, if the latest date shown is 10-1-90 and the case is still pending 2-1-91, RASI will have a date break of 1-1-91 for the COL increase. Therefore, you must submit a new 953 with the same data that was on the original plus the appropriate rate for 1-1-91. A 30 day call-up will be set and a tracer referral will be generated after that period.

- 228/150 WIDOW BENEFITS

This is an informational referral indicating the type of benefit annuitant is receiving. Submit a 950/1 with correct benefit data.

- 358 VDB RATE INVALID - 911 REQ - IMPACT NOW ZERO

VDB component on G-230 or 911 exceeds maximum or is otherwise incorrect. Submit corrected 911. Show all three components of rate. If any one field is invalid, the others remain zero.

- 190 WORKER'S COMP/PUBLIC DISABILITY DEVELOPMENT REQUIRED-IMPACT NOW ZERO

On the AA-1, the EE has indicated entitlement to either worker's compensation or public disability (Megacap) benefits. RASI has zeroed out the IMPACT rate to prevent an overpayment. If a WC or PD offset may apply, secure the AMW PIA 1 if it is an AIME case. Also determine the actual or estimated earnings and compute the required offset amount. See RCM 8.5 for details.

No immediate action is required of the examiner other than the offset development until and unless the EE is rated disabled. If the EE is rated disabled, message #191 will be

produced. ("DA RATED - WC/PD INVOLVED (MISSING) SUBMIT 996 - IMPACT NOW ZERO.") See the instructions for that message when you receive it.

This message is also produced when one or both items on the AA-1 have been left blank.

- 192 WC/PD INVOLVED - CASE DUMPED

The examiner has indicated on a 996 that a worker's compensation or public disability offset must be made. Pay the case final manually.

- 240 162 WRONG SSA NO IF CORRECT CHANGE MANUAL OP CODE TO ZERO

A TRIC reply contains discrepant identifying MBR data such as DOB, sex, etc., or possibly an incorrect claim number. Verify the SSA number involved and correct it on RASI if necessary. (The employee SSN field name is "SSANO." The spouse SSN field name is "SPSSANO." If the number is other than one of these, refer the claim number to P/P&S-RAC via e-mail.) Once the SSN is correct on REQUEST, submit a 995 to clear the man op.

If the SSN is correct, and the error is in some other field, and thus will not affect payment, submit a 995 to clear the man op.

9.3.14 Employee And Spouse Award Messages

The following messages will appear on RASI award forms (G-354R and G-355R).

ABD LATER THAN PARTIAL COMPUTE ONLY

RASI prints this message to indicate it cannot handle a case where the final ABD is later than the partial payment ABD, resulting in an overpayment. Handle manually.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

ADJUST MANUALLY WHEN SPOUSE AGE 62

This message is produced for spouse cases in which the employee, an '83 law year 60/30 annuitant, has attained age 62 and has been recertified with a recalculated PIA 1. However, the spouse is not yet 62, and thus cannot be paid yet with the recalculated PIA. If the spouse will attain age 62 within 90 days of the RASI award, control the case manually for recertification. If not, it will be called up mechanically.

ADVANCE FILE CASE

This message is printed for an employee or dual spouse case when the date last worked for the railroad is later than the filing date. This is not a review message.

This message does not require review. Examiner action is not necessary.

APPLY PERMANENT W/D FOR PRIOR YEAR

Temporary work deductions (TWD's) have been applied in a year prior to the current (voucher) year and ceased prior to the award date (end of initial accrual period). If TWD's have been withheld for any period during the current (voucher) year, the annuity will be policed for current year LPE work and/or earnings. LPE work and/or earnings for the previous year will be processed when current year permanent work deductions are assessed. If TWD's have been withheld and restored correctly, no additional action is required at this time.

If the annuity will not be policed for current year LPE work and/or earnings estimate (no TWD's withheld since December of prior year) forward case to RPS to make the final work deduction adjustments for the previous year.

ASSUMED NOT VESTED

This message appears in 60/30 employee cases where a quarterly breakdown is needed for the 1937-1950 period to determine if the employee is vested.

RASI has paid this case final and issued any tax refund payable, assuming the employee is not vested. When CESC secures the quarterly breakdown for the 1937-1950 period, a new G-90 with a vesting determination will be produced. If the employee is vested, the G-90 will be sent to CESC and then to Imaging. If the employee is not vested, the G-90 will just be sent to Imaging. No examiner action is required unless the employee is vested. In this event, any tax refund paid by RASI should be recovered from the vested dual benefit accrual.

This message does not require review. Examiner action is not necessary.

CHECK ABD - INJURY SETTLEMENT OR PAY FOR TIME LOST INVOLVED

Items 51 and 52 indicate that this employee received compensation for one of these two situations. RASI will consider the "TO" date in item 52 when setting the ABD, and will not set it earlier than that date.

Compare the "TO" date in item 52 with the DLW in item 11 of Form G-88A.2, if applicable, and item 40 of the AA-1. The corrected DLW-RR should be the latest of these. Review the documentation in the file to verify that the DLW-RR and ABD is correct.

CHECK EE DATE OF BIRTH

RASI prints this message when the probative value of the document used to verify the claimed date of birth is 30 or less. Compare the established date of birth with that shown on other file material (i.e., SSA MBR on Form G-90 or MOR's) to rule out conflicting evidence.

CHECK FOR POSSIBLE ENTITLEMENT BASED ON MINOR CHILD PRIOR TO CURRENT ABD

The spouse was paid based on age, but item 27 on the AA-3 indicates a minor child, unmarried and less than age 18. Investigate for possible earlier ABD or one-payment-only.

CHECK RRA MAX APPLICATION: PSP INVOLVED AFTER ABD

An RRA MAX reduction has been applied to the spouse's Tier 2, and a PSP offset applies in Tier 1 effective sometime after the spouse ABD and prior to the final award date. The RRA maximum must be redetermined when the spouse becomes entitled to a PSP subsequent to the annuity beginning date. Take appropriate action to retest the RRA maximum per RCM 8.6 G-354.4 and adjust spouse tier 2 and EE tier 2 and/or supplemental annuity if applicable.

This message is obsolete.

CHECK SPOUSE LAW YEAR

During the implementation of the 1983 Amendment provisions, some RASI employee disability awards were not coded correctly as '83 law year cases. As a result, the spouse may have been incorrectly paid under the '81 Amendments. Review the law year determination and adjust the spouse if necessary.

CHECK TWD FOR PERIOD BEFORE FULL RETIREMENT AGE

RASI will print this review message when the annuitant was full retirement age or older on the filing date. Therefore, RASI did not apply TWD's in this case. Review case to see if TWD's should have been applied to the period prior to full retirement age attainment.

CHILD ATTAINS AGE 18 - BENEFIT TERMINATES (DATE)

This message appears on a G-355R to inform examiner that child will attain age 18 within 90 days of award date. Control the case to insure that correct termination action is taken effective with the month the child attains age 18.

The RIS supervisor controls the case to ensure that the benefit is terminated timely. No examiner review required.

CHILD CARE DROP-OUT MAY APPLY

This message occurs in employee disability annuity cases in which the ABD is 7-1-80 or later and the employee is under age 37 in his ABD year. The 1980 Disability Amendments provide for the inclusion of an additional drop-out year in the computation of the employee's PIA's 1, 3, and 9 if he or she had a child under age 3 in any year used in computing the PIA and he or she had no earnings in that year. Refer to [RCM 4.7.120](#) for instructions on how to develop a possible child care drop-out year.

COMPUTE ONLY ABD OR AWARD DATE, AND CALCULATED ACCRUAL INCONSISTENT

This G-354R or G-355R message indicates that RASI has attempted to pay an amount accrued prior to the ABD or after the award date. Review calculations and voucher award manually. Prepare a full set of award forms.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

COMPUTE ONLY BUSI EXCEEDS ACCRUAL

This G-354R message indicates that RASI cannot pay an annuity because the BUSI deductions exceed the annuity accrual. Handle manually. Prepare a full set of award forms.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

COMPUTE ONLY EE C/O

This message appears on a spouse award form whenever a "compute only" message appears on the employee award. Handle spouse case manually, along with employee. Prepare a full set of award forms.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

COMPUTE ONLY MECHANICAL ZERO ANNUITY RATE

This message will be printed on the award form in spouse cases where the annuity rate computed by RASI is zero. Release an award letter. Prepare a PREH update award. When all action has been taken, forward case to "TCIU". Note on the G-26 "ZERO RATE CASE".

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

COMPUTE ONLY ONE PAYMENT ONLY

This message is printed on the G-355R when a spouse annuity should be terminated during the accrual period (e.g., spouse's last child attains age 18). Pay spouse manually. Complete a full set of award forms.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

COMPUTE ONLY PARTIAL EXCEEDS FINAL

The partial (IMPACT or SPAR) rate exceeds the final rate, and cannot be recovered from the accrual check. Handle manually. Prepare a full set of award forms.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

COMPUTE ONLY RRA MAX AMOUNT EXCEEDS SPOUSE TIER TWO

This message appears on the G-355R when the RRA maximum reduction amount is greater than the spouse's Tier 2. However, if an employee award is also pending, that award will also be a compute-only, and the same message will appear on the G-354R.

In either case, retest to see if the RRA Max Applies. (Test at both the ABD and the Tier 1 effective dates, if they are different.) If the RRA Max does not apply, pay the award(s) final manually.

If the RRA Max applies, check to see if the total family benefit will be less as a result of the spouse's filing; i.e., total of employee and spouse annuities with reductions for RRA Max is less than total annuities payable to employee without a reduction for the RRA Max. If the spouse's filing does not result in a reduction in the total family benefit payable, pay the award(s) manually. If the employee is already in final pay status, adjust that annuity for the RRA Max, and recover any overpayment in the usual manner.

If the total family benefit is less due to the spouse's filing, contact the appropriate district office. Give the relevant facts and request a cancellation of the spouse's application. Hold finalization of the employee's award, if pending, until the reply is received. If the spouse chooses not to cancel the application, pay the award(s) final manually, applying the RRA Max reduction to both. If the employee is already in final pay status, adjust the annuity for the RRA Max and recover any overpayment in the usual manner.

If the spouse does cancel the application, handle according to RCM 5.1.

For whichever course of action applies, prepare a full set of award forms for each compute-only award which will be paid manually.

This message is obsolete.

COMPUTE ONLY TOO MANY DATEBREAKS

This message appears on the award form when the number of rate changes exceeds the number of rate changes RASI can process. Pay the case manually. Prepare full set of award forms.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

CONTROL FOR SUP - CHECK DRR

This message is printed when the employee is not eligible for a supplemental annuity at the time the regular annuity is ready to pay final, but will be within three months of the final award date. RASI will not produce a 954 referral because the employee was not entitled as of the final award date. If the SUP ANN can be paid before MAP activates it as a SUP ANN attainment (the third month after the SUP ANN effective date), enter the data under type code 954. (The SUP ANN cannot be paid under type code 150 until Research has been updated for the award action.)

A referral is established in USTAR (RIS 0SU) upon receipt of the award. An examiner EDP Review is not required.

DLW-LPE IS, REMOVE LPE WORK DEDUCTIONS

This message is generated when a future DLW-LPE is entered on the employee or spouse application and is still in the future as of the paid final date. LPE work deductions are being withheld on a recurring basis.

If the DLW-LPE is 90 days or less in the future at the time the RASI award is reviewed, the case should be controlled in RIS and adjustment made to restore the tier II and Sup TWD amount (and the tier I or VDB TWD amount if appropriate). If the DLW-LPE is more than 90 days after the review date, the RIS examiner should establish a call-up for RPS to remove the TWD's.

DETERMINE IF MIN PIA APPLIES

This message indicates that although RASI paid this case final using the actual PIA, which is less than the minimum PIA, examiners should check to see if the minimum PIA will apply.

The minimum PIA will apply if the eligibility year is 1981 or earlier. The eligibility year is the earliest of:

- ABD;
- DF onset date;
- age 62; or
- date of death.

If the minimum PIA applies, recertify the case.

DIS ONSET DTE USED FOR PIA'S - DIS FREEZE INDICATED AT SSA CHECK VDB

This message is generated for disability cases filed 9-1-83 or later in which the first month of the disability waiting period is in a year prior to the ABD year. Verify that PIA's 4, 7 and 8 have been computed with the correct eligibility year. If the freeze and onset dates are in the same year, no action is necessary. If they are not, and if the PIA's are incorrect, adjust VDB accordingly.

DIS ONSET DATE USED FOR PIA'S - RECALCULATE USING ABD - THEN CHECK VDB

This message is generated for disability cases filed 9-1-83 or later in which the first month of the disability waiting period is in a year prior to the ABD year. In this case, there is no freeze at SSA, but RASI assumes one solely to obtain a valid PIA 1 based on the RRA onset date. RASI's assumption will produce incorrect VDB PIA's if the employee is under age 62 in the disability onset year. Put a note on the G-90 to indicate that the VDB PIA's are invalid.

When the VDB is payable, obtain correct PIA's 4, 7, and 8 from CESC. Send the G-90 from RASI attached to a G-563. In Remarks, write: "NO DF. COMPUTE PIA's 4, 7 and 8 BASED ON DOB." When the correct PIA's are available, pay the case accordingly. Send a G-59 to the P&S-RAC G-59 Group Mailbox to correct PIA's 4, 7, and 8 in the Research record.

DIS ONSET DTE USED FOR PIA's - RECALCULATE USING ABD

This message is generated for disability cases filed 9-1-83 or later in which the first month of the disability waiting period is in a year prior to the ABD year. In this case there is no freeze at SSA and no apparent vested dual benefit entitlement. Obtain correct PIA's 4, 7, and 8 from CESC. Send the G-90 from RASI attached to a G-563. In Remarks, write: "DISABILITY ONSET PRIOR TO ABD YEAR. COMPUTE PIA's 4, 7, 8 BASED ON ABD YEAR [DATE]". When the correct PIA's are available, pay the case accordingly. Send a G-59, with the G-90a attached, to the P&S-RAC G-59 Group Mailbox to correct PIA's 4, 7, and 8 in the Research record.

DRC's NOT ADDED - SPEC MIN PIA APPLIES

Although the award in this case shows that DRC's are creditable, they have not been included in the computation because Tier 1 is based on the special minimum PIA. Test whether the regular PIA plus DRC's exceeds the special minimum PIA; and if so, recertify the annuity to pay the higher amount. If the special minimum PIA exceeds the regular PIA plus DRC's no action is necessary. However, if in the future a regular PIA should apply, DRC's may be included.

DUAL ENTITLEMENT CORRECT PREH RECORD FOR EMPLOYEE

RASI prints this message on employee and/or spouse awards when information is entered under "Other RR Annuity" on the application. Entries need to be made on the employee PREH record, screen 3200 (RHRRID) using the PREH correction system. The specific fields are DUAL-ANN-RED-TYP-CODE, OTH-RRB-CLM-NO, OTH-BENF-TYP-CODE, and OTH-BENF-AMT. Review all annuities to determine if the spouse annuity requires adjusting for dual entitlement.

EEACCRBUS NOT EQUAL TO AWARD LESS BUSI - REFER TO RAC

EEACCRAMT NOT SHOWN - REVIEW AWARD

RASI has produced this review message as a result of a duplicate award form being requested after the SUP ANN attainment has been paid final.

EE ACCRUAL DUE NOT EQUAL TO AWARD AMOUNT DUE - REFER TO RAC

EEACCRPP NOT EQUAL TO EEACCRPP AWARD - REFER TO RAC

EE ALSO

This message does not require review. Examiner action is not necessary.

EE ATTAINS AGE 62 (Year - Month) ADJUST MANUALLY

This is an '83 law year 60/30 case, in which the employee was 60-61 on the ABD, and was paid with an age-reduced PIA 1.

PIA 1 must be recalculated when the employee attains age 62, and the case must be recertified with that PIA.

If the employee and/or spouse will attain age 62 within 90 days of the RASI award, control the case manually for recalculation of PIA 1 and recertification. If not, the case will be called up mechanically.

This message is obsolete.

EE C/O

Appears on Spouse Award when employee was compute-only. Spouse is compute-only also.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

EE POSSIBLE RAIL - CHECK SP DATA

This is a review message that appears in spouse-only cases in which the employee's PREH data was obtained only once, and may not be the latest due to possible RESCUE activity. Check the data used to pay the spouse and recertify if necessary.

EXCESS EARNINGS NO ADJUSTMENT REQUIRED

This message is produced when excess earnings are indicated by the employee and/or spouse annuitant and a work deduction insured status exists, but no TWD amount is withheld from tier I because of a social security offset effective with the ABD, and VDB entitlement is not involved. No additional action is necessary.

This message does not require review. Examiner action is not necessary.

FRZ INDICATED - CHECK FOR W/F

This message appears on the G-354r produced in disability cases if there is an indication on the G-325 that the annuitant is entitled to a freeze.

G-90 MORE THAN 9 MONTHS OLD

RASI will print this review message when an award is made more than nine months after the G-90 date. RAC routinely purges its files to remove any G-90 data more than nine months old.

Request a current G-90. If the new G-90 data matches the old G-90 data, send a G-59 with the new G-90 date to the P&S-RAC G-59 Group Mailbox. If the new G-90 data is not the same as the old, and no tolerance applies, recertify the award. If tolerance applies, send a G-59 with

the new G-90 date to the P&S-RAC G-59 Group Mailbox. Also, if any of the tier components change, send P&S-RAC an "information only" award form or work sheet showing the new amounts.

This message does not require review. Examiner action is not necessary.

HOLD

This message will appear on the G-354r if the employee award is being paid final but the spouse's claim is still pending on the computer. (NOTE: Partial award forms are no longer printed effective 5/97.)

This message does not require review. Examiner action is not necessary.

INSUFFICIENT SERVICE MONTHS FOR ANNUITY TYPE CODE, CONSIDER DEEMING

When a 958 for the lag year is entered, RASI will determine if sufficient service has been established for eligibility. If not, RASI will issue this referral. Refer to [FOM1 207.5](#) for an explanation of deemed railroad service months. Request the Compensation and Employer Services Center (CESC) to release Form GL-99, Employer's Deemed Service Months Questionnaire, to develop the necessary information and determine if deemed railroad service months could be credited.

LAG REQUIRED FOR ELIGIBILITY

This message does not require review. Examiner action is not necessary.

LAG SERVICE MAY PROVIDE SUPP ELIGIBILITY.

Lag was not required to establish regular annuity eligibility, but may provide SUP ANN entitlement. This message will be produced only when the employee meets all other conditions for SUP ANN eligibility and is 65 or within three months of attaining age 65 on the award date.

RESCUE will pay the supplemental annuity for these cases if the employer's year-end earnings report provides sufficient railroad service to qualify the employee for a SUP ANN and the employee is old enough to be entitled to the supplemental annuity when RESCUE runs. If PREH does not have information about whether the employee is entitled to a RR pension or not, RESCUE will not pay the supplemental annuity but rather a referral will go to USTAR (RUE 040). If the employee is not yet old enough to receive the supplemental annuity, RESCUE will update the total service in PREH, and MAP will issue a referral when the employee attains the required age.

When lag provides SUP ANN eligibility, verify the amount of any employer pension and pay the SUP ANN on ROC. Edits will require the examiner to recertify both the regular annuity and SUP Ann to make sure the railroad service months are the same for both.

LAG YEARS ()

This message does not require review. Examiner action is not necessary.

LAST NON-RAILROAD WORK WAS FEDERAL EMPLOYMENT

This message is generated because the annuitant indicated on his application that his LPE employer was a federal agency. If RASI certified the annuity without a current connection, the C/C must be retested and the indexed T2 developed if LPE is an exempt federal agency. If RASI paid the employee with a current connection an indexed T2 may still need to be developed if the LPE employer is an exempt federal agency.

Refer to [FOM1 225.35.2](#) to determine if the employee's federal employment did not break his C/C. Refer to [FOM1 214.1](#) to determine if an indexed Tier 2 is warranted.

IF	THEN
Federal employer <u>is not listed</u> in FOM1 225.35.2	Sign, date, and indicate NAN on the RASI award.
Federal employer <u>is listed</u> in FOM1 225.35.2	<ol style="list-style-type: none"> 1. Retest for current connection if annuitant paid final without a C/C. 2. Correct PREH C/C indicator, if necessary. 3. Consider indexing T2 by: <ul style="list-style-type: none"> • Verifying federal employer by securing DEQY or evidence from field office • Verifying federal employment was the major employer in the 60 month period preceding the ABD and that the employee did not work in the railroad industry in that 60 month period • Prepare G-563, request an indexed T2, recertify annuity 4. Complete a G-59 to request that EE-SPEC-CALC-CD (PREH screen 3300) be changed to "2" (indexed T2 applies). 5. Reconsider effect on SUPP ANN entitlement.

LEGAL PROCESS CONSIDERED

This message does not require review. Examiner action is not necessary.

LPE WORK DEDUCTIONS WITHHELD T2 SUP ANN

This message indicates the amount of the latest Tier 2 and/or supplemental annuity LPE work deduction. It is a recurring amount if the DLW LPE is "CONT" (continuing).

Review the accuracy of the deduction, and check the claim folder for changes in LPE earnings or employment requiring an adjustment.

M/S ACCOUNTING: MANUAL CALCULATION REQUIRED

Effective in 1995 cases involving M/S accounting are handled as part of a yearly special project. The reimbursable amounts are computed and any necessary adjudication is done at that time.

This message does not require review. Examiner action is not necessary.

M/S AS WAGES REQ. FOR VDB ELG. BUT EE CLAIMED BENS AT OTHER AGENCY

The claimed M/S is creditable as compensation, but if used as wages will vest the employee. RASI will pay the case using M/S as compensation.

Using the instructions in [FOM1 215](#), determine whether the M/S can be used to pay the VDB, and if so, recertify the case.

- M/S MOS XXX
- M/S COMP XXXX

This message does not require review. Examiner action is not necessary.

M/S NOT USED - EE CLAIMED BENEFITS WITH OTHER AGENCY

If the employee indicates on the AA-1 that he has filed for benefits with a federal agency other than the VA and the M/S is not needed for eligibility, and the claimed M/S is only one period, and is entirely pre-1957, RASI will pay the case despite the other M/S benefit. However, if all of those conditions are not met, RASI will pay the case without the M/S. Request a G-90 to see if the M/S is creditable and to get the PIA computations with the M/S. If the M/S is creditable and will increase the annuity payments, recertify the case to include it.

This message is obsolete.

M/S NOT USED - PROOF OF M/S NOT IN FILE

This message appears on the G-354r award form when the case was paid final without M/S because proof of such service was not submitted. It is also an alert that further tracer action is necessary with the field if the M/S is still not available.

If proof of M/S is not available, trace for the proof with the appropriate field office. If the field abandons their efforts to secure the proof, close out USTAR. Enter in Remarks that the field office abandoned their efforts to secure the proof.

If the proof of M/S is available, request a G-90 with the M/S included. If a higher benefit results, recertify the annuity to include the M/S. If the M/S does not cause an increase in the annuitant's benefit, the M/S data still must be entered into PREH.

A referral is established in USTAR (RIS 0MS) upon receipt of the award. An examiner EDP Review is not required.

M/S NOT USED - REQUIRED FOR VDB ENTITLEMENT

The claimed M/S is creditable as compensation, but if used as wages, it will vest the employee. The VDB eligibility date is more than six months in advance, however, so case must be handled according to [FOM1 215.110.2](#).

M/S USED AS COMPENSATION REQUIRED FOR ANNUITY ELIGIBILITY

M/S which is creditable as compensation must be included in the annuity computation in order to provide the minimum number of service months required for eligibility.

If the employee is not due a VDB with the M/S used as compensation, but would have been vested had the M/S been used as wages (see the G-90), check for a tax refund which is due because he is not vested with the M/S used as comp. Use Form G-357 as explained in [RCM 8.6](#) and [RCM 5.13](#).

This message does not require review. Examiner action is not necessary.

M/S USED AS WAGES - REQUIRED FOR VDB ELIGIBILITY

The claimed M/S is creditable as compensation, but if used as wages, will vest the employee. The VDB DOE precedes the ABD or falls within the accrual period or within three months of the accrual ending date.

NET TIER I DECREASE - ZERO TB

This message appears when the 12-83 net Tier 1 rate is greater than zero but less than the 11-83 Tier 1 rate, and the reason for the decrease is not due to the initial SS entitlement effective in 12-83. RASI will compute the 5% takeback amount based on the 11-83 net Tier 1, but will not make any reduction for take back in Tier 2. No examiner action is required.

This message is obsolete.

NEXT - TO LAST NON - RAILROAD WORK WAS FEDERAL EMPLOYMENT

This message is generated because the annuitant indicated on his application that his next to last LPE employer was a federal agency. If RASI certified the annuity without a current

connection, the C/C must be retested if the LPE employer was an exempt federal agency. An indexed T2 may still need to be developed if the LPE employer was an exempt federal agency. Consult [FOM1 225.35.2](#) to determine whether the federal agency is one which does not break a C/C. Refer to [FOM1 214.1](#) to determine if an indexed T2 is warranted.

IF	THEN
Federal employer <u>is not listed</u> in FOM1 225.35.2	Sign, date, and indicate NAN on the RASI award.
Federal employer <u>is listed</u> in FOM1 225.35.2	<ol style="list-style-type: none"> 1. Retest for current connection if annuitant paid final without a C/C 2. Correct PREH C/C indicator if necessary 3. Consider indexing T2 by: <ul style="list-style-type: none"> • Verifying federal employer by securing DEQY or evidence from field office • Verifying federal employment was the major employer in the 60 month period preceding the ABD and that the employee did not work in the railroad industry in that 60 month period • Prepare G-563, request an indexed T2, recertify annuity 4. Complete a G-59 to request that EE-SPEC-CALC-CD (PREH screen 3300) be changed to "2" (indexed T2 applies). 5. Reconsider effect on SUPP ANN entitlement

NO AGE 62 RECALC FOR EE ADJUST EE AND SP MANUALLY

This message is produced for spouse cases in which the employee, an '83 law year 60/30 annuitant, has attained age 62, but has not yet been recertified with a recalculated PIA 1. Take the necessary action regarding the employee annuity, and if the spouse will attain age 62 within 90 days of the RASI award, control the case manually for recertification. If not, the case will be called up mechanically.

NO C/C ASSUMED

If this message is printed on the G-354R, review the C/C determination made by RASI (see [RCM 9.1.22.](#)) In any case where the RASI C/C determination was incorrect, send a G-59 to the P&S-RAC G-59 Mailbox to correct the Research record. If an incorrect "NO C/C" code is not corrected in the record, the case will not be called up for SUP ANN development when

the employee attains age 65. This is especially important when the case involves service by a Canadian for a U.S. employer in Canada.

NO EDP REVIEW MESSAGE

This is a final award for which no special handling or follow-up action is required, other than EDP review procedures currently in effect. (This message replaces "FILE ONLY.")

NO EXCESS EARNINGS INDICATED FOR NEXT YEAR

This message is printed when the employee or spouse has Tier 1 work deductions beginning in the year of filing and carrying over into the next year, and the accrual period extends from the year of filing into the next year. The application was filed in September through December and was paid final prior to December 31 of the filing year. The application indicated that excess earnings were expected for all months of the "current" year, the filing year, but not for the "next" year, the year after the filing year. Examine the case for possible removal of Tier 1 work deductions effective with January of the year after the filing year (the actual current year). If the adjustment is not made now, incorrect temporary Tier 1 work deductions may remain in force until the case is policed for excess earnings.

NOT DISABLED - PAID AN A&S ANNUITY

This is a RASI EDP Review message that requires examiner action. The employee filed for a disability annuity but was rated not disabled. Based on the employee's age and service data in file, RASI converted processing of the disability application to an age and service annuity. Review the application and PIA's provided on the G-90 and other applicable data in file to ensure that the tier components and the award are accurate.

O/M DOES NOT APPLY

This message does not require review. Examiner action is not necessary.

O/M MAY APPLY - CHILDREN

For age and service and disability cases in which the disability freeze was granted along with the initial onset, test the O/M with the PC program using the claimed minor and/or disabled child(ren) as auxiliaries. If the O/M does not apply, sign, date, and indicate NAN on the RASI award. If the O/M applies, attach a copy of the O/M test to the RASI award and return it to the RIS supervisor. The case will be assigned to a post examiner to process the O/M award.

O/M MAY APPLY - SPOUSE OVER 62

This message does not require review. Examiner action is not necessary.

PARTIAL EXCEEDS FINAL

The partial (IMPACT or SPAR) rate paid by RASI exceeds the final rate. If the overpayment cannot be recovered from the accrual check, "COMPUTE ONLY" will also be printed. See the instructions for "COMPUTE ONLY - PARTIAL EXCEEDS FINAL".

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

PIA 1 ADJUSTED AT 62

This message is produced when the '83 law year 60/30 employee in this case has already been recertified with a recalculated PIA 1. The spouse was age 62 or older on the ABD, and was paid based on the recalculated PIA 1 amount.

This message does not require review. Examiner action is not necessary.

PIA 17 = 9999

This message is printed in employee cases in which there is no PIA 2 because the employee had no railroad service prior to 1975. To assess TWD's correctly, RASI substitutes PIA 1 for PIA 2 for calculating the Tier 1 W/D amount.

For EDP review, PREH screens 3210(RHTIER1) and 3278(RHWKDED) should be looked at. On screen 3210(RHTIER1), T1-SUBJ-WD-AMT, T1-AGE-RED-AMT, you should check the information for PIA 1 and age reduction amounts. Compare those amounts to the current PIA 1 and age reduction. If they are correct, no action is needed. If the amount is incorrect, a ROC rectification must be completed.

Example: 3210(RHTIER1) shows PIA 1 and age reduction correct for the 12-1-99 rate, but for the tier 1 subject to work deductions it received the PIA 1 before the cost-of-living due to the date of the G-90 being produced. Screen 3278(RHWKDED) shows the incorrect work deduction being withheld.

PIA 17 = 9999 - EE HAS WDIS

This message is printed in employee cases in which there is no PIA 2 because the employee had no railroad service prior to 1975. Although the employee has a WDIS, no work deductions were applicable in this award. For these cases, PIA 1 will be used in place of PIA 2.

Review the application for LPE and excess earnings.

POSSIBLE ADJ IN SP T1 DUE TO PIA 1 CHANGE IN EE

This message appears on RASI spouse awards with multiple date breaks in which a discrepancy exists between the employee and spouse PIA 1. It is an alert that a possible adjustment to the tier one portion of the spouse annuity may be necessary for the period prior to the latest date break.

POSSIBLE 1988 AMENDMENT M/S CASE. CONSIDER M/S AS COMPENSATION

Release a G-60 request which includes the entire M/S period, and release a G-563 to get Tier 2 data based on the period of M/S that is creditable as compensation before the 1988 Amendments. When both the G-90 and G-563 are received, manually recertify with a 12-1-88 date break. Send a G-59 to the P&S-RAC G-59 Mailbox. Enter the appropriate G-90 date on the G-357.

This message is obsolete.

POSSIBLE 1988 AMENDMENT M/S CASE. G-90 RE-ENTRY DATE BEFORE THE 1988 AMENDMENT COULD BE CONSIDERED

This message will appear when the ABD is 12-1-88 or later, there is M/S in the 6-15-48 through 12-15-50 period, and the G-90 RASI used to pay the case was prepared before the 1988 Amendments could be considered.

Check the IC M/S proof screen for 6-15-48 thru 12-15-50 M/S. If any is claimed, release a G-60 request which includes the entire M/S period (including months now creditable under the 1988 Amendments). When received, recertify from ABD. Prepare G-59R (M/S) (2-89) for Research and enter the appropriate G-90 date on the G-357.

This message is obsolete.

POSSIBLE DEEMED CURRENT CONNECTION

It has been determined that the employee does not have a current connection, yet because item 75 on the AA-1 (8-90) has been answered "YES", it may be possible to establish a deemed C/C for supplemental and survivor annuity purposes.

If items 76 or 77 have been answered "YES", and item 78 has been answered "NO", evaluate and determine if a deemed C/C can be established per [FOM1 225.45](#).

If a deemed C/C is established, notate the file and send a G-59 to the P&S-RAC G-59 Mailbox. The Research record must be corrected to generate a call up at age 65 for annuities with at least 25 years of service, or at age 60 for a D/A case with 30 years of service for supplemental annuity development. If the employee is currently eligible for a supplemental annuity, or will be within 90 days, control the case and initiate development and payment.

If a deemed C/C is not established per [FOM1 225.45](#), and code paragraph 406A was not included on the final RASI award, prepare a denial of the supplemental annuity per [FOM1 315.10](#).

POSSIBLE DUPLICATE EARNINGS INVOLVED. WAGES FOR SOME YEARS NOT USED IN PIA CALCULATION

Wages posted to a year or years after 1977 equal (plus or minus \$1) the railroad compensation for the same year(s). These wages appear to be the result of duplicate reporting of earnings and have not been included in the computation of the PIAs used to pay the annuity.

No investigation is normally required for these cases. However, if the wages posted are not equal (difference is greater than plus or minus \$1) to the compensation shown for any year or years adjacent to a year where wages and compensation are equal, follow the handling instructions for the G-90 referral POSSIBLE DUPLICATE EARNINGS BA 9999 in [RCM 9.14.110](#).

POSSIBLE LPE WD'S NEEDED DUE TO EE LPE

PREH data indicates the EE no longer has LPE TWD's in force. Review the case to see if LPE WD's should be applied to the spouse annuity based on the EE's earnings.

POSSIBLE RECOMP IN YEAR AFTER 62

(POSSIBLE RECOMP YEAR AFTER EMPLOYEE AGE 62)

This message appears on a G-354R (G-355R) when a RECOMP PIA appears on employee's G-90 and employee is not yet 62. New annuity rate based on RECOMP PIA will be payable effective January 1 of the year after employee attains age 62.

POSSIBLE RESTORATION OF TIER I BENEFIT

See [RCM 5.7.54](#) - 5.7.55.

POSSIBLE UI O/P. CHECK PAR RECORD. APPLY RR ACCRUAL TO UI O/P

This is a RASI review message which requires examiner action. In order to prevent any UI overpayment from not being recovered by a RASI accrual, RASI has been modified that when the UI indicator is "Y", RASI will automatically make these a comp only award. This code of "Y" signifies an open RUIA debt (either uncollectible or regular) on PAR. The RASI award will be initially reviewed by a lead examiner in Operations and forwarded to an examiner for handling. The examiner needs to review PAR and Debt Checker to see if a UI overpayment exists. Any RASI accrual should be used to offset any UI overpayment.

POSSIBLE W/D INSURED STATUS

This message appears when TRIC cannot make a work deduction insured status determination because SSA did not furnish a wage QC pattern for the 1937-1952 period. When this happens, TRIC prints a dash (-) in the QTR I/S ACQUIRED block in item 7(B) on the G-90. Take the necessary action to make a manual W/D insured status determination. If a work deduction insured status does exist, send a G-59 to the P&S-RAC G-59 Mailbox with "W/D INSURED STATUS ACQUIRED IN (QTR/YR)" entered in Remarks.

PREPARE RL-183

This message appears on G-354R or G-355R. Release RL-183.

This message is obsolete.

PRIOR M/S NOT USED

RASI will print this message on the G-354R if the annuitant has prior military service. If the prior M/S can be used to increase the employee's annuity, recertify the award. If the prior M/S cannot be used, advise the annuitant in a letter using code paragraph 333.

This message does not require review. Examiner action is not necessary.

PSP EFFECTIVE DATE IS [DATE], APPLY REDUCTION

This message is generated when a future PSP effective date is entered in response to the 957 request for PSP data, and it is still in the future as of the paid final date. A PSP reduction has not been applied to the spouse tier 1.

If the PSP effective date is 90 days or less in the future at the time the RASI award is reviewed, the case should be controlled in RIS and adjustment made to apply PSP offset to the spouse tier 1 (and new RRA max test, if applicable).

If the PSP effective date is more than 90 days after the award review date, the RIS examiner should establish a call-up, with Form G-662, for RPS to initiate PSP reduction timely, and retest the RRA maximum and adjust the appropriate components accordingly.

REDUCED FOR PUBLIC SERVICE PENSION

This message is produced in spouse cases in which a 957 call-up was set for public service pension data to be input by an examiner. Verify that the reduction amount is correct based on the application and Form G-208.

RELEASE RL-13G.1 FOR EE

This message is printed for a spouse-only case in which the employee was awarded a disability annuity under the provisions of the 1974 Act, the filing date was 1-1-77 or later, there is no ROR on file, and the ee is not age 65 on the spouse's ABD. An RL-13g.1 must be released to the ee's last RR employer to notify that rights have been relinquished due to spouse's annuity eligibility.

RELEASE RL-13G.1 WHEN G-88 RECEIVED

This message is printed for a spouse-only case in which the employee was awarded a disability annuity under the provisions of the 1974 Act, the filing date was 12-31-76 or earlier, there is no ROR on file, and the ee is not age 65 on the spouse's ABD. Depending upon the revision date of the AA-1d, or Form G-346, a G-88 may or may not have been required. Check to see that the referral message "NO REL OF RTS INFO FOR EE. GET G-88." was handled correctly. The spouse should not have been paid final if a G-88 was required, but was not obtained. Release an RL-13g.1 to the ee's last RR employer to notify that rights have been relinquished due to spouse's annuity eligibility.

REVIEW

See [RCM 9.1.44](#)

REVIEW DUAL SPOUSE

RASI will print this review message on the G-355R when it has paid a dual spouse case final. Review the spouse's own employee annuity data on PREH and review the award to see if the proper reductions were made in Tier 1 and the proper restoration amount was included in Tier 2.

REVIEW EE AND FOR EARLIER ABD

RASI prints this message on the G-355r when it appears that a full age spouse may qualify a reduced age employee for up to 6 months of retroactivity from the spouse's filing date. Review both employee and spouse awards to see if this provision applies. RASI will restrict the spouse's ABD so as not to precede the employee's. Therefore, if this provision does apply, both employee and spouse will have to be manually re-opened and paid with a new ABD. When re-opening, remember that the employee's ABD in these cases is restricted not only by the usual age and eligibility requirements, but is also restricted by the spouse's ABD.

REVIEW M/S

This message does not require review. Examiner action is not necessary.

RRA MAX AMOUNT EXCEEDS SPOUSE TIER TWO

When both an employee and spouse are on the system, and the MAX applies, if the reduction amount cannot be recovered completely from the spouse's Tier 2, RASI produces two compute-only awards. Both awards must be paid manually, with the reduction applied to both.

When only the spouse is on the system, RASI DROPS THE SPOUSE AS COMPUTE ONLY. The employee's annuity must be recertified with the spouse's to apply the MAX reduction.

This message is obsolete.

RRA MAXIMUM ()

This message is obsolete.

RRA MAXIMUM APPLIES

This is printed on spouse awards when the spouse's tier 2 has been reduced for the RRA maximum. Verify that the maximum does apply, and that the amount used for the reduction is correct. Use Form G-354.4 (PC) or ROC for folder documentation. This should be attached to the AA-3 for release to claim files if you are processing the spouse application folderless.

This message is obsolete.

RRA MAXIMUM MAY APPLY

In SUP ANN attainment cases, RASI will test for the RRA maximum and print this review message, if the testing shows the RRA max may apply. Review the case by testing manually. Use Form G-354.4 (PC) or ROC for folder documentation. Handle as follows:

- 1) If the RRA max does not apply, no additional action will be required.
- 2) If the RRA max applies based on the employee's regular and SUP annuities, adjust case and recover any overpayment. Check the "SP Invokes Max" box on ROC - RRA Max Calculation screen so a referral will be released if the spouse files for an annuity.
- 3) If the RRA max applies based on the employee, spouse and SUP annuities:

If the spouse has filed, adjust his/her annuity and recover any overpayment.

If the spouse has not filed, go to PREH using the on-line correction system and complete screen 3300 (RHEE)RRA-MAX-APPBL-CODE using 1-Spouse invokes maximum.

This message is obsolete.

SALSA CALCULATED - CONSIDER MANUAL AWARD

The SEARCH reply indicates a separation allowance lump-sum amount, shown on the G-90 as a LUMP-SUM SEC 6E. Pay the SALSA manually, deducting any amount previously paid the employee. A disabled annuitant could have received the SALSA under an earlier period of entitlement. Send a G-59 to the P&S-RAC G-59 Mailbox if the SALSA is a one-pay-only award.

Do not pay the SALSA if there is a chance that the SALSA mass adjustment would duplicate your award. An overpayment could result if, at the time of the mass adjustment, the record has been updated with data from the final RASI award, but not from the G-59 or the manual SALSA award.

A referral is established in USTAR (RIS 0SA) upon receipt of the award. An examiner EDP Review is not required.

SEC (3G) 4(D) CUMULATIVE COL

This message displays the COL increases applied to Tier 2.

This message does not require review. Examiner action is not necessary.

SEP/PREMIUM SURCHARGE RELIEF CLAIMED - FWD TO MS

Item 114 on the AA-1 or Item 105 on the AA-3 was answered "NO". Forward the award form to the Medicare Section. (If this cannot be done, forward a copy of the award form.) If there is a G-44b and/or a RL-311-F with the material received for the annuity application, attach the G-44b and/or the RL-311-F to the award form and send to the Medicare Section.

This message does not require review. Examiner action is not necessary.

SERVICE BEGINNING DATE IS AFTER 8/83

This message does not require review. Examiner action is not necessary.

SERVICE MONTH DEEMING APPLIED

The employee was credited with deemed service months based on the amount of Tier 2 compensation reported for the lag year in this case.

This message does not require review. Examiner action is not necessary.

SP LWYR83 60/30 CASE: CONSIDER ABD RETROACTIVITY

The spouse in this case could be eligible for an earlier ABD, based upon the criteria listed in [FOM1 112.7](#). If the spouse is eligible for retroactivity, recertify the case to pay the additional amount due and correct the ABD. No new application or notice to the spouse is required if the AA-3 indicates the spouse wanted the earliest ABD possible, and filed for a reduced 60/30 annuity. If retroactivity does not apply, notify P&S-RAC through your supervisor.

SP T1 WD COMPONENT EXCEEDS SP T1 RT

EE TIER 1 W/D COMPONENT _____

SP TIER 1 W/D FACTOR _____

SP W/D EFF DATE _____

ACTUAL PIA 2 AMOUNTS USED

This message occurs when the spouse annuitant's Tier 1 involves a reduction for a public service pension (PSP) and/or for spouse's own employee annuity (DUAL).

If the Tier 1 is reduced to zero or is not payable, no work deductions based on the spouse and/or employee's earnings estimate can be applied. If a net Tier 1 amount remains after the reduction for a PSP and/or spouse's own EE annuity, work deductions will be withheld from this amount.

SPOUSE ATTAINS AGE 65 (YEAR - MONTH) NOW ENTITLED BASED ON AGE

The spouse attains age 65 during the accrual period, and is receiving an annuity based on a minor or disabled child. As of the month the spouse is 65, entitlement should be based on age only. Send a G-59 to the P&S-RAC G-59 Mailbox to notify RAC of the change in the basis of entitlement.

SPOUSE ATTAINS AGE 65 (YEAR - MONTH) PAY TIER I BASED ON SPOUSE AGE 65

The spouse is receiving an annuity based on a minor child older than 16, but less than 18, and only Tier 2 is being paid. The spouse will attain age 65 within three months of the RASI award date. Control the case to recertify as a full age annuity, including Tier 1.

This message is obsolete.

SPOUSE ELIGIBLE FOR REDUCED 60/30 – AA-3 REQUIRED

The spouse is receiving an annuity based on a minor child who is at least age 16, but not yet 18, and thus Tier 2 is being paid. Since the spouse is at least age 60, but not yet 65, and the employee is receiving an '83 law year 60/30 annuity, the spouse is eligible for a reduced annuity. A new AA-3 is required.

SPOUSE PARTIAL EXCEEDS FINAL RATE

The SPAR rate paid by RASI exceeds the final rate, and the difference cannot be recovered from the accrual. Handle manually.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

SPOUSE PENDING - DO NOT SEND TO CLAIM FILES

A current spouse application is pending on RASI. Hold the file in dormant until the spouse recert or final award is matched.

This message does not require review. Examiner action is not necessary.

SS BENS CLAIMED - NO TIER 1 REDUCTION

The AA-1 or AA-3 indicated that the annuitant is receiving social security benefits, but the final award contained no reduction to Tier 1. Verify that no SS entitlement currently exists, with special attention to SOLAR/WORKLIST pending activity. Review all account numbers. If the results are questionable or inconclusive, secure an MBR for resolution and take whatever action is appropriate. If the annuitant is not currently entitled to benefits, note the RASI award to that effect.

SUBMIT 150 or 954 - CHECK RR PENS ENTITLEMENT

The SUP ANN cannot be paid with the final award because necessary pension information is outstanding. Check for RR pension entitlement. If entitlement is indicated, verify with a G-88p. When G-88p has been returned by the RR employer, follow the instructions in [FOM1 315.19](#). Use 954 if it will be submitted within 90 days of the RASI award. If it will be submitted later, use code 150.

A referral is established in USTAR (RIS 0SU) upon receipt of the award. An examiner EDP Review is not required.

SUPPLEMENTAL ANNUITY NOT PAYABLE – NO RR SERVICE PRIOR TO 10/1/1981

According to EDMA the annuitant does not have one month of creditable railroad service prior to October 1, 1981. Therefore, a supplemental annuity is not payable to an employee even if all other age and service requirements are met. Refer to [FOM1 315](#) for detailed supplemental annuity information and requirements.

TAX REFUND POSSIBLE - CHECK DF STATUS

RASI does not pay tax refunds to disability annuitants because, at the time that payment is made, RASI does not know if a DF determination has been made. Upon receipt of this message, take the following action:

1. If the DF determination has been made and the EE -
 - a. Is vested, no action is necessary.
 - b. Is not vested, pay the tax refund.
2. If the DF determination has not been made, the case will be called up mechanically for DPS to do the DF rating. After the case has been rated, the following will occur:
 - a. If a DF is granted, a DF G-90 will be produced mechanically. When it is received, the tax refund should be paid if the G-90 indicates one and if the ee is not vested. If the ee is vested, take action to pay the vested dual benefit, if all requirements for payment are met.
 - b. If the DF is denied, DPS will forward non-vested cases to the operations unit for payment of the tax refund if any is due and the employee is not vested.

TERMINATION REJECT

RASI has received a termination code from CHICO. Pay manually any accrual that is due annuitant.

A referral is established in USTAR (RIS 0CO) upon receipt of the award. An examiner EDP Review is not required.

TIER I BASED ON RED PIA 1 - PIA 1 ADJUSTED AT 62

This message is produced when the '83 law year 60/30 employee has attained age 62 and has been adjusted for the recalculated PIA 1, but the spouse attained age 62 during the accrual period. The spouse annuity must be recertified with the correct PIA 1 amount.

TIER-I BASED ON RED PIA-1 – SP ATTAINS AGE 62 (YR-MO) – ADJUST MANUALLY WHEN SPOUSE AGE 62

This message is produced when the '83 law year 60/30 employee has attained age 62, and has been adjusted for the recalculated PIA 1 amount, but the spouse has not yet attained age 62. If the spouse will attain age 62 within 90 days of the RASI award, control the case manually for recertification. If not, the case will be called up mechanically.

TIER-2 AFTER TAKEBACK LESS THAN \$10.00 - GUARANTY APPLIED

This message occurs in post-'83 ABD spouse cases when the Tier 2 before 4(d)(2) takeback is \$9.99 or less. 50% of the employee's T/B amount will be shown in item 21 on the G-355R, however that amount will not be considered in the annuity calculations.

T2 REDUCED FOR RRA MAXIMUM

Examiners should review this case to verify that the RRA max test was made correctly. Use Form G-354.4 (PC) or ROC for folder documentation. This should be attached to the AA-3 for release to claim files if you are processing the spouse application folderless. If a 996 was submitted with the tier 2 max reduction amount, be sure that amount was based on 45 percent of the employee's tier 2 if the spouse is a 1981 amendment case.

This message is obsolete.

\$10.00 MINIMUM RULE APPLIES

This message occurs in pre-'84 ABD Spouse cases when the Tier 2 amount after takeback is \$9.99 or less. The takeback amount will be shown to the right of the "12-83" or "12-84 TAKEBACK" designation; however, the net Tier 2 paid will be \$10.00.

This message is obsolete.

TRIC REPLY - (AUX)(SP) MBR EARMARK REJECT

The employee, spouse or aux. TRIC reply contains a code indicating that correction of the RRB earmark in SSA's records may be necessary. See [RCM 7.4.68](#) for instructions.

VDB DOE (MOYR)

This message is printed when the month of the VDB beginning date is later than the month of the RASI award run date and within the following three months. Control the case to pay the VDB.

W/D INSURED STATUS QUESTIONABLE

Determine if W/D insured status exists. If a determination cannot be made on basis of evidence in file, secure a G-90. When G-90 is in file, handle according to FOM1 Art. 11. RASI will pay the full rate in questionable W/D cases.

VDB CUTBACK APPLIED FROM DATE OF ENTITLEMENT - REVIEW

This message will be printed in employee partial to final recertifications paid on April, 1988 or later vouchers in which the VDB date of entitlement and the partial ABD are before 3-1-88. RASI cannot apply the correct VDB cutback for months prior to 3-1-88 in this situation. Adjust the case as necessary based on procedure for applying the VDB cutback in partial to final recertifications. See [RCM 8.6 G-354WF](#) Special Situations.

WORK DEDUCTIONS COMPUTED

EMPLOYEE TIER I W/D COMPONENT _____

SPOUSE TIER I W/D FACTOR _____

SP WD EFF DATE _____

ACTUAL PIA 2 AMOUNT USED

Work deductions have been applied to the spouse Tier I based on the spouse's own and/or the employee's earnings estimate. The employee's latest WD component (PIA 2) will be displayed, as well as, spouse's WD component. In addition, the actual TWD amount after applicable age reduction will be shown for each rate change.

Review the accuracy of the components used and deductions made. Check the application and Imaging for any correspondence that indicate a change in the earnings estimate or employment. Following the guidelines established in [FOM1 1120](#), make any adjustment necessary to correct the current WD components.

However, it must be noted that due to system limitations RASI is unable to forward employee work deduction information to the spouse award message when the employee has no railroad service prior to 1975. Even though the work deduction information is not printed on the spouse RASI award, work deductions should still be considered.

WORK DEDUCTIONS COMPUTED

(EXCESS EARNINGS ABD MONTH ONLY)

T1 PIA 2 _____

EE WD EFF DATE _____

ACTUAL PIA 2 AMOUNTS USED

This message appears when work deductions are applied to the employee Tier I based on the employee's earnings estimate. The employee's latest PIA 2 (WD component) will be displayed. In addition, the actual WD amount withheld, including the applicable age reduction or DRC increase, will be shown for each rate change.

Review the accuracy of the components used and deductions made. Check the application and Imaging for any correspondence that indicate a change in the earnings estimate or

employment. Following the guidelines established in [FOM1 1120](#), make any adjustment necessary to correct the current WD components.

WORKERS COMP TERMINATED - CHECK ACCRUAL PERIOD

This message will be printed in "spouse only" cases when Research records indicate the employee's workers compensation benefits have terminated. Check Imaging to determine when these benefits actually terminated. If they terminated prior to the spouse's accrual period, no examiner action is required. However, if they terminated in the spouse's accrual period, an overpayment exists for the accrual period preceding the termination date. Recover this overpayment in the usual way.

YRS W/O M/S XX XX XX - YRS WITH M/S XX XX XX

This information appears on G-354R when RASI has used M/S in the annuity computation.

This message does not require review. Examiner action is not necessary.

9.3.15 Employee And Spouse RASI Input And Mech G-60 Reject

MESSAGES

When data is input to RASI, an edit of the input is made. If an error or a situation which warrants investigation is discovered, a RASI input reject is issued, describing the missing or invalid data.

The referral is printed on 805 (5 1/2" x 8") paper. "RASI INPUT REJECT" appears at the top with the date of the computer run. For identification, the SSA number, RRB claim number, code name and type code of the document appear next, followed by the message.

805 reject messages can also be viewed on HSL, in the "RASI 805 REJ REF REPORT." Messages for the ten most recent RASI runs are available. Messages are listed in SSN order.

The following list shows the various referral messages that may appear and the corrective action required. Many referrals are self-explanatory, indicating that data is missing or incorrect. In certain cases, Research data can be corrected by use of Form G-59R. (See RCM 9.4) In other cases, incorrect or inconsistent data can be corrected and reentered.

A. RASI produces the following referrals when erroneous or incomplete information is received from Research or SEARCH.

- **AIME/TRANS PIA IN RESEARCH IS ZERO**

RASI cannot pay the spouse final in this case until Research is furnished the EE's AIME/TRANS PIA. Because of the long delays Research has in updating its record, examiners should dump and pay manually. After final payment, furnish Research with the AIME/TRANS PIA via a G-59R.

- CURRENT SSA DATA IS PRIOR TO LATEST COL

ANOTHER TRIC REQUEST SENT TO BDPA

RASI produces an input reject referral with this message if a TRIC reply does not show an SS benefit rate which includes the latest Cost-of-Living increase. (The last effective date shown on the MBR will be printed after the referral message.) RASI will not accept the TRIC reply and will continue to generate TRIC request until the latest COL increase appears on the annuitant's MBR.

- DETAIL NOT ACCEPTED - NO CALL-UP - REFER TO RCA

RASI received an input document which it did not need for processing a particular application.

- DUPLICATE TRIC REPLY

This is an information referral indicating that a second TRIC reply was requested.

- EE ABD YEAR

This is a G-60 mechanical reject.

- EE DLW RR INVALID OR ZERO - 946 CALL UP

No date or an invalid date is entered on the AA-1. RASI will not reject the application, but will set a 946 (SEARCH) call-up. Secure correct DLW, and prepare a 996 to enter the date into RASI. The field name is EEDLWRR.

- EE NOT AGE 60 ** CHECK SUPP ABD**

This message occurs when a 150 is submitted in advance of the month the employee attains age 60. Review the file to determine the month in which the employee will be eligible for a supplemental annuity. If the employee will be eligible in the next 90 days, take no action. RASI will process the SUP ANN at that time. If the month of SUP ANN eligibility is more than 90 days from the date of the reject message dump the case.

- EE RESEARCH AMT - SERV CONTAINS ZEROS

Research has no record of years or months of service. These cases should be dumped and paid manually. Send a G-59R to Research with a current G-90 date.

- EE RESEARCH CLAIM NUMBER 999999 NOT EQUAL TO APPLICATION CLAIM NUMBER 999999; MANUAL OP CODE SET

This message occurs only in cases with six digit claim numbers. The Research file contains a different claim number from that shown on the RASI file. RASI will accept

Research's claim number but will set a manual op code. Investigate discrepancy. If Research's number is correct, clear the manual op code. If Research's number is incorrect, dump the case and handle manually. Notify Research of the correct claim number.

- EE RESEARCH RECORD NOT IN FINAL PAY STATUS - 30 DAY CALL-UP SET

Message is generated in SUPP ANN attainment case when the EE's Research record is not in final pay status.

- If EE paid final within 90 days prior to the date of the referral, allow the case to pend for up to 90 days from the date of the final award. If this referral is still produced after that time, send the folder to Research to update their records.
- If EE paid final more than 90 days prior to the date of the referral, send the folder to Research to update their records.
- If EE not paid final, recertify to final rate.
- EE RESEARCH RECORD SHOWS SUPP PAID-MMY; CASE DUMPED

RASI will dump this case and generate this referral in SUP ANN attainment cases when research records show the SUP ANN has already been paid. If the SUP ANN has not been paid, pay the case manually.

- EE TIER 2 BEFORE COL CONTAINS ZEROS

Message is generated when the employee's tier II amount before any section 3(g) increases is missing from Research records. Examiners should dump the case and pay manually.

- ERROR IN SSA NUMBER OF TYPE CODE FROM FILE

RASI produces this referral when it cannot identify a particular type of activity. If an SSA number or type code can be determined, re-enter input. Otherwise, no action can be taken on this referral.

- 1ST (2ND) MIL SERV BEG DATE INVALID

SEARCH rejected RASI's TRIC request because the MS beginning date is incomplete. Enter the full date of the period(s) with a 996. The present contents of the RASI field are indicated in the 805 referral's "Contents of Field." Enter the correct date in CCYYMMDD order. The RASI field name is MSBEGDT1 or MSBDGDT2.

- 1ST (2ND) PER MEANS ENTRY CD INV

SEARCH rejected RASI's TRIC request because the code is missing or incorrect for the EE's means of entry into MS. If there are two periods of MS, check the means of entry for both; RASI might have an incorrect "voluntary/involuntary" code for one MS period and no code for a second period.

Correct any erroneous code with a 996. The present contents of the RASI field are indicated in the 805 referral's "Contents of Field." Enter the changed code as follows: 1 for voluntary entry (enlisted, re-enlisted, or commissioned), or 2 for involuntary entry (inducted, or called from inactive duty). The RASI field name is MSINCDE for the first period, or MSINCD2 for the second. Space out unused positions.

- **INVALID G-230 TYPE CODE - ACTIVITY NOT PROCESSED**

The type code has been entered incorrectly on the G-230. This is a D/O error. Refer to the case to PES if there is no indication that it has already been handled.

- **INVALID RECTYP OR SPTYP CODE - REFER TO RCA**

Refer case via Outlook to Dawn Farganus, P&S-RAC.

- **MASTER RECORD FOR THIS DETAIL NOT IN FILE**

RASI has received a document for which there is no master record. Handle the case manually.

- **M/S INDICATOR DISCREPANCY (M/S NOT INVOLVED - DATA IN INPUT)**

There is a discrepancy between the M/S claimed on the annuity application and EDMA. RASI will not drop case but will continue to process claim using the claimed M/S. If the case is paid incorrectly, recertify award without M/S.

- **NAME RECONCILIATION REQUIRED - BDP CODE NAME VERIFY THAT ACCOUNT NUMBER IS CORRECT**

Analyze the file information to determine the cause of the referral. If there is no real discrepancy (i.e., female employee who worked under a maiden name) enter a 946 to bypass the discrepancy. If the discrepancy between the record on EDMA and the RASI record is correct on EDMA and incorrect on RASI, submit a 997. If the two names are irreconcilable, contact the district office to determine if the application was filed under an incorrect number. See RCM 4.8 for additional instructions on name reconciliations.

In addition to checking the name, examiners must verify the account number. If the account number is incorrect, the case must be dumped and re-entered using the correct account number.

- PREVIOUS CLAIM NUMBER FROM BDP - MANUAL OP CODE SET - IMPACT RATE ZEROED OUT

RASI received an application with a nine-digit claim number but found a previous six-digit number in BCC records. The application has been accepted but a manual OP code has been entered to prevent final payment and the IMPACT rate, if any, has been zeroed out. Obtain other folder and send both folders to claim files for consolidation. Prepare a 996 to change claim number to six-digit number before changing manual OP code to zero. After RASI has been corrected to the six-digit number, examiners must manually enter the IMPACT rate if they want one paid. However, do not enter the IMPACT rate until the six-digit number is accepted in the system and appears on REQUEST.

- REX PAID DATE ZERO

This message occurs in spouse-only cases where there is no voucher date for the employee's final payment in Research records. If there is a final voucher date in file, notify Research.

- REX PARTIAL IS ONE

This referral occurs in spouse-only cases where there is only a partial award for the employee in Research records. If the file indicates that employee has paid final, notify Research so that its records may be corrected.

- SEARCH OUTSTANDING - DETAIL NOT PROCESSED

RASI has an input document, but cannot find a master record. After several attempts at finding a record, RASI will finally reject input document and produce this referral.

- T1-PIA-1 IN RES RECORD NOT CORRECT XXX.XT1AMW1XXXX
- 932 CALL UP SET

RASI cannot pay the spouse final in this case until Research is furnished the EE's tier one AMW PIA. Because of the possible delay Research may have in updating its record, examiners should dump and pay manually. After final payment, furnish Research with the AMW PIA via a G-59R.

- T1 PIA-1 IN RESEARCH RECORD NOT CORRECT. 932 CALL-UP SET

This referral occurs in spouse-only cases where Research does not have consistent AMW - PIA information in its records. Furnish Research with correct T1 PIA-1 and the associated G-90 date. Use Form G-59R to transmit referral. (See G-59R instructions in RCM 9.4)

A 99998 AMW will appear on the referral when a transitional PIA 1 was used to compute the employee's annuity. RASI rejects this type of case because of 99998 AMW does not correspond to a PIA amount. If the PIA amount shown on the referral is correct (i.e., a transitional PIA 1 is applicable for the employee), it is not necessary to complete Form G-59R, since the Research record is correct. Instead, case must be dumped and paid manually.

- **TRIC REPLY SHOW EXCESS M/S XXX**

An excess amount of creditable M/S has appeared on the TRIC reply. RASI will automatically regenerate TRIC. If this 805 is generated twice for the same code, refer to P&S-CAS.

- **TRIC TIER 2 RATE CONTAINS ZEROS**

These referrals are handled in P&S-RAC.

B. The following category of RASI rejects involves applications (AA-1, AA-3, AA-6, AA-7). Unless otherwise indicated, whenever a message indicates that data is invalid, missing, or incorrect, the application has rejected.

"Incorrect" data implies that a wrong code was entered into RASI. For instance, a particular item on the application could be answered "1" (yes) or "2" (no). If the item is incorrectly entered with a "3", RASI will produce a referral message indicating "incorrect" data. "Invalid" refers to impossible data. For example, if RASI receives alpha data when the system needs numeric data, an "invalid" message will be produced.

Whether the reject is the result of invalid or incorrect data, forward the file to PES for their action. PES charges the field office with an error, if necessary, and re-enters the application.

- **AA-1 DESIGNATED ABD INVALID**

Item 80 of AA-1 and item 79 of AA-3.

- **AA-1 (AA-3) G-230 SSA NOT EQUAL AA-1 (AA-3) EE SSA NO G-230 SSN AA-1 (AA-3) SSN - REPUNCH**

The employee SSN shown in item 4 of Form G-230 is different from the one entered in item 2 of the application. Determine the correct number. Correct the erroneous form and send the folder to PES.

- **APP FILING DATE MORE THAN 9 MONTHS PRIOR TO CURRENT DATE**

Filing date on G-230.

- **APPLICATION SIGNED BY REPRESENTATIVE CODED INCORRECTLY**

Item 127 of AA-1, item 113 of the AA-3.

- ANNUITY FILED FOR DOES NOT MATCH TYPE CODE ON G-230

Item 25 of the AA-1, item 25 of the AA-3.

- BA NO LAST (2nd LAST) RR EMPLOYER SHOULD NOT BE ZERO

ER number on AA-1.

- CHILD CLAIMED AND VERIFIED DOB BLANK

Forward this referral with file to P&S-RAS.

- CHILD'S DATE OF BIRTH MISSING

Item 31 of AA-3.

- CHILD UNDER 18 CODED INCORRECTLY

Item 27 of AA-3.

- CHILDRENS DATE OF BIRTH MISSING

Item 31 or 35 of AA-3.

- CLAIM WITH OTHER FEDERAL AGENCY CODED INCORRECTLY

Item 30 of AA-1.

- CODE NAMES IN MASTER AND DETAIL NOT EQUAL

Item 3 of AA-1, AA-3, AA-6, and AA-7.

- DATE OF BIRTH INVALID

Item 8 of AA-1, item 6 of AA-6, item 11 of AA-3, item 7 of AA-7.

- DATE OF MARRIAGE INVALID

Item 12 of AA-1.

- DATE RTS REL LAST RR EMPLOYER GREATER THAN 90 DAYS FROM CURRENT DATE (INVALID) (SHOULD NOT BE ZERO)

Item 41 of AA-1.

- DATE RTS REL 2nd LAST RR EMPLOYER GREATER THAN 90 DAYS FROM CURRENT DATE (INVALID) (SHOULD NOT BE ZERO)

Item 48 of AA-1.

- DEPENDENT CHILD CODED INCORRECTLY

Item 16 of AA-1.

- DESIGNATED ABD INVALID

Item 79 of AA-3.

- DISABLED CHILD CODED INCORRECTLY

Item 36 of AA-3.

- DIVORCED SPOUSE - MANUAL HANDLING REQUIRED

Item 13 of AA-3.

- DLW FOR 2ND OUTSIDE ER INVALID

Item 64 of AA-1.

Item 68 of AA-3.

- DLW LAST RR EMPLOYER GREATER THAN 90 DAYS FROM CURRENT DATE (INVALID)

Item 40 of AA-1.

- DLW OTHER RR EMPLOYMENT INVALID OR ZERO

Item 58 of AA-3.

- DLW OUTSIDE INVALID

Item 59 of AA-1, item 65 of AA-3.

- DLW OUTSIDE SHOULD NOT BE ZERO

Item 59 and/or 64 of AA-1, and item 65 and/or 68 of AA-3. In continuing LPE cases, the DLW can be zero, but the "still working" box must be checked.

- DLW 2nd LAST RR EMPLOYER GREATER THAN 90 DAYS FROM CURRENT DATE (INVALID)

Item 47 of AA-1.

- EARLIEST DATE CODED INCORRECTLY

Item 79 of AA-1 and item 78 of AA-3.

- EARLIEST DATE CODED ONE - DESIGNATED BEG DATE SHOULD BE ZERO

Item 80 of AA-1 and item 79 of AA-3.

- ELECTED PUBLIC OFFICE CODED INCORRECTLY

Item 66 of AA-1 and item 69 of AA-3.

- EMP PREV ON (DATE) AA-1 REJECTED - SPOUSE IN MASTER FILE

Employee award has already been made. A second employee application is keypunched into RASI and, therefore, rejects. This referral is a reminder that there is still an active spouse on record.

- EMP SSA NO ON AA-7 INVALID

Item 1 on AA-7.

- ESTIMATED TOTAL EARNINGS CURRENT (LAST) (NEXT) YEAR SHOULD NOT BE BLANK OR ZERO

Items 87, 83, and 92 of AA-1 and items 86, 82, and 97 of AA-3.

- EXCESS ANNUAL EARNINGS CURRENT (LAST) (NEXT) YEAR CODED INCORRECTLY

Items 86, 82, and 91 of AA-1 and items 85, 81, and 90 of AA-3.

- EXCESS MONTHLY EARNINGS CURRENT (LAST) YEAR CODED INCORRECTLY

Items 88 and 84 of AA-1 and items 87 and 83 of AA-3.

- FELONY CODE INVALID OF MISSING

Item 19 of AA-1, item 19 of AA-3.

- FILED APPLICATION WITH SSA CODED INCORRECTLY

Item 95 of AA-1 and 94 of AA-3, item 14 of AA-6 and item 27 of AA-7.

- FILING DATE GREATER THAN CURRENT DATE (INVALID)

Filing date of AA-1 and AA-3.

- FILING DATE INVALID

Filing date of AA-1 or AA-3.

- INVALID G-230 TYPE CODE - ACTIVITY NOT PROCESSED

Type code item on G-230 omitted.

- LAST RR EMPLOYMENT - RIGHTS NOT RELINQUISHED OR MISSING

Item 52 of AA-3.

- MANUAL REVIEW CODE INVALID

Item 10 of G-230.

- MARITAL STATUS CODED INCORRECTLY

Item 9 of AA-1.

- MECHANICAL DUMP-POSSIBLE SPOUSE DUAL ANNUITY-COMPUTE MANUALLY

This reject referral is generated for spouse annuitants when a dual annuity is indicated on the application. It alerts the examiner that RASI will dump the case and the annuity must be computed manually either on ROC or the P.C. award shell program.

The p.c. award shell program must be used if neither the employee annuitant nor the spouse applicant have any railroad service prior to 1975. With these types of cases the entire spouse annuity must be reduced by the full amount of their own employee annuity based on their own earnings.

- MINOR CHILDREN CODED INCORRECTLY

Item 27 of AA-3.

- M/S CODED INCORRECTLY

Item 27 of AA-1.

- MONTHS OF NO EXCESS EARNINGS CURRENT (LAST) YEAR (CODED INCORRECTLY) SHOULD NOT BE ZERO

Items 89 and 85 of AA-1 and items 88 and 84 of AA-3.

- NO SECOND LAST RR EMPLOYER BA NO. SECOND EMPLOYER SHOULD BE ZERO

Next to last ER number on AA-1.

- NON-RR JOB LAST 12 MONTHS AFTER DLW-RR. AA-1 ITEM 55 BLANK

Item 55 of AA-1.

- OTHER RAILROAD EMPLOYMENT - ITEM 53 BLANK
Item 53 of AA-3.
- OTHER RR EMPLOYMENT - RIGHTS NOT RELINQUISHED OR MISSING
Item 59 of AA-3.
- OTHER (SPOUSE) SSA NO INVALID (CODED INCORRECTLY)
Item 100 of AA-1, item 99 of AA-3.
- OUTSIDE EMPLOYMENT WITH FEDERAL AGENCY
Item 60 of AA-1.
- POSSIBLE LEGAL PROCESS CASE - FORWARD TO CCR
Item 18 of AA-1.
- PREVIOUS APPLICATION IN FILE - MASTER TYPE---
A second application of the same type is received. The second application is rejected for manual handling.
- PREVIOUS MARRIAGE CODED INCORRECTLY
Item 16 of AA-3.
- PREVIOUS RRB CLAIM NO INVALID
Item 106 of AA-1 and item 103 of AA-3.
- PREVIOUS SPOUSE SSA NO INVALID
Item 15a of AA-1 and item 18a of AA-3.
- PREVIOUSLY FILED FOR RRB BENEFITS CODED INCORRECTLY
Item 104 of AA-1 and item 101 of AA-3.
- PRIOR SERVICE CODED INCORRECTLY
Item 35 of AA-1.
- PUBIC SERVICE PENSION CODED INCORRECTLY
Item 104 of AA-3.

- RR RTS REL CODED INCORRECTLY

Item 49 of AA-1.

- RR EMPLOYMENT CLAIMED - DLW SHOULD NOT BE ZERO

Item 51 of AA-3.

- RR EMPLOYMENT CODED INCORRECTLY

Item 46 of AA-3.

- RR RTS NOT REL

Item 41 of AA-1.

- RR SENIORITY RIGHTS NOT RELINQUISHED OR MISSING

Item 60 of AA-3.

- SECOND YOUNGEST CHILD'S DOB INVALID

Item 35 of AA-3.

- SELF-EMPLOYMENT LAST 12 MO CODED INCORRECTLY

Item 72 of AA-1 and item 75 of AA-3.

- SEX CODE INCORRECT

Item 6 of AA-1, item 10 of AA-3, item 7 of AA-6, item 8 of AA-7.

- SMIB OPTION CODED INCORRECTLY

Item 118 of AA-1 and item 108 of AA-3, item 18 of AA-6, item 31 of AA-7.

- SPOUSE DATE OF BIRTH INVALID

Item 11 of AA-1.

- SPOUSE DATE OF BIRTH MISSING

The AA-1 does not reject and payment will not be delayed. The spouse DOB in item 11 is missing. No action is necessary if the spouse has filed for an annuity or if the D/O does not submit the information. If the DOB is available, prepare a G-59r after the EE's final award to notify Research of the spouse's DOB. The data is used in the RL-100 program to alert potential annuitants of their eligibility.

- SPOUSE REP PAYEE CODED INCORRECTLY

Item 33 of AA-7.

- SPOUSE SSA NO SHOULD NOT BE ZERO

Item 10 of AA-7.

- SPOUSE PREVIOUS MARRIAGE CODED INCORRECTLY

Item 16 of AA-3.

- SPOUSE PREVIOUSLY FILED - AA-3 NOT PROCESSED

A second AA-3 is received before RASI has completed processing of original application. The second application is rejected for manual handling.

- SSA NO INVALID

Employee SSA number on AA-1, AA-3, AA-6, AA-7.

- STILL SELF-EMPLOYED CODED INCORRECTLY

Item 73 on AA-1 and item 76 on AA-3.

- 360 MO CLAIM CODED INCORRECTLY O - DOB = XXXXXX - REPUNCH

Item 34 of AA-1. The application will reject for this error only if the employee's claimed date of birth is before 1927.

- TYPE OF ANNUITY INVALID - REPUNCH

Item 25 of AA-1, item 25 of AA-3.

- YOUNGEST CHILD'S DOB INVALID

Item 31 of AA-3.

C. RASI will reject RE-ENTRY DATA input for the following reasons. Re-enter the data correctly to clear the applicable call-up.

Type code 150

- CURRENT PENSION AMOUNT INVALID

- CURRENT PENSION EFFECTIVE DATE INVALID

- EE CONTRIBUTION AMT GREATER THAN PENSION AMOUNT

- EE CONTRIBUTION AMOUNT INVALID
- EE CONTRIBUTION AMT NOT ZEROS. ENTER FULL PENSION AMOUNT
- EE SSA NUMBER INVALID
- EMPLOYER BA NUMBER INVALID
- INVALID CB BA NUMBER
- INVALID CLOSING DATE or INVALID CLOSING DATE CODE
- INVALID OTHER BENEFIT CODE - LABOR ORG. BA NO

The SUP ANN should not be reduced in this case.

- OTHER BENEFITS CODE INVALID
- PENSION AMOUNT OF REDUCTION EXCEEDS \$43.00
- PENSION AMOUNT REDUCTION FOR SUPP INVALID
- PENSION AMT RED GREATER THAN PENS AMT
- PENSION EFFECTIVE DATE GREATER THAN CURRENT DATE
- SUPPLEMENTAL ANNUITY PREVIOUSLY PAID EFFECTIVE _____ SUP ANN data was submitted on this date. If no SUP ANN was paid, refer the case to P&S-RAC after taking manual action to pay SUP ANN.
- SUPPLEMENTAL PENSION AMOUNT SHOULD NOT BE ZEROS
- SUPPLEMENTAL PENSION DATE SHOULD NOT BE ZEROS
- TOTAL SERVICE MONTHS INVALID
- 150 ENTERED, EMPLOYEE ANNUITY NOT PAID FINAL - SUP ANN data must be coded as 954.
- 150 ENTERED WITH PLUG RATES; SUPP NEEDS TO BE HANDLED MANUALLY.

This case cannot be handled mechanically.

- 150 FORM PREVIOUSLY SUBMITTED, INPUT FORM IGNORED. SUP ANN data has already been entered, but the SUP ANN cannot be paid yet. If the SUP ANN ABD has elapsed, refer the case to RAPT.

Type Code 933

- DISABLED CHILD CODE INVALID
- DOCUMENT NOT REQUIRED - REFER TO ESA. 933 data is not required.
- ELIGIBILITY CODE INVALID
- INVALID DOM DETERMINATION CODE FOR ABD
- PREVIOUS MARRIAGE CODE INVALID

Type code 947

- (947) IMPOSSIBLE CODE IN SWE CUR CON - REFER TO RCA
- (947) IMPOSSIBLE CUR CON DETERMINATION CODE
- (947, 948) SECOND DOCUMENT NOT REQUIRED -947 data has already been submitted.

Type code 948

- (948) IMPOSSIBLE CODE IN RED CAP - REFER TO RCA
- (948) IMPOSSIBLE RED CAP CODE
- (947, 948) SECOND DOCUMENT NOT REQUIRED -948 data has already been submitted.

Type code 954

- (954) BA NUMBER
- (954) CURRENT EFFECTIVE DATE
- (954) CURR PENSION AMOUNT
- (954) CURR PENS HIGHER BY MORE THAN 43.00
- (954) EE - CONTRIBUTION AMOUNT
- (954) EE CONTRIBUTION AMOUNT NOT ZEROS
- (954) EMPLOYEE HAS BEEN DUMPED -Pay the supp with the manual award if either is payable.
- (954) ENTER FULL PENSION AMOUNT
- (954) INCORRECT C/D CODE
- (954) INCORRECT PENSION STATUS WORD. Refer to RCA.

- (954) INVALID OTHER BENEFIT CODE
- INVALID OTHER BENEFIT CODE - LABOR ORG. BA NO

The supp should not be reduced in this case.

- (954) INVALID SPECIAL CLOSING DATE
- (954) PENS AMT RED FOR SUPP ANN HIGHER THAN SUPP ANN
- (954) SPECIAL C/D BLANK

Type Code 998

- P/S MONTHS INVALID
- P/S AVERAGE INVALID
- P/S METHOD CODE INVALID
- SECOND DOCUMENT NOT REQUIRED
- VERIFIED DOB CODE INVALID

D. RASI will reject TIER ONE OFFSET data for the following reasons. Where erroneous entries are indicated, re-enter correct data to clear 950/951, 953 or 957 call-up. Where no type code is indicated, the reject refers to 950/951 activity.

- ALL RATES AND/OR DATES ARE BLANK
- CURRENT SSA RATE PRIOR TO (eff date of latest COL increase). See instructions in RCM 9.2 for 950/951 activity.
- (DATE) EFFECTIVE DATE IS EARLIER THAN PRECEDING DATE
- (DATE) EFFECTIVE DATE IS SAME AS PRECEDING DATE
- 953 ALL RATES AND/OR DATES ARE BLANK
- 953 EFF DATE IS EARLIER THAN PRECEDING DATE
- 953 EFF DATE IS INVALID
- 953 EFF DATE IS THE SAME AS PRECEDING DATE
- 953 FIRST DATE IS EARLIER THAN SPOUSE ABD
- 953 OTHER BENEFIT CONTAINS AN INVALID CODE

- 953 SPOUSE DUMPED
- 953 SPOUSE PAID FINAL
- 953 CODED FOR PSP - NO DATES/RATES - RESUBMIT 953
- 953 EFFECTIVE DATE IS EARLIER THAN SPOUSE TIER 1 DATE
- OTHER BENEFIT CONTAINS INVALID CODE
- PREVIOUS SS EFFECTIVE DATE INVALID
- PREVIOUS SS EFFECTIVE DATE IS LATER THAN CURRENT SS EFFECTIVE DATE
- **** RATE IS INVALID (BLANK)
- SSA CLAIM NO DOES NOT MATCH NUMBER SHOWN ON AA-3
- SSA CLAIM NO INVALID
- SUFFIX (2 MAR) CONTAINS INVALID CODE
- SWE RR4 CONTAINS INVALID CODE - REFER TO RCA
- SWS IN STAT CONTAINS INVALID CODE - REFER TO RCA.

E. RASI will produce input reject referrals for 958 - LAG SVC input for the following reasons. Where incorrect or invalid data is indicated, resubmit. The messages are arranged alphabetically ignoring the preceding type code designation.

- 958 - BA NO. DOES NOT MATCH CLAIMED NUMBER

Item 3 on the 958 does not agree with the last employer BA number shown in the master record. Determine which is correct. If the master record is wrong, prepare a 996 to change "EELSTBA," and then submit the 958 one run later. If the form is wrong, resubmit with the correct number.

- 958 - BA NO. INVALID

Item 3 on the 958 is blank, incomplete or contains alpha characters.

- 958 - BA NO. INVALID - NEXT TO LAST EMPLOYER

Item 6 is blank, incomplete or contains alpha characters.

- 958 - CODE NAME INVALID

Item 2 on the 958 is blank or numeric.

- 958 - CURRENT LAG YEAR DIFFERENT FROM DLW YEAR
Item 9 must be the same year as the date in item 4.
- 958 - CURRENT LAG YEAR INVALID
Item 9 is blank or alpha characters.
- 958 - CURRENT YEAR ACTUAL SERVICE MONTHS INVALID
Item 10 is blank or alpha characters.
- 958 - CURRENT YEAR DEEMED SERVICE MONTHS INVALID
Item 11 is alpha characters.
- 958 - CURRENT YEAR SERVICE INDICATOR INVALID
Item 9 is blank.
- 958 - CURRENT YEAR SERVICE MONTHS INVALID
Item 10 is required because 15A is "NO," but is blank or alpha characters.
- 958 - CURRENT YEAR TOTAL SERVICE MONTHS = 0
Items 10 11 and 10-C are blank.
- 958 - CURRENT YEAR TOTAL SERVICE MONTHS INVALID - GREATER THAN 12
Items 10 11 and 10-C, when added, exceed 12 months.
- 958 - DLW INVALID
Item 4 on the 958 is blank, or alpha or not 6 digits.
- 958 - DLW INVALID - NEXT TO LAST EMPLOYER
Item 7 is blank or alpha or not 6 digits.
- 958 - DLW LATER THAN CURRENT DATE
Item 4 on the 958.
- 958 - DLW LATER THAN CURRENT DATE - NEXT TO LAST EMPLOYER
Item 7.
- 958 - DRR EARLIER THAN DLW

Item 5.

- 958 - DRR EARLIER THAN DLW - NEXT TO LAST EMPLOYER

Item 8.

- 958 - DRR INVALID

Item 5 is blank, incomplete or alpha characters, and this is not a disability case.

- 958 - DRR INVALID - NEXT TO LAST EMPLOYER

Item 6 is blank, incomplete or alpha characters, and this not a disability case.

- 958 - DRR LATER THAN CURRENT DATE

Item 5.

- 958 - DRR LATER THAN CURRENT DATE - NEXT TO LAST EMPLOYER

Item 8

- 958 - INSUFFICIENT SERVICE MONTHS FOR ANNUITY TYPE CODE. CONSIDER DEEMING.

RASI has determined that the service months in the SEARCH record plus the total creditable actual railroad service lag months from the G-88A.2 are insufficient to provide eligibility for the type of annuity being considered. Because this is prior to TRIC clearance, any claimed military service months used as compensation have not been considered. If creditable military service months are sufficient to provide eligibility, no further action is required. Control for the TRIC reply to verify that the military service months are creditable and provide eligibility. If not, and RASI dumps the case for denial for insufficient service.

Deemed railroad service months are explained in RCM 5.2.44-5.2.46. The most common situation is a disability case in which the additional service months are deemed in the 5-month waiting period to establish 240 months for an occupational disability. If there are months available between the employee's claimed actual date last worked and date rights relinquished (age and service), or between the claimed date last worked and the annuity beginning date (disability), consider deemed railroad service months.

When notice of the RASI dump action is received, and deemed railroad service months could apply, refer the case to the Employer Service and Training Center in Assessment and Training. They will contact the railroad and verify the number of creditable deemed railroad service months. If deemed railroad service months are creditable, they will obtain a new G-90 before returning the case to RIS.

Then, process the case as follows:

If deemed months are sufficient to establish eligibility, pay the case on ROC; or,

If deemed months are insufficient to establish eligibility, deny the case.

- 958 - NO MATCH ON NEXT-TO-LAST BA NO.

Item 6 does not agree with the next-to-last employer number in the master record. Determine which is correct. If the master record is wrong, prepare a 996 to change "EEPRVBA," and then submit the 958 one run later.

- 958 - NO NEXT-TO-LAST EMPLOYER. SECOND BA NO. INVALID

Item 6. The master record shows only one lag employer. If there are two, refer case to OP-RIS. Otherwise, resubmit 958.

- 958 - NO SECOND BA NO. TWO EMPLOYERS CLAIMED

The master record shows two lag employers. If there is one lag employer, refer case to P&S-RIS. Otherwise, enter both employers' lag data onto a 958 and submit.

- 958 - PRIOR LAG YEAR INVALID

Item 12 is blank or alpha characters.

- 958 - PRIOR YEAR ACTUAL SERVICE MONTHS VALID

Item 13 is alpha characters.

- 958 - PRIOR YEAR DEEMED SERVICE MONTHS INVALID

Item 14 is alpha characters.

- 958 - PRIOR YEAR SERVICE INDICATOR INVALID

Item 12 is required because there are two lag years, but it is blank.

- 958 - PRIOR YEAR SERVICE MONTHS INVALID

Item 12 is required because 15-A is "NO," but it is blank or alpha or one number.

- 958 - PRIOR YEAR TOTAL SERVICE MONTHS = 0

Item 13 is blank, but 14 is also blank.

- 958 - PRIOR YEAR TOTAL SERVICE MONTHS INVALID - GREATER THAN 12

Item 13 and 14, when added, exceed 12 months.

- 958 - SUBMITTED FOR NON-LAG YEAR. CERTHRUDTE IS 12 (___). CORRECT DATES AND RESUBMIT, OR REFER TO RAPT TO CLEAR LAG CALL-UP

Item 4 on the 958 (DLW - last employer) is not in the current lag period. If the DLW is different from the AA-1 (item 38), and is no longer in a lag period, refer the case to P&S-RIS to clear the 958 call-up after submitting a 996 to change "EEDLWRR." If the form is wrong, submit a 958.

- F. RASI produces the following input reject referrals explaining why a proof was rejected. Where action is required, submit a correct 900 to establish a proof on the master record.

- AA-3 DOM UNEQUAL TO G-91 DOM

There is a discrepancy between the date of marriage claimed on the AA-3 and the date of marriage verified. Investigate discrepancy. If DOM on AA-3 is correct, resubmit a corrected 900. If DOM on 900 is correct, prepare a 996 to correct DOM in master record before submitting 900.

- CHILD VERIFIED DOB NOT AS CLAIMED

Handle as for message below.

- CHILD DOB DOES NOT MATCH CLAIMED DOB

If a minor child was claimed on the AA-3 and is needed for spouse eligibility, investigate the discrepancy. If the child's DOB on the AA-3 is correct, submit a correct 900. If the DOB on the 900 is valid, prepare a 996 to correct DOB in the master record before submitting a 900.

If a child's POA is not required (Child is disabled or the spouse has claimed a minor child but is entitled without one) take the following action:

Prepare two (2) 996's. Item 1 and 2 on both forms should be completed normally for a spouse. Items 3-7 should be completed as follows:

First 996

3.	CODE NAME	SP996
4.	EXAM NO	RCA (Do not use exam#.) CORRECTED OR CHANGED DATA
5.	PRESENT CONTENTS	4
6.	CHANGED CONTENTS	0 (zero)
7.	FIELD NAME	SWSAGERELCHLD

Second 996

3.	CODE NAME	SP996
4.	EXAM NO	RCA (Do not use exam#.) CORRECTED OR CHANGED DATA
5.	PRESENT CONTENTS	(blank)
6.	CHANGED CONTENTS	0 (zero)
7.	FIELD NAME	CLS902

Note: For both 996's, space out unused positions.

9.	INQ CD	F
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NOTE: Do NOT resubmit child's proof of age or the 902 call-up will be reset.

- DISCREPANCY IN 1ST OR 2ND M/S PERIOD BEGINNING OR ENDING DATES

The dates of M/S indicated on the 900 are discrepant with those found in BDP records. RASI will accept 900 and continue to process claim. If annuity is paid incorrectly, recertify award with correct M/S.

- INVALID CODE IN M/S MEANS OF ENTRY
- INVALID CODE IN M/S TYPE OF DISCHARGE
- INVALID DATA IN DATE OF MARRIAGE
- INVALID DATA IN EE (SP) (CHILD) DOB (DOB WT) -
- INVALID DATE IN M/S
- M/S ENDING DATE PRIOR TO M/S BEGINNING DATE
- M/S PROOF NOT ACCEPTED - END DATE PRIOR TO 1-37

RASI will not accept proof for prior military service; an examiner determination is necessary to determine acceptability of proof before using prior M/S in annuity computation.

- M/S START DATE PRIOR TO 1-1-37, CHANGE TO 1-37

For mechanical computation purposes, RASI will only consider military service after 1-1937. If an annuity computation is to include prior M/S, handle manually.

- SECOND PERIOD M/S REJECTED - DUPLICATE OF FIRST
- (EE) (SP) (CHILD) VERIFIED DOB NOT AS CLAIMED -

Investigate discrepancy. If claimed DOB is incorrect, prepare a 996 to change master record before submitting 900.

G. DUMP data is rejected by RASI for the following reasons. When invalid or discrepant data is found, submit corrected 991.

- ATTEMPTED DUMP OF DUMMY EMPLOYEE RECORD SUBMIT 991 FOR SPOUSE ONLY DUMP
- CHANGE OF CHARGE FIELD CONTAINS INVALID CODE
- (EE) (SP) DUMPED CASE CODED FOR IMMEDIATE DROP

RASI has already dumped case; do not reenter 991.

- FORM CODE INVALID
- NAME DOES NOT MATCH MASTER RECORD
- (EE) (SP) PD FINAL CASE CODED FOR IMMEDIATE DROP

RASI has already paid case; do not reenter 991.

- SP RECORD NOT FOUND

H. RASI will reject IMPACT/SPAR input for the following reasons.

- TIER 1 (2) RATE INVALID \$XXXXXX - RESUBMIT 911
- VDB RATE INVALID \$XXX - RESUBMIT 911
- IMPACT ALREADY PAID - 911 REJECTED
- CODE NAME DOES NOT MATCH RASI BE CODE NAME - RESUBMIT 911.
- SPAR TIER 1 (2) RATE INVALID \$XXXXXX - RESUBMIT 911
- SPAR ALREADY PAID - 911 REJECTED
- CODE NAME DOES NOT MATCH RASI SPOUSE CODE NAME - RESUBMIT 911.
- SPAR TIER 1 AND SPAR TIER 2 IS GREATER THAN \$999.

NEW SPAR TIER 1 CONTENTS

NEW SPAR TIER 2 CONTENTS

I. RASI will reject a G-325 for the following reasons. Send folder to DPS for corrective action and re-entry.

- DIAGNOSTIC CODE INVALID
- DISABILITY BEGINNING DATE OR RATING CODE INVALID
- FREEZE CODE OR FREEZE DISABILITY DATE INVALID
- NAME ON FORM DOES NOT MATCH MASTER RECORD
- REP PAYEE CODE INVALID
- SWE DISABILITY NOT EQUAL TO 3 - REFER TO RCA

J. NAME-ADD data will reject for the following reasons. Prepare corrected 997 and re-submit.

- ADDRESS MUST BE AT LEAST TWO LINES LONG

If address consists of only one line, then city and state must be written on separate lines.

- AT LEAST TWO NAME LINES ARE REQUIRED

If a change in name and address is being made and a representative payee is being added, at least two name lines must be used.

- CHANGE CODE INVALID
- CLAIMANT'S NAME MUST BEGIN IMMEDIATELY AFTER THE WORD **FOR**

If a representative payee is part of a name and address entry, the word "FOR" must be written at the beginning of the second name line (followed by a blank space) and must be followed by claimant's name.

- CODE NAME DOES NOT MATCH MASTER RECORD
- CONFLICTING ITEMS - CHANGE CODE**** NAME AND ADDRESS CODE***

RASI will accept a 997 submitted for both employee and spouse in cases where only an address change is being made. If the codes used indicate any other type of change, RASI will reject the 997.

- DATA FOUND BEYOND 3RD POSITION OF 1ST NAME LINE

Only three items may be entered on the name line of the 997: first and middle name or initials and surname. If a fourth item is entered, RASI will reject. However, RASI will not reject for the suffixes "II", "III", "MD", "JR", or "SR".

- EMPLOYEE AND SPOUSE ADDRESS CHANGE NO SPOUSE RECORD FOUND

997 will not reject; change in employee's address will be made.

- FIRST LINE OF A TWO LINE NAME SHOULD BE TWO CHARACTERS LONG

In a two line name, RASI will not accept a single initial as one line. Either add a second initial or spell out entire first name.

- FIRST POSITION OF ADDRESS LINE IS BLANK

Group mark must be in first box of address line.

- 997 REQUIRED - G/M MISSING IN FIRST POSITION OF ADDRESS

This message occurs when both the name and address are being changed, but no group mark was entered before the address. Without the group mark, RASI cannot differentiate between the name or address. Therefore, when preparing a new 997, be sure to enter both the name and address, separated by a group mark.

- INCOMING ADDRESS CONTAINS MULTIPLE GROUP MARKS

Only one group mark at beginning of address line is necessary

- INCOMING ADDRESS DOES NOT HAVE GROUP MARK

- INCOMING ADDRESS EXCEEDS FOUR LINES

Rewrite address to fit on four lines.

- INCOMING NAME/ADDRESS LINE IS BLANK

Item 5 is coded for name or address change; therefore, a name or address entry is necessary.

- INITIALS MUST BE SEPARATED BY A SPACE

- INVALID THREE LINE NAME IN MASTER - REFER TO RCA

- INVALID WORD IN NAME LINE

RASI will not accept numeric characters in a name entry.

- LINE DOES NOT BEGIN WITH GROUP MARK

997 is coded for address change only. Therefore, the first line must begin with a blank space.

- LINE 1 THRU 5 SHOULD BE BLANK

Item 2 is coded 4 or 5; therefore, no entry should be made in name-address area.

- LINE 3 THRU 5 SHOULD BE BLANK

997 is coded for name change only; therefore, no address entry should be made.

- MASTER RECORD CONTAINS AN INVALID ADDRESS SUBMIT 997 TO REENTER CLAIMANT NAME AND ADDRESS

Name and address on application was incorrectly written (e.g., no blank space at beginning of address; more than four lines long, etc.). Correctly enter name and address on 997.

- MASTER RECORD INDICATES AN ACTIVE REP PAYEE

Item 2 was coded "0", but master record indicates a representative payee. Enter appropriate payee code.

- MORE THAN ONE WORD IN SURNAME

Surnames with two words should be written as one name, e.g., STJOHN.

- MORE THAN TWO NAME LINES SHOW

Name entry must be limited to two lines.

- NAME/ADDRESS CODE IS INVALID

- NAME LINE CANNOT BEGIN WITH GROUP MARK

A space was entered in the first position of the name.

- NAME LINE CONTAINS AN INVALID ONE POSITION WORD

A last name must contain more than one character.

- NAME LINE CONTAINS NUMERIC DATA

- NAME LINE MUST CONTAIN MORE THAN ONE WORD

RASI will reject 997 if there are not two or more "words" in name entry.

- NO ACTIVE MASTER FOUND FOR EMPLOYEE (SPOUSE)

RASI does not have active record for annuitant. Use G-607 to change address.

- NO NAME FOUND IN INCOMING NAME AND ADDRESS

997 was coded for change of name and address but only address entry was made. This message also occurs if no group mark was used in the address entry (without a group mark RASI cannot differentiate between name and address).

- NO REP PAYEE FOUND IN MASTER RECORD

Item 2 was coded "5", but there is no indication of a representative payee on master record.

- PAYEE CODE INVALID

- PAYEE CODE INVALID FOR ADDRESS CHANGE

- POSITION FOLLOWING GROUP MARK IS BLANK

Address must begin in space immediately following blank position.

- POSITION 21/22 OF NAME OR ADDRESS LINE IS GREATER THAN BLANKS

Each line of name and address must be limited to 20 characters.

- PROPOSED NAME AND/OR ADDRESS CHANGE WOULD REQUIRE SIX LINES

Rewrite entry to fit on five lines.

- WORD **FOR** MUST PRECEDE CLAIMANT NAME

When entering representative payee, the word "FOR" (followed by a space) must be written on the second line along with claimant's name.

K. A 996 will be rejected for the following reasons. Where incorrect or impossible data is indicated, submit a corrected 996. If the message indicates that a manual op code has been set, submit a 995 to clear that as well.

- CODE NAME IN MASTER DOES NOT MATCH RASI EE (SP) CODE NAME MANUAL OP CODE SET TO 2. 995, 996 REQUIRED.

The 996 rejected because the code name entered in item 3 is incorrect. It is either misspelled or does not match the code name of the payee code in item 2.

- CORRECTION ATTEMPTED BY (EXAMINER NUMBER) MASTER CONTENTS **** DO NOT EQUAL 996 PRESENT **** MANUAL OP CODE SET FOR CORRECTION FAILURE AT LOCATION ****

996 entries do not agree with the master record contents. The digital location is also shown. A manual OP code is set to prevent payment until record correction can be made. This manual OP code will clear when another 996 is submitted. If none will be submitted, refer the case to RAPT to clear the 995 and 996 call-ups.

- NO MATCHING RASI FIELD NAME

The entry in item 7 does not match any field in the RASI master. Check the 996 data for a discrepancy. Also check the field names printed on the reject notice.

- PRESENT CONTENTS ____ AND/OR CHANGED CONTENTS ____ NOT NUMERIC

There are alpha characters shown for a field which should contain only numeric characters.

L. RASI rejects a 995 for the following reasons. Where erroneous information is indicated, submit a corrected 995.

- CHANGE CODE INVALID

- CHANGE CODE IS 1 (3) DUMMY EMPLOYEE RECORD

RASI has a spouse-only application and no active employee record. Change code on 995 was incorrectly marked "1" or "3".

- INVALID CODE NAME

- NO ACTIVE SPOUSE DETAIL PROCESSED FOR EMPLOYEE

Change code on 995 was "3", but only employee application is on master record. Manual OP code will change for employee.

- TYPE OF ACTION INVALID

RASI did not set a man OP code; therefore, 995 was unnecessary.

9.3.20 Survivor (SURVEA) Referral Messages - General

SURVEA (Survivor Electronic Attainments) is the computer program that selects survivor annuitants for annuity adjustments or notices when they attain a certain age. SURVEA uses Research's MBF for the initial selection and compares these records to CHICO. If a match is made, a particular referral or listing is issued, followed by the specific age attainment notice. This message will be more fully explained in Section C below.

A. Referral Messages Printed on Listings

1. In Suspense FRA - These cases are selected in the month of FRA attainment, the third month after attainment if the case has not been handled; and every

month after the third month until the case is handled. This listing is used by the survivor post section to investigate cases where a widow(er) is attaining full retirement age and has been in suspense due to work. Also listed are cases where the referral of "NO PAYMENT RECORD FOR THIS RESEARCH RECORD," as described in Section C below, is issued.

2. HI Entitlement - These cases are selected six months before the month of age 65 attainment. This listing is used by the Medicare Program Section to set up or verify enrollment for HI entitlement at age 65. Also, a listing is prepared for MPS of cases where the widow(er) came on the rolls from one to five months in advance of age 65 attainment.

B. RL-175a Advance Notices

There are four situations in which an RL-175a advance notice is released.

SITUATION		RL-175a
1.	Age 18 Attainment	
	A. child age 18; no widow(er) involved	RL-175a #1
	B. Last child age 18; widow(er) involved	RL-175a #1 & #4
2.	Any student attaining age 19	RL-175a #11
3.	Age 16 Attainment	
	Last child attaining age 16, and the parent involved is a 1981 Amendment beneficiary	RL-175a #6

The RL-175a advance notices are released 4 months before attainment. The four RL-175a letters are displayed in section 9.3.22 of this chapter.

A copy of the letter is sent to the field office for their records. Another copy is filed in the folder. No examiner action is needed in these cases.

- C. 805 Referral Notices - The 805 referral is matched with the folder and sent to examiners for any necessary action. The specific messages are as follows:

1. CASE IN SUSPENSE. DEVELOP. This message is only issued one time.
2. CHILD AGE 17 AND 11 MONTHS. This message is issued in the month prior to age 18 attainment. There are no referrals for the next two subsequent months.

3. CHILD OVER 18 NOT DISABLED NOR FTS BORN 99-99. This message is issued the third month after the child attains age 18 if the case has not been handled. A referral is issued every subsequent month until handled or until the child is age 22, whichever is earlier.
4. WIDOW FULL RETIREMENT AGE. CHILD INVOLVED. This message is issued in the month a widow(er), who is being paid as a young mother or father with a child in care, is attaining full retirement age. There is no referral for the next two subsequent months. If the case has not been handled by the third month after the initial referral another referral will be released and one each month thereafter until the case is handled.
5. IN SUSP RIB/DIB AGE REDUCTION ADJUSTMENT REQ. This message is issued in the month a widow(er) type annuitant attains FRA and a RIB/DIB adjustment is necessary.
6. INTERIM WIDOW FOR 6 MOS. - INVESTIGATE. These cases are selected for the sixth month and all following months after the employee's death if a spouse is involved who has not been converted to a widow(er) or been terminated. If the DOD is unknown at the time of the employee's termination, Research uses an assumed DOD, 1 month prior to the time of termination. (Their records are earmarked that this is an assumed DOD). If an assumed DOD was used and the employee was enrolled in Medicare, send the case to MPS to correct their records after all other action is completed.
7. STUDENT AGE 19. This message is issued in the month of age 19 attainment. There are no referrals for the next two subsequent months.
8. STUDENT OVER 19 NOT DISABLED BORN 99-99. This message is issued in the third month after the student attains age 19, if the case has not been handled. A referral is issued every subsequent month until handled. The month and year of DOB is entered in the "9's" area.
9. LAST CHILD ATTAINING AGE 16. This message is issued in the month prior to age 16 attainment. There are no referrals for the next two subsequent months.
10. CHILD 17 + 8 MOS--BAD FAMILY CODES--NO FAST. This message is issued 4 months prior to age 18 attainment. This message is issued in cases in which the PREH family code and the CHICO family codes do not match and SURVEA cannot determine which record to select for termination.
11. NO PAYMENT RECORD FOR THIS RESEARCH RECORD. Generally, this message is issued when the Research record and the CHICO record do not agree on payee code or date of birth or a CHICO record, with the same prefix and claim number as the Research record, cannot be found. SURVEA will not issue the specific message or notice for the age attainment with this type of discrepancy because it cannot verify pay status. Under this message, the reason

for the selection will also be given, along with the date of birth in Research's record. In addition to the reasons listed in 1. through 10. above, other reasons are:

- CHILD AGE 17 AND 8 MOS - RL-175a (#1 or #1 and #4)
- CHILD AGE 15 AND 8 MOS - RL-175a (#6)
- STUDENT AGE 18 AND 8 MOS - RL-175a (#11)

The timetable for the release of message 10 is determined by the specific reason which initially selected the case.

Examiners must determine the source of the discrepancy and take appropriate action. This could include correcting the Research record via a G-59, correcting the CHICO record via a G-607, releasing an RL-175a type letter manually, and adjusting the case for the age attainment.

9.3.21 SURVEA Criteria For Message Selection

SURVEA initially selects attainment records from the Research file. Research has an individual record for each survivor beneficiary. SURVEA then attempts to match the record on CHICO. CHICO only has a record for a particular payee code.

1. Whenever the prefix and claim number from the Research record cannot be found on CHICO, a referral of "NO PAYMENT RECORD FOR THIS RESEARCH RECORD" will be issued.
2. If the payee code on Research records matches the payee code on CHICO, SURVEA then looks at the dates of birth. (See 3 below.) If the payee codes do not match and CHICO's payee code is greater than Research's payee code, a referral of "NO PAYMENT RECORD FOR THIS RESEARCH RECORD" is issued. If the payee codes do not match and CHICO's payee code is not greater than Research's payee code, SURVEA continues to read the CHICO records for that claim number until payee codes either match or CHICO's payee code is greater than Research's payee code.
3. If the date of birth on Research records matches the date of birth on CHICO and there is no termination on CHICO, the record is selected and the normal referral message is issued. If there is a termination on CHICO, the record is not selected. If there is a suspension on CHICO, a referral of "NO PAYMENT RECORD FOR THIS RESEARCH RECORD" is issued. If the dates of birth do not match, SURVEA looks at the activity date. If CHICO's activity date is greater than Research's activity date, a referral of "NO PAYMENT RECORD FOR THIS RESEARCH RECORD" is issued.

Exception: The COL voucher number is 471. Since Research is not updated for the COL as quickly as CHICO, SURVEA will by-pass the activity date edit check if the

voucher number on CHICO is 4/1 and Research's voucher date is different. In these cases, the normal referral message will be issued.

If CHICO's activity date is equal to or less than Research's activity date and there is no termination on CHICO, the case will be selected and the normal referral message is issued. If there is a termination on CHICO, the record is not selected.

9.3.22 SURVEA RL-175A Notices

RL-175A #1 A CHILD IN THIS CASE WILL ATTAIN AGE 18 IN _____.

THE CHILD'S ANNUITY WILL TERMINATE WITH THE MONTH AGE 18 IS ATTAINED UNLESS THE CHILD IS TOTALLY AND PERMANENTLY DISABLED, OR IS A FULL-TIME STUDENT IN AN ELEMENTARY OR SECONDARY SCHOOL. IF EITHER OF THESE CONDITIONS EXIST, CALL OR WRITE THE RAILROAD RETIREMENT BOARD OFFICE NEAREST YOU RIGHT AWAY.

IF YOU BELIEVE THIS DECISION IS NOT CORRECT, YOU MAY REQUEST THAT THE DECISION BE RECONSIDERED. YOUR REQUEST MUST BE IN WRITING AND SHOULD EXPLAIN WHY YOU DISAGREE. IF YOU WITH THIS RECONSIDERATION, YOUR REQUEST MUST BE RECEIVED BY THE RAILROAD RETIREMENT BOARD WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE. YOU MAY SEND YOUR REQUEST TO ANY FIELD OFFICE OF THE RAILROAD RETIREMENT BOARD, OR YOU MAY SEND IT DIRECTLY TO THE FOLLOWING ADDRESS: RAILROAD RETIREMENT BOARD, RECONSIDERATION SECTION, 844 NORTH RUST STREET, CHICAGO, ILLINOIS 60611-2092. IF YOU HAVE ANY ADDITIONAL EVIDENCE TO BE CONSIDERED, YOU SHOULD INCLUDE IT WITH YOUR REQUEST.

IF YOU DISAGREE WITH THE RECONSIDERATION DECISION, YOU MAY THEN APPEAL TO THE BUREAU OF HEARINGS AND APPEALS WITHIN 60 DAYS FROM THE DATE OF THE RECONSIDERATION DECISION.

IF YOU DO NOT REQUEST RECONSIDERATION WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE, YOU MAY NOT FILE AN APPEAL AT A LATER DATE.

THERE IS AN OFFICE LOCATED AT

PHONE _____

ROBERT J. DUDA

DIRECTOR OF OPERATIONS

RL-175A #4 A CHILD IN THIS CASE WILL ATTAIN AGE 18 IN _____.

WHEN A CHILD ATTAINS 18, HE MAY CONTINUE TO RECEIVE AN INSURANCE ANNUITY IF HE IS TOTALLY AND PERMANENTLY DISABLED, OR IF HE IS A FULL-TIME STUDENT IN AN ELEMENTARY OR SECONDARY SCHOOL.

YOUR ANNUITY WILL END WHEN THE CHILD REACHES AGE 18 UNLESS HE IS IN YOUR CARE AND ENTITLED TO A DISABLED CHILD'S INSURANCE ANNUITY, OR YOU ARE AGE 50 OR OLDER AND HAVE A PERMANENT DISABILITY WHICH PREVENTS YOU FROM DOING ANY WORK. A WIDOW UNDER AGE 60 CANNOT QUALIFY FOR AN ANNUITY BASED ON HAVING A FULL-TIME STUDENT IN HER CARE.

IF YOU ARE AT LEAST 50 AND DISABLED, OR IF THE CHILD IS DISABLED OR A FULL-TIME STUDENT IN AN ELEMENTARY OR SECONDARY SCHOOL, CALL OR WRITE THE RAILROAD RETIREMENT BOARD OFFICE NEAREST YOU RIGHT AWAY.

IF YOU BELIEVE THIS DECISION IS NOT CORRECT, YOU MAY REQUEST THAT THE DECISION BE RECONSIDERED. YOUR REQUEST MUST BE IN WRITING AND SHOULD EXPLAIN WHY YOU DISAGREE. IF YOU WISH THIS RECONSIDERATION, YOUR REQUEST MUST BE RECEIVED BY THE RAILROAD RETIREMENT BOARD WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE. YOU MAY SEND YOUR REQUEST TO ANY FIELD OFFICE OF THE RAILROAD RETIREMENT BOARD, OR YOU MAY SEND IT DIRECTLY TO THE FOLLOWING ADDRESS: RAILROAD RETIREMENT BOARD, RECONSIDERATION SECTION, 844 NORTH RUSH STREET, CHICAGO, ILLINOIS 60611-2092. IF YOU HAVE ANY ADDITIONAL EVIDENCE TO BE CONSIDERED, YOU SHOULD INCLUDE IT WITH YOUR REQUEST.

IF YOU DISAGREE WITH THE RECONSIDERATION DECISION, YOU MAY THEN APPEAL TO THE BUREAU OF HEARINGS AND APPEALS WITHIN 60 DAYS FROM THE DATE OF THE

RECONSIDERATION DECISION.

IF YOU DO NOT REQUEST RECONSIDERATION WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE, YOU MAY NOT FILE AN APPEAL AT A LATER DATE.

THERE IS AN OFFICE LOCATED AT

(NEAREST FIELD OFFICE)

ROBERT J. DUDA

DIRECTOR OF OPERATIONS

RL-175A #11 YOU WILL ATTAIN AGE 19 IN _____.

A STUDENT'S ANNUITY ENDS WITH THE EARLIER OF GRADUATION FROM HIGH SCHOOL OR ATTAINMENT OF AGE 19. IF YOU ARE IN FULL-TIME ATTENDANCE AT A SECONDARY SCHOOL IN THE MONTH YOU ATTAIN AGE 19, AND HAVE NOT COMPLETED THE REQUIREMENTS FOR, OR RECEIVED A DIPLOMA, ANNUITY PAYMENTS MAY BE EXTENDED FOR A SHORT TIME PAST YOUR 19TH BIRTHDAY. OUR FIELD OFFICE WILL BE CONTACTING YOU SOON TO DETERMINE WHEN YOUR ANNUITY WILL END.

IF YOU ARE DISABLED, CONTACT THE NEAREST RAILROAD RETIREMENT BOARD OFFICE AS SOON AS POSSIBLE SINCE YOU MAY BE ELIGIBLE FOR AN ANNUITY BASED ON DISABILITY.

IF YOU BELIEVE THIS DECISION IS NOT CORRECT, YOU MAY REQUEST THAT THE DECISION BE RECONSIDERED. YOUR REQUEST MUST BE IN WRITING AND SHOULD EXPLAIN WHY YOU DISAGREE. IF YOU WISH THIS RECONSIDERATION, YOUR REQUEST MUST BE RECEIVED BY THE RAILROAD RETIREMENT BOARD WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE. YOU MAY SEND YOUR REQUEST TO ANY FIELD OFFICE OF THE RAILROAD RETIREMENT BOARD, OR YOU MAY SEND IT DIRECTLY TO THE FOLLOWING ADDRESS: RAILROAD RETIREMENT BOARD, RECONSIDERATION SECTION, 844 RUSH STREET, CHICAGO, ILLINOIS 60611-2092. IF YOU HAVE ANY ADDITIONAL EVIDENCE TO BE CONSIDERED, YOU SHOULD INCLUDE IT WITH YOUR REQUEST.

IF YOU DISAGREE WITH THE RECONSIDERATION DECISION, YOU MAY THEN APPEAL TO THE BUREAU OF HEARINGS AND APPEALS WITHIN 60 DAYS FROM THE DATE OF THE RECONSIDERATION DECISION.

IF YOU DO NOT REQUEST RECONSIDERATION WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE, YOU MAY NOT FILE AN APPEAL AT A LATER DATE.

THERE IS AN OFFICE LOCATED AT
(NEAREST FIELD OFFICE)

ROBERT J. DUDA
DIRECTOR OF OPERATIONS

RL-1175A #6 YOUR CHILD WILL ATTAIN AGE 16 IN _____.

YOUR ANNUITY WILL END WHEN THE CHILD REACHES AGE 16. HOWEVER, THE CHILD'S ANNUITY CAN BE PAID UP TO THE MONTH THE CHILD REACHES AGE 18.

YOUR ANNUITY CAN CONTINUE IF YOU HAVE IN YOUR CARE AN UNMARRIED DISABLED CHILD UNDER AGE 22 OR A CHILD WHO BECAME DISABLED BEFORE AGE 22. YOU CAN ALSO GET AN ANNUITY IF YOU ARE AT LEAST 50, DISABLED FOR ALL WORK, AND MEET THE NECESSARY MARRIAGE REQUIREMENTS. IF EITHER OF THESE CONDITIONS EXIST, CONTACT THE NEAREST OFFICE OF THE RAILROAD RETIREMENT BOARD AS SOON AS POSSIBLE.

IF YOU BELIEVE THIS DECISION IS NOT CORRECT, YOU MAY REQUEST THAT THE DECISION BE RECONSIDERED. YOUR REQUEST MUST BE IN WRITING AND SHOULD EXPLAIN WHY YOU DISAGREE. IF YOU WISH THIS RECONSIDERATION, YOUR REQUEST MUST BE RECEIVED BY THE RAILROAD RETIREMENT BOARD WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE. YOU MAY SEND YOUR REQUEST TO ANY FIELD OFFICE OF THE RAILROAD RETIREMENT BOARD, OR YOU MAY SEND IT DIRECTLY TO THE FOLLOWING ADDRESS: RAILROAD RETIREMENT BOARD, RECONSIDERATION SECTION, 844 NORTH RUSH STREET, CHICAGO, ILLINOIS 60611-2092. IF YOU HAVE ANY ADDITIONAL EVIDENCE TO BE CONSIDERED, YOU SHOULD INCLUDE IT WITH YOUR REQUEST.

IF YOU DISAGREE WITH THE RECONSIDERATION DECISION, YOU MAY THEN APPEAL TO THE BUREAU OF HEARINGS AND APPEALS WITHIN 60 DAYS FROM THE DATE OF THE RECONSIDERATION DECISION.

IF YOU DO NOT REQUEST RECONSIDERATION WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE, YOU MAY NOT FILE AN APPEAL AT A LATER DATE.

THERE IS AN OFFICE LOCATED AT
(NEAREST FIELD OFFICE)

ROBERT J. DUDA

DIRECTOR OF OPERATIONS

9.3.30 PAM Referral Messages

PAM edits and processes all incoming Social Security transmissions from the Social Security Automated Data Transfer System (SSADTS). Whenever possible, it processes to completion and pays transmitted award records. If the final PAM award requires examiner review, PAM prints a message or messages on the RR-1a award form.

In other cases, omissions or discrepancies in the payment records preclude payment. PAM refers such cases out for manual handling with a descriptive message printed on the Mechanical Output Referral (MOR) form. A SOLAR award is also generated if the transmission indicates a payment activity to be taken, but the MOR message is not printed on it.

A. The following list of PAM messages is arranged alphabetically for easy reference. Each message has its numeric equivalent displayed in parentheses after it. If too many messages are necessary on PAM output, the numeric codes will be printed for the remaining messages instead of the actual message.

All messages with a numeric code beginning with "5" are reject referrals. These transmissions are referred to examiners for manual handling. Numeric codes beginning with a "6" indicate "alert" messages. These records are coded for examiner review after PAM processes the case. Numeric codes beginning with a "7" are non-review, informational messages which do not require examiner action.

All of these messages are produced by PAM as the result of its evaluation and interpretation of SSADTS data. No message is directly transmitted from SSA.

- ALERT - ACTIVE RECORD ON PAM (701)

If there is an active unpaid record remaining in the PAM system when another record is referred out for manual handling, this message is printed. Although the active record may not be for the same beneficiary as the one referred out, it will be in the same family group.

- ALERT - BENE'S OWN NUMBER EXTRACTED FROM CHICO (609)

A record was transmitted without the beneficiary's own account number but the BOAN is on CHICO. PAM will update the record with the BOAN from CHICO.

- ALERT - CASE ON RASI (613)

PAM has processed a case for payment and RASI contains a pending record.

- ALERT - CHECK FOR POSSIBLE SS COL REFERRAL (618)

PAM has processed an ss adjustment action but there could be an 805 referral still outstanding for the case from the mechanical COL run. If there is a referral, follow existing instructions for handling it.

- ALERT - CHECK RRB's USE OF MIL SERV (603)

If PAM is able to process to completion a BIC initial SS award transmission for an RR employee and there is an RR annuity and item 33(B) is E, I, M or S, the message will be printed. If RRB is using M/S as compensation in the annuity computation, use an RR-3 to notify the PC of RRB's use of M/S. (SSA may have to recompute the beneficiary's PIA to exclude M/S.)

- ALERT - CHICO/SS RATES INCONSISTENT (612)

PAM has processed a non-award action such as a suspension, termination, or change of address even though the SS rate on CHICO is not equal to the rate in the PAM record. Review the case to determine if a rate correction is necessary.

- ALERT - COA INDICATOR (642)

PAM did not process an SSA transmission to completion and a change of address is indicated on the SSA transmission. The change of address should be considered when the award is manually processed.

- ALERT - COA NOT PROCESSED/RR IN FORCE (608)

The SSADTS transmission contains a change of address for the SS benefit, but there is an RR annuity in force. PAM will not process the COA. Review the file to verify that SSA's address is not an old or invalid one and if a change is required, prepare a G607.

- ALERT - CORRECT PART RATE BEGINNING DATE MO-YR (614)

An adjustment action in a partial rate case has caused the partial rate beginning date to change to the voucher date of the current award. Examiner must complete a form G-607 to change the beginning date to the date of the first award which initiated the partial rate (see RCM 9.4, G-607 procedure). The date shown in the message is the voucher date now in the record which must be changed to the correct partial rate beginning date.

- ALERT - DPA/SSA NAME DISCREPANCY (639)

The surname of the SS beneficiary is not the RR employee's surname in the SEARCH record. In some cases, this may not indicate a problem (for example, RRB pays certain divorced wives' SS benefits). In other cases, it may indicate incorrect or discrepant information on SSA's transmission which should be corrected.

- ALERT - DOB DISCREPANCY - CHECK CHICO-RASI-DPA (604)

If the DOB on SSA's record does not match the DOB in RRB's record (the RRB DOB as shown on CHICO or the SEARCH DOB-EE only or the RASI DOB, or the SSA DOB as shown on CHICO - If the RRB on CHICO is blank), this message will be printed. A DOB discrepancy will not prevent payment. Existing procedure should be followed to resolve the DOB discrepancy.

- ALERT - EARMARK MBR WITH CORRECT RR CLAIM NO/PREFIX (602)

If SSA transmits no RRB claim number or the RRB claim number transmitted cannot be verified by SEARCH, a SEARCH request is made on the SSA claim number. If SEARCH verifies a valid RRB claim number, this number will be printed in item 1 as well as the above message. Examiners must complete a code "90" G-60 to enter the correct RRB claim number as shown in item 1 on the MBR. (See RCM 9.1 Appendix C.) This message will continue to appear until the correct RRCLNO is earmarked on the MBR. (See RCM 9.1 Appendix C.) This message will continue to appear until the correct RRCLNO is earmarked on the MBR. The earmarking process usually takes two weeks from the date the G-60 is submitted.

- ALERT - ESTABLISH FOLDER (700)

If the SCORE file data indicates that no general file and no claim file have been established, for the verified claim number, this message is printed as an aid to determine if a folder should be established. All RR-1a's are to be sent to claim files for matching with a folder or establishment of a file.

- ALERT - ESTABLISH SS ACCTS REC (616)

A G-376b must be prepared in any case where PAM initiates partial withholding. This review message will alert examiners to prepare a G-376b in such cases.

- ALERT - FORWARD CASE TO DB (607)

If a current pay SS award with a BIC A and a DOED is transmitted for an RR employee with no pending or paid RR annuity, this message will be produced. Forward the case to DB on a G-26.

- ALERT - IMPACC PAYMENT MADE (705)

If SSA transmits the IMPACC indicator and the SSADTS accrual does not equal the accrual computed by PAM, this message will be printed for informational purposes. In addition, a special paragraph on the RL-130Z will be printed to tell the beneficiary that his check does not include the amount already paid by SSA.

- ALERT - JURIS DETERM REQUIRED (601)

PAM converts SSA's request for a jurisdiction determination into this message and prints the SSADTS record data out on the MOR. This message appears in conjunction with type of activity "TERM" and "INFO".

- ALERT - MANUAL HI CLEARANCE REQ (605)

The only instances in which mechanical clearances will not be sent are:

- a) if it is a survivor case;
- b) if the RR claim number on the transmission has not been verified by SEARCH;
- c) if 120 months of service have not been verified; or
- d) if the transmission contained invalid critical data fields.

In these cases, the HI-SMI data (DOEH = HI EFF DATE, DOES = SMI EFF DATE, SENC = SMI CODE, SPAC = SMI PREMIUM) will be printed on the Mechanical Output Referral with the above message.

Follow current procedure for securing HI-SMI clearance if RRB has certification responsibility for payment of the SS benefit.

- ALERT - POSSIBLE TRUST FUND CHANGE (606)

This message will be printed if the DOEI, DOEC, and DOED are all present and the DOEI and DOEC match but the DOED is different or the DOEI and DOED match but the DOEC is different and the case is a current pay award with no old LAF.

This message will be printed on adjustment awards if the trust fund indication on CHICO does not equal the trust fund on the latest transmission. Prepare a G-607 to change trust funds (see RCM 9.4).

If a trust fund change was not made timely or if there is a trust fund change in the accrual, prepare a G-92 to make the trust fund correction.

- ALERT - REP PAYEE CODE ASSUMED (704)

SSA does not consider a parent receiving benefits for a child to be a representative payee. When PAM identifies this type of case (BIC "C" and the presence of "FOR" in the PNA), the word "PARENT" will be shown in the RPC followed by an asterisk as long as there is no CHICO record or conflict with the RPC on CHICO. For other rep payee situations when no RPC is transmitted, PAM will assume and print "OTHER".

- ALERT - RR ALREADY REDUCED (619)

PAM has processed a partial rate adjustment that includes an RR annuity in force or in suspense. The offset for SS benefits in an RR annuity is not affected by a change in the SS benefit due to partial withholding.

- ALERT - SS IN FRCE/SUSP - LAF C CASE (620)

SSA has transmitted an "OLD LAF C" to "NEW LAF T1" transmission. CHICO shows that an SS benefit (LAF E) is being paid or is in suspense. Investigate to determine if duplicate payments have been made by SSA and RRB.

- ALERT - T-3WD REQUIRED (600)

SSA's request for a T-3WD is converted by PAM into this message which causes the SSADTS record to be referred out for manual handling and release of a T-3WD or T-3.

This message will also appear in some partial rate cases when it appears that SSA has neglected to request a T-3/T-3WD before authorizing us to recover an overpayment.

- ASSOCIATE AND FILE DOWN (702)

If a miscellaneous transmission has an OLAF and NLA of D or S, this message will be printed. The activity is the result of some action to the beneficiary's MBR while it is in a deferred or suspended status. No examiner action is required.

- AWARD NOT BALANCED TO ACCRUAL

SSA ACCRUAL \$9999.99

COMPUTED ACCRUAL \$9999.99

THRU MO-YY (615)

The accrual that SSA authorized us to pay is not equal to the accrual that PAM computed based on the payment histories that were also transmitted.

In initial cases, most discrepancies are due to attorney's fees or IMPACC payments.

Therefore, do not question a discrepancy in current pay awards unless an error is readily apparent.

In adjustment cases, do not try to resolve a discrepancy unless you are working with the accrual period in question or if an error is immediately detectable. For example, in some cases, the old history that SSA has used may not equal the actual amount that we have paid. These cases may be referred to the OSR.

(NOTE: The accrual amount for adjustment cases that SSA transmits to us and which is printed in this message includes the old recurring check rate as does PAM's computed accrual shown in line 3. However, PAM correctly subtracts this amount before paying SSA's accrual.

The "thru date" is SSA's accrual date. It is the date through which the SSA and computed accruals in this message are calculated. This date may differ from PAM's actual accrual date if PAM vouchers the case through a later month. In such cases, PAM extends the accrual and adds on the difference due for the additional time period when it pays the case.

- CANNOT DETERMINE IF CHICO MATCHES PARCEL (523)

If it cannot be determined whether the CHICO reply which PAM requested matches the SSADTS transmission record (parcel) because of a discrepant name, BIC, BEN SYN, Payee Code, DOB, or BOAN, PAM does not continue to process the case but refers it out for manual handling with this message. Determine if CHICO contains incorrect data which resulted in a no match situation and correct such data with a G-607.

- CANNOT DEVELOP UNIQUE BEN SYN/PAYEE CODE

(DEVELOPED CODES ALREADY USED) (525)

For each SSADTS transmission record, PAM attempts to convert the MBR data into the RRB payment format. If PAM cannot develop a unique benefit symbol or a payee code from the MBR or RRB data available, the case is rejected for manual handling.

Determine if CHICO contains incorrect data which resulted in a no match situation and correct such data with a G-607.

- CASE PAID OR DUMPED BY RASI (520)

The RASI Reply to PAM's inquiry is "Paid Partial," "Paid Final," or "Case Dumped."

- CHANGE PAYEE NAME (626)

If SSA transmits an address that does not conform to our procedures (for example, the word "for" in rep payee cases is in line 1), PAM will try to correct SSA's address before it pays the case. Sometimes the correction cannot be done due to space limitations. Rather than rejecting the case, PAM will pay it.

Correct the name and/or address with a G-607. In most cases, this will involve moving the word "for" to line 2 and abbreviating the first name of the payee on that line.

- CHECK JURIS OF BIC C - NOT ON RR EMP'S ACCT (544)

The claim account number for a BIC C record is not equal to the RR employee's social security number. The RRB has certification responsibility for the payment of benefits to the children of living RR employees only if the benefits are claimed on the employee's record. Return all other BIC C claims to SSA.

- CHICO SS NUMBER INCONSISTENT (535)

Although the transmission record has no beneficiary's own account number (BOAN), PAM is able to match with CHICO on SS CL NO and BIC but the SS CL NO, BOAN and BIC are not consistent, i.e., the SS CL NO is not the same as the BOAN but the BIC is A and, conversely, the SS CL NO is the same as the BOAN but the BIC is not A. PAM does not update the pseudo number 729-01-2345 with the CHICO BOAN. Examiner action is necessary to resolve the discrepancy and correct CHICO using a G-607 if CHICO's BOAN is wrong or to correct the SOLAR award if the BOAN on the transmission record is wrong. Refer to Interim Procedure A-79-34 "Use of G-607 to Correct Boan on CHICO."

- COA NOT PROCESSED - SS TERM (710)

A termination request and a change of address were received from SSA. Since CHICO cannot accept a COA for a terminated CASE, the COA will not process. However, the system will send the termination notice to the new address.

- COA PROCESSED ON MM/DD/YY (707)

PAM has processed a change of address based on a non-award SSADTS transmission.

- CODE PAR

In current pay award cases with OLAF other than T1, T4, and T6 and no critical case indication which are referred out for manual handling, an RL-130Z letter is release. The wording of this letter has been coded as follows:

002 - "Under the law, social security benefits for railroad workers and their families are certified by the Social Security Administration to the U.S. Railroad Retirement Board for payment. The Social Security Administration has notified you and the Board that you are entitled to monthly SS benefits."

003 - "We have received payment information from the Social Security Administration and we will process your monthly benefit award as soon as possible. We regret any inconvenience this delay may cause you."

- COL MATCHED PAM - UNABLE TO PROCESS (538)

PAM is not able to process a COL transmission for a PAM record. An 805 referral will also be produced. Follow current instructions for handling 805 referrals.

- CORRECT BIC ON CHICO (617)

In certain cases, PAM will process an award action even though the BIC suffix on CHICO does not match the suffix on the SSADTS transmission. Examiners must prepare a Form G-607 to add or correct the BIC suffix on the CHICO record (see RCM 9.4).

- DOD IN DPA DATA/RR EE IN FORCE (646)

The SCORE file contains a date of death (DOD) for the railroad employee, but the CHICO record shown a check is being issued to him/her. In almost all cases, the SCORE file DOD is several years prior to the current year and is clearly erroneous. In such cases, complete a G-563, showing in item 24 the following:

"Erroneous DOD in SCORE file for EE. Please remove; EE is alive".

Send the G-563 to the Claims Certification Section. If you have reason to suspect that the SCORE file DOD may be valid, verify the EE's current status before removing the DOD from SCORE (this should be a very rare situation).]

- DOWNWARD ADJUSTMENT RATE CORRECTED (625)

If SSA transmits a downward adjustment and the NEW MBF equals the accrual due, PAM will process the case as a zero accrual recertification. That is, it will adjust the current rate to the NEW MBF effective with the following month's recurring check rate. (If SSA transmits an accrual due with a downward adjustment, PAM will pay the accrual amount and this message will not be printed unless PAM is processing the award later than SSA's accrual date and, consequently, an overpayment may exist.

These cases should be reviewed to determine if an overpayment is involved and a T-3/T-3WD should be released if necessary.

- DUAL ENTITLEMENT INVOLVED (543)

The SSADTS and CHICO records match on the beneficiary's own account number, but not on the claim account number and BIC. Benefits from the same trust fund should be combined. If different trust funds are involved, the benefits must be paid separately.

- FORWARD CASE TO DB IF RR DIS INVOLVED (631)

SSA has transmitted a suspension or termination for a DIB beneficiary because of work or a possible or actual recovery from disability and there is an RR employee, widow, or surviving child in pay status.

If the RR annuitant is receiving an RR annuity based on disability and DB has not taken any action based on SSA's report, forward the case to DB after the SS benefits are suspended or terminated.

- G-96 NOT PROCESSED TIMELY (622)

The SS date of termination is before the SS accrual date or PAM's date of termination is after SSA's accrual date. In either case, an overpayment may have occurred. Release Form T-3 to notify SSA of any overpayment. In death cases, follow the applicable procedure for last checks. (See RCM 6.6)

- LAF CODE C ON RR TYPE ACTIVITY (546)

The SSADTS record transmitting award activity reflects a LAF code C which means that SSA is certifying benefits. It may be necessary to coordinate with SSA in order to resolve any certification responsibility discrepancy.

- MANUAL DUMP REQUESTED (534)

This message will be produced if a G-394 is completed by an examiner to dump a pending PAM record.

- MECHANICAL HI CLEARANCE GENERATED ON MM/DD/YY

DOER MM/YY DOES MM/YY (703)

PAM will be able to generate mechanical HI clearances to the MIRTEL system for most initial cases transmitted with HI-SMI data. For these cases, this message will be printed to indicate the date the mechanical clearance was sent.

- MORE THAN 8 PARCELS ON MASTER (521)

A PAM "master" RRB claim number is established for each transmission record unless a prior "master" has been established. Each master can contain 8 separate "parcels." A "parcel" is a record with any type of activity for a beneficiary with the same RRB claim number. If the master contains 8 records, the additional transmitted activity is referred out for manual handling with this message.

- 9 PAYEE CODES USED (524)

The CHICO reply indicates that 9 payee codes have been assigned for the RRB claim number. Examiners must combine benefits if additional beneficiaries are involved.

- NO RECORD ON CHICO (539)

The SSADTS transmission is for an adjustment action but the CHICO record does not contain an indication that a benefit is being paid. Any previous unpaid SSADTS transmissions should be considered before processing the adjustment action.

- NO REINS REC'D ON DEF AWD - DEF OT MM/YY (526)

PAM holds deferred awards which do not contain HI/SMI on the system and converts them to current pay awards when the reinstatement activity is received from SSA. If 30 days have elapsed after the DOEC or DEFERRAL DATE (whichever is applicable) and no

reinstatement activity is received, the case is rejected for investigation and manual handling. Notify SSA that a payment appears to be in order. Occasionally, SSA's mechanical call-up system does not work; this will allow them to correct their records timely.

- PAM ADJ PROCESSED EFF DD-YY

SSA ADJUSTMENT EFF DT MM-YY (610)

The effective date of a downward adjustment processed by PAM is later than the effective date transmitted by SSA. If an overpayment is involved, the time lag must be considered when removing partial withholding or when determining the actual amount of the overpayment.

- PARCEL MATCHED CHICO - BEN STAT INCONSIST. (528)

The status of benefits on CHICO is inconsistent with the status of benefits on SSA's transmission. For example, SSA shows current pay activity, but CHICO contains a terminated record.

- PARCEL MATCHED CHICO NAME DOB DISCREPANCY (632)

The beneficiary's own account number matches the one on CHICO but there is either a name or DOB discrepancy. Examine both records and resolve any discrepancies between them.

- PARCEL MATCHED CHICO WITH DUE PROC. INC 532

The CHICO reply has a due process indicator for the SS beneficiary.

- PNA ALERT (711)

If SSA's transmission does not contain a change of address indication, but the address is too long as shown for CHICO, PAM will not supply CHICO with the address.

There is no action to be taken. If the case pays mechanically, the check will be sent to CHICO's address. If the case has to be paid manually, care should be taken not to use the address as shown on the transmission.

- POSSIBLE DUPLICATE PAYMENTS

BA NUMBER XXXX PREV XXXX (636)

SSA may have posted RR compensation as wages for the following employers during the years shown:

EMPLOYER	YEARS
American Federation of Labor Railway Employees' Department (BA 8913)	1980
Apache Railway Co. (2701)	1980
Atlantic Land and Improvement Co. (9517)	1972 or later
Baltimore and Annapolis RR Co. (5402)	1979
Brotherhood of Railway and Airline Clerks (8922)	1978 or later
Canton Railroad Co. (4310)	1978 or later
Clarendon and Pittsford RR Co. (2103)	1978 or later
Colorado and Wyoming RR Co. (1724)	1980 and 1981
Cybernetics and Systems (9518)	1972 or later
Florida East Coast Inspection (7529)	1969 or later
Fruit Growers Express (6401)	1978 and later
Gainesville Midland RR Co. (2517)	1978 or later
Hamburg Industries (9512)	1974 or later
International Brotherhood of Boilermakers and Blacksmiths (8908)	1980
Lambert's Point Docks, Inc. (4408)	1973 through 1977
Port Authority Trans-Hudson Corp. (5219)	1978 and 1979
RSTX, Inc. (9831)	1978 or later
San Manuel Arizona Railroad Company (2745)	1979
Soo Line Railroad (1606)	1978
Southwest Railway Equipment Corp. (9832)	1967 or later
Texas Mexican Railway Co. (1821)	1980
Vermont Railway, Inc. (2114)	1978 or later

Wabash Valley (3326)	1978
Washington Terminal Co. (4353)	1981
Winston-Salem Southbound RR Co. (2543)	1980

If the G-90 in file shows wages for the period shown above for the Ee's railroad employer, send the claim folder to the Claims Certification Section. If there is no G-90 (SS-only case), release a G-37b teletype to SSA to determine if the railroad shows up as an employer at SSA for the years in questions.

When it is determined that SSA's record is in error, release an RR-3 explaining the problem. Adjust the RR annuity and process the SS benefit in file. SSA will send an amended benefit award later if necessary.

- POSSIBLE INSTALLMENT PAYMENT (627)

SSA is unable to transmit an "I" partial rate code to indicate an installment payment. PAM will try to identify possible installment cases by printing this message if the MBA is greater than the PIA, no DRIMS are posted and dual entitlement is not involved. Ask the OSR to determine if an installment payment is involved before attempting to adjust an RR annuity for the SS benefit.

- POSSIBLE U/P CHECK OLD HST (621)

SSA has transmitted an initial award with a deferred status indicator due to current excess earnings, but some monies are payable for a previous year. PAM holds these records in the system until the future deferred date; it does not attempt to process a one check only for the money due in the previous year.

If SSA transmits a second revised record before PAM pays the case, SSA assumes that all monies due have been paid and computes the accrual accordingly. Since PAM pays the latest accrual amount from SSA when it processes the case for payment, an underpayment may occur.

Check the OLD HISTORY DATA on the RR-1a award form. If it shows that an amount was paid, but a review of the file shows that this is not the case, redetermine the accrual using the correct history data and pay the additional amount due.

- PREV MO NOT PAYABLE - POSSIBLE O/P (549)

SSA's mechanical system is incorrectly sending duplicate accruals for cases with two or more transmissions in the same accrual month. (See the Informational Bulletin dated September 17, 1980). PAM is able to identify some of these cases if the OLD HISTORY total money amount is more than the NEW HISTORY total money amount and the monthly rates are the same. If this message appears, check the file for other MOR's with the same

accrual date, then calculate the total money due or owed based on the transmissions' histories. If a discrepancy exists, request the OSR to reconcile the inconsistencies.

- RASI REDUCTION/SS DATES AND RATES INCONSISTENT (542)

The SS rates and effective dates in the RASI record do not match the record pending payment in the PAM system. If the discrepancy cannot be resolved after an examination of the file, refer the case to the OSR.

- RATE CORRECTED/TOLERANCE APPLIE (709)

If SSA transmits an adjustment award that is within ten cents of the recurring SS rate, PAM will adjust the benefit in the current month only. Since tolerance applies, no overpayment amount or underpayment accrual will be computed and no further action is necessary.

- RR CLM NO. DIS.

RASI 999999; PAM 999999 (533)

The RASI RRB claim number does not match the PAM RRB claim number. Determine the proper claim number and correct the discrepant one.

- RR EE IN PAY STATUS - CHECK O/M (636)

A BIC C award has been processed and there is an indication that there is an RR EE in pay status. Determine if an adjustment should be made in the Ee annuity.

- RR ESTABLISHED - NOT "PURE" (519)

A CHICO record has been established for the SS beneficiary under the same RRB claim number as the SSADTS transmission record.

- RR G-96 PROCESSED ON NM-DD-YY CAUSE CD 999 LTR CDE 999 (628)

PAM has processed a G-96 to terminate an RR annuity due to death. The effective date of the G-96 is the month shown in the message. That is, assume that if the processing date is in one month, the following month's check will be stopped. RCM 9.4, G-96 Instructions, contains a list of G-96 cause codes and letters.

- RR INVOLVED (624)

There is an RR annuity in force for the beneficiary whose SS benefit PAM has suspended or terminated. Review the file to determine if the suspension or termination affects the RR annuity.

- RR RATES ON CHICO AND RASI UNEQUAL (531)

PAM cannot determine if an RR annuity has been reduced for the pending SS benefit if the RR rate on CHICO is not the last rate that was shown on RASI. The SS benefit and RR annuity, if necessary, must be manually processed.

- REP PAYEE CODE DISC (516)

There appears to be a representative payee discrepancy because:

- SSA's transmission contains a rep payee code for the beneficiary but CHICO does not;
- CHICO has a rep payee code, but SSA's record does not;
- The rep payee codes on each record differ;
- SSA's record contains a rep payee code, but there is no "FOR" in the address.
- SEARCH REPLY REC'D - LESS THAN 120 MO OF SERV (518)

SEARCH verifies the claim number but the number of railroad service months for that claim number through the last full year of posted service months and compensation is less than 120. Complete Form RR-3 to notify the PC that RRB does not have certification responsibility because the RR EE has less than 120 months of RR service. However, the possibility of lag or M/S or prior service should be explored, if it appears from the year last worked or the service months from 37-46 that additional service would produce 120 months.

- SMIB BEING DEDUCTED (706)

SMI premiums are being deducted from the SS benefit. Item 37 (E, G) on the RR-1a reflects the benefit rate after the SMI deduction.

- SMIB RATE EXCEEDS RECURRING RATE (548)

SSA has transmitted an SS amount for payment that is less than the SMI premium rate for the beneficiary. In most cases, partial withholding will be involved. Process the award without a deduction for SMIB and forward the case to HB to establish direct billing.

- SS G-96 PROCESSED ON MM-DD-YY CAUSE CD 999 LTR CDE 999 (708)

PAM has processed a mechanical G-96 to suspend or terminate SS benefits. The effective date of the G-96 is the month shown in the message. That is, assume that if the processing date is in one month, the following month's check will be stopped. RCM 9.4 contains a list of G-96 cause codes and letters.

- SSA ACCRUAL AMOUNT \$99999.99

RATE CORRECTED (611)

If SSA transmits an accrual amount in DPRD = 01/99 cases, PAM will adjust the current rate, but it will not pay the accrual since any money due should be used towards recovery of the overpayment. The accrual transmitted by SSA will be printed as a review message.

- SSA DATA EXCEPTION - BENCD (507)

Benefit code is missing or invalid.

- SSA DATA EXCEPTION - BENNAME (508)

Beneficiary's name is missing or contains numeric data.

- SSA DATA EXCEPTION - BIC (502)

Beneficiary identification code is missing or not logical, or it is not consistent with the CAN and BOAN.

- SSA DATA EXCEPTION - BOAN (510)

Beneficiary's own account number is missing or invalid or it is not consistent with the CAN and BIC.

- SSA DATA EXCEPTION - CAN (501)

SSA claim number on which the payment is based is missing or invalid or it is not consistent with the BOAN and BIC.

- SSA DATA EXCEPTION - DOB (629)

Date of birth is missing or invalid.

- SSA DATA EXCEPTION - DOEC (504)

Date of current entitlement is missing or invalid.

- SSA DATA EXCEPTION - DOEI (505)

Date of initial entitlement is missing or invalid.

- SSA DATA EXCEPTION - DOST (514)

Date of suspension or termination is missing or invalid.

- SSA DATA EXCEPTION - MBP (506)

Monthly benefit payable amount is missing.

- SSA DATA EXCEPTION - NO ACCRUAL (529)

The SSADTS record transmitting an award activity does not contain an accrual amount that SSA has authorized the RRB to pay.

- SSA DATA EXCEPTION - PNA (512)

The name or address line contains more than 20 characters or SSA's transmission is for combined beneficiaries.

- SSA DATA EXCEPTION - RRBCAN (500)

RRB claim number was not verified in the SEARCH program.

- SSA DATA EXCEPTION - RRBBS (513)

SSA's benefit suffix cannot be converted into RRB prefix.

- SSA DATA EXCEPTION - TOA (503)

Type of activity indicator is missing or not logical.

- SSA "SHORT MONTH"

WITHHOLD 999.99

RATE CORRECTED (623)

SSA has transmitted an upward or downward adjustment and an accrual amount that is less than the monthly rate. This "short" month accrual indicates that there is an amount to be withheld from one monthly check. A temporary work deduction due to excess earnings is usually involved.

PAM will handle these cases as zero accrual recertifications and adjust the current rate to the NEWMBP effective with the following month's recurring check rate. The amount in the message is the money to be withheld from one monthly check. (PAM determines this amount by subtracting the accrual amount on SSA's transmission from the MBP.) Although these cases must be suspended in order to withhold the amount in the message, they can usually be immediately reinstated.

- TRANS MATCHED PARCEL - UNABLE TO PROCESS (527)

If a SSADTS transmission record is received for a beneficiary and an existing record is pending in PAM, PAM determines if it can process either or both parcels (records). If PAM cannot process both parcels, the records are rejected for manual handling.

- UNABLE TO COMPUTE AMT PAYABLE (522)

ACC AMT \$9999.99

If PAM has processed the SSADTS record through the initial edits for missing or discrepant data and it meets the other payment criteria, the program which computes the amount payable attempts to compute the accrual amount as transmitted. If PAM cannot interpret SSA's information or accrual account, the case will reject.

In initial or adjustment cases, pay the amount SSA has authorized (extending the accrual, if necessary) unless an error is readily apparent. Discrepant accruals in initial cases usually reflect attorney's fees or IMPACC payments and, therefore, are correct. In adjustment cases, SSA's old history data may not equal what we actually paid. Refer those cases to the OSR if you are unable to resolve the discrepancy. If an error is detected, it is important to notify SSA so that their records can be corrected.

- UNABLE TO PROCESS ADJ (536)

The NEW MBP on the adjustment transmission equals the OLD MBP, but SSA has posted an accrual amount due or the partial rate code is "N".

- UNABLE TO PROCESS CPA - LAST ACTION NOT ON RASI (541)

PAM cannot determine if an RR annuity has been reduced for the pending benefit if there is no RASI record or if the voucher number on CHICO is not a RASI voucher number. The SS benefit and RR annuity, if necessary, must be processed manually.

- UNABLE TO PROCESS CPA - NO RR REDUCTION MADE (540)

PAM will not process a current pay SS benefit if the corresponding offset has not been made in the RR annuity.

- UNABLE TO PROCESS G-96 T/S (547)

PAM cannot interpret SSA's transmission (for example, the LAF code is illogical) or SSA's transmission contains a LAF S9 "Jurisdiction determination required" for an auxiliary beneficiary due to the death of the primary beneficiary. If the SS auxiliary is an RR A&S or disability annuitant, a jurisdiction determination is not required and PAM will not suspend the benefits. PAM will also not terminate "TO" LAF cases if the beneficiary is an RR A&S or disability annuitant, "T+" LAF cases if an RR annuity is involved, and deferred adjustment cases where reinstatement action is to be taken the month following the date of suspension.

- UNABLE TO PROCESS - NO COL RATE (537)

SSA has not transmitted the latest COL increase and effective date for a record.

- UNABLE TO PROCESS - NO NEW HISTORY (545)

This message appears in conjunction with termination referrals when SSA is deleting an MBR due to incorrect information. Their "Kill Credit" transmission corresponds to our code

62 G-96. Take appropriate action to correct the benefit record including completion of a code 62 G-96, if necessary (see RCM 9.4).

- **UNABLE TO PROCESS ON PREF OR BEN SYM SURV/PENS CASE (517)**

PAM determines that it is a survivor or pensioner case if the RRB benefit symbol/prefix is "D" or "H", or the employee is dead, or there is a widow's record on CHICO, or there is a WC record on CHICO with RR benefits.

- **UNABLE TO PROCESS - SS BEN AMTS NOT EQUAL (530)**

The current recurring SS benefit rate on CHICO does not match the OLD MBP on the adjustment transmission. Since this may indicate a prior adjustment action that has not been processed, PAM will reject the record and an MOR/SOLAR award will be produced.

9.3.40 Mechanical G-90 Reject Messages

A G-90 request has rejected from a mechanical G-90 request run. The request could be from the monthly DF mechanical run, the monthly MAP age 62 recalculation mechanical run, or any special one-time mechanical G-90 run. The following reject messages explain the cause of the reject. Submit a G-60 request in order to obtain the G-90. When completing the G-60, pay particular attention to the information which caused the mechanical reject.

- **ABD YEAR BEFORE 1975**

The mechanical G-90 request contained a "01" type of request code, but an ABD prior to 1975. Verify and enter the correct ABD in item 8 of the G-60. If the ABD is prior to 1/1/75, enter a "13" in item 13 of the G-60. If the ABD is 1/1/75 or later, furnish the appropriate entry (either "01" or "10") in item 13 of the G-60.

- **ABD YEAR**

- **REC REQ CD INVALID FOR ABD YEAR**

The mechanical G-90 request contained an ABD prior to 1937. Verify and enter the correct ABD in item 8 of the G-60.

- **ABD YR GREATER THAN CURRENT YR**

The mechanical G-90 request contained a "01" type of request code but an ABD later than the current year plus one. For example a G-90 request made in 1989, (with a "01" type of request code), the ABD cannot be later than 1990. Verify and enter the correct ABD in item 8 of the G-60.

- **ABD YR LESS THAN DLW RR YR**

The mechanical G-90 request contained an ABD prior to the RR (DLW). Verify and enter the correct ABD and RR (DLW) in items 8 and 11 of the G-60.

- APPL FILING DATE ERROR

The mechanical G-90 request contained an invalid application filing date. Verify and enter the correct application filing date in item 16 of the G-60. (Enter preceding zeroes where necessary.)

- CLAIM NO NOT NUMERIC

The mechanical G-90 request contained a non-numerical claim number. Verify and enter the correct claim number in item 2 (or item 1 if the claim number is a six digit claim number) of the G-60.

- DATE OF BIRTH ERROR

The mechanical G-90 request contained an invalid date of birth. Verify and enter the correct date of birth in item 5 of the G-60.

- DF DATE REQUIRED

The mechanical G-90 request did not contain a DF year. Verify and enter the correct DF beginning date in item 24a of the G-60.

- DF PRIOR SERVICE MONTHS

The mechanical G-90 request contained either a non-numerical prior service month total or a total greater than 360 months. Verify and enter the correct number of prior service months, (not more than 360), in item 22 of the G-60.

- DF YEAR GREATER THAN CURR YR

The mechanical G-90 request contained a DF beginning date later than the current year. Verify and enter the correct DF beginning date in item 24a of the G-60.

- DF YEAR LESS THAN 40

The mechanical G-90 request contained a DF beginning date prior to 1940. Verify and enter the correct DF beginning date in item 24a of the G-60.

- DF 1ST PER BEG DATE ERR

The mechanical G-90 request contained an invalid DF beginning date. Verify and enter the correct DF beginning date in item 24a of the G-60. (Enter preceding zeroes where necessary.)

- EE ANN CODE WRONG FOR ABD YEAR

The mechanical G-90 request contained an incorrect type of annuity code for the ABD. Verify and enter the correct ABD and type of annuity code in items 8 and 14 of the G-60.

- 1ST MS OVERLAP INVALID W/USE
- 1ST MS USE MUST BE - 1
- 2ND MS OVERLAP INVALID W/USE
- 2ND MS USE MUST BE - 1
- 3RD MS OVERLAP INVALID W/USE
- 3RD MS USE MUST BE - 1
- 4TH MS OVERLAP INVALID W/USE
- 4TH MS USE MUST BE - 1

The military service period is shown with overlapping railroad service months, while the military service period is shown as being "used" other than as compensation. Overlapping railroad service months apply only when the M/S period is "used" as compensation. Leave items 29e, 30e, 31e, or 32e blank if the corresponding M/S period is not being "used" as compensation in the annuity computation. Complete correct M/S data as appropriate on the G-60.

- 1ST M/S PER OVRLAP MOS NOT ZERO
- 2ND M/S PER OVRLAP MOS NOT ZERO
- 3RD M/S PER OVRLAP MOS NOT ZERO
- 4TH M/S PER OVRLAP MOS NOT ZERO

The mechanical G-90 request contained an invalid type of request code for matching military service information. Verify and enter the correct codes for items 13 and 28.

- 1ST MS PER USE CODE INVALID
- MS CODE - 1ST PER - INVALID
- 2ND MS PER USE CODE INVALID
- MS CODE - 2ND PER - INVALID
- 3RD MS PER USE CODE INVALID
- MS CODE - 3RD PER - INVALID
- 4TH MS PER USE CODE INVALID

- MS CODE - 4TH PER - INVALID

The military service period does not show how it is being "used" in the annuity computation. Complete correct M/S data including "use" code in items 29c, 30c, 31c and 32c as appropriate on the G-60.

- GROSS 1959 CODE NOT 1 OR 2

The mechanical G-90 request contained an invalid (not "1" or "2") '59 Gross Earnings Code. Enter either "1" or "2" in item 17 of the G-60 according to the G-60 instructions in RCM 9.1, Appendix C.

- GRS 59 CD NOT 1 - APP DATE

The mechanical G-90 request contained an application filing date later than 10-15-87, but a '59 Gross Earnings Code of "2". If the correct application filing date is later than 10-15-87, enter a "1" in item 17 of the G-60. If the correct application filing date is prior to 10-15-87, check item 1H of the G-90 which was used to finalize the annuity. If the "date into system" is 10-16-87 or later, enter a "1" in item 17 of the G-60. If the "date into system" is prior to 10-16-87, enter a "2" in item 17 of the G-60. (This message often results from missing G-90 information from the preceding award.)

- INV MIL SER CRED CD - 1ST PER

- INV MIL SER CRED CD - 2ND PER

- INV MIL SER CRED CD - 3RD PER

- INV MIL SER CRED CD - 4TH PER

The mechanical G-90 request contained an invalid military service creditability code. Complete item 29c, 30c, 31c, or 32c as appropriate of the G-60.

- INVALID CLAIM NO PREFIX

The mechanical G-90 request contained an invalid claim number prefix. Verify and enter the correct claim number prefix ("A", "D", or "H") in item 1 of the G-60.

- INVALID CURRENT CONNECTION

The mechanical G-90 request contained an invalid current connection code. If the employee does not have a current connection, leave item 10 of the G-60 blank. If the employee had a current connection on 12-31-74, but not on his ABD, enter a "3" in item 10 of the G-60. If the employee has a current connection on his ABD (either before or after 12-31-74), enter a "4" in item 10 of the G-60.

- INV DATES FOR INTV EARNS CODE

- 1ST MS PER INTV EARNNS CODE INV
- 2ND MS PER INTV EARNNS CODE INV
- 3RD MS PER INTV EARNNS CODE INV
- 4TH MS PER INTV EARNNS CODE INV

An intervening earnings code is shown in the Research record for the M/S period for which it is unnecessary. The M/S period may be completely outside the 6-15-48 through 12-15-50 period. Code 1 = YES, Code 2 = NO. Delete the intervening earnings code from your G-60 request, if applicable.

- INVALID DF UNIT CODE

The mechanical G-90 request contained an invalid unit code for a DF record. Complete G-60 per usual instructions.

- INVALID DF YEAR

The mechanical G-90 request contained an invalid DF beginning date. Verify and enter the correct DF beginning date in item 24a of the G-60. (Enter preceding zeroes where necessary.)

- INVALID DLW - LPS

The mechanical G-90 request contained an invalid LPS date last worked. Verify and enter the correct LPS (DLW) in item 12 of the G-60. (Enter preceding zeroes where necessary.)

- INVALID DLW - RR

The mechanical G-90 request contained an invalid RR date last worked. Verify and enter the correct RR (DLW) in item 11 of the G-60. (Enter preceding zeroes where necessary.)

- INVALID EMP ANN CODE FOR DF

- INVALID EE ANN CODE

The mechanical G-90 request contained an invalid employee annuity code. Verify and enter the correct employee annuity code in item 14 of the G-60.

- INVALID EMPLOYEE ABD

The mechanical G-90 request contained an invalid employee ABD. Verify and enter the correct employee ABD in item 8 of the G-60.

- INVALID INITIALS

The mechanical G-90 request contained invalid initials in the employee's name. Enter the correct initials in item 4 of the G-60.

- INVALID MIL SER CODE

The mechanical G-90 request contained an invalid military service code. Enter the correct military service code ("1", "2", "3", or "4") in item 28 of the G-60.

- INVALID SEARCH ACCT NO.
- INVALID SSA NO.

The mechanical G-90 request contained an invalid RRB claim number and/or an invalid SSA number. Enter the correct RRB claim number and SSA number in items 1 and 2 of the G-60.

- INVALID SURNAME

The mechanical G-90 request contained an invalid employee surname. Verify and enter the correct surname, up to 10 letters, in item 4 of the G-60.

- MS BEG 1ST PER MONTH INVALID
- MS BEG 2ND PER MONTH INVALID
- MS BEG 3RD PER MONTH INVALID
- MS BEG 4TH PER MONTH INVALID

The mechanical G-90 request contained an invalid military service beginning date (the month of the beginning date was not "01" through "12"). Verify and enter the correct military service beginning date in item 29a, 30a, 31a, or 32a of the G-60.

- MS BEG 1ST PER YR NOT NUMERIC
- MS BEG 2ND PER YR NOT NUMERIC
- MS BEG 3RD PER YR NOT NUMERIC
- MS BEG 4TH PER YR NOT NUMERIC

The mechanical G-90 request contained an invalid military service beginning date (the year of the beginning date was not numeric). Verify and enter the correct military service beginning date in item 29a, 30a, 31a, or 32a of the G-60.

- MS DATA FOUND - -WRONG MS CODE

The mechanical G-90 request indicated that no military service was claimed, however data has been found in one or more of the subsequent military service entries. If the employee has military service which should be considered in the PIA computations, enter the appropriate military service code in item 28 of the G-60. If no military service has been claimed, all G-60 items 28 through 35 should be blank.

- MS DATES ARE NOT IN SEQUENCE

The mechanical G-90 request contained military service dates which were out of sequence. Review and enter the correct military service dates in items 29a and 29b, 30a and 30b, 31a and 31b, or 32a and 32b, if applicable, of the G-60.

- MS END 1ST PER MONTH INVALID
- MS END 2ND PER MONTH INVALID
- MS END 3RD PER MONTH INVALID
- MS END 4TH PER MONTH INVALID

The mechanical G-90 request contained an invalid military service ending date (the month of the ending date was not "01" through "12"). Verify and enter the correct military service ending date in item 29b, 30b, 31b, or 32b of the G-60.

- MS END 1ST PER YR NOT NUMERIC
- MS END 2ND PER YR NOT NUMERIC
- MS END 3RD PER YR NOT NUMERIC
- MS END 4TH PER YR NOT NUMERIC

The mechanical G-90 request contained an invalid military service ending date (the year of the ending date was not numeric). Verify and enter the correct military service ending date in item 29b, 30b, 31b, or 32b on the G-60.

- MS 1 BEG DATE FOUND
- MS 2 BEG DATE FOUND
- MS 3 BEG DATE FOUND
- MS 4 BEG DATE FOUND

The mechanical G-90 request indicated that no military service was claimed, however a M/S beginning date was entered on the request. If the employee has military service which should be considered in the PIA computations, enter the appropriate military service code

in item 28 of the G-60. If no military service has been claimed, all G-60 items 28 through 35 should be blank.

- MS 1 END DATE BEFORE BEG DATE
- MS 2 END DATE BEFORE BEG DATE
- MS 3 END DATE BEFORE BEG DATE
- MS 4 END DATE BEFORE BEG DATE

The mechanical G-90 request contained a military service ending date which was earlier than the corresponding beginning date. Review and enter the correct military service dates in items 29a and 29b, 30a and 30b, 31a and 31b, or 32a and 32b, if applicable of the G-60.

- MS 1 END DATE FOUND
- MS 2 END DATE FOUND
- MS 3 END DATE FOUND
- MS 4 END DATE FOUND

The mechanical G-90 request indicated that no military service was claimed, however, a M/S ending date was entered on the request. If the employee has military service which should be considered in the PIA computations, enter the appropriate military service code in item 28 of the G-60. If no military service has been claimed, all G-60 items 28 through 35 should be blank.

- MS 1 MS CODE FOUND
- MS 2 MS CODE FOUND
- MS 3 MS CODE FOUND
- MS 4 MS CODE FOUND

The mechanical G-90 request indicated that no military service was claimed, however a separate mechanical entry indicated that either 1, 2, 3, or 4 periods of military service were claimed. Enter the correct M/S code in item 28 of the G-60.

- MS 1 USE CODE FOUND
- MS 2 USE CODE FOUND
- MS 3 USE CODE FOUND
- MS 4 USE CODE FOUND

- MS DATA FOUND - WRONG MS CODE

Incomplete M/S data is shown for the M/S period listed on the reject. If the M/S period is valid, enter complete M/S data on the G-60. If the M/S data listed is incorrect, delete the M/S data from the G-60 request.

- REC REQ CD INVALID FOR ABD YR

- ABD YEAR

The mechanical G-90 request contained an annuity beginning date prior to 1937. Verify and enter the correct ABD in item 8 of the G-60.

- SEARCH ACCT NO. BLANK

The mechanical G-90 request contained zeroes or spaces in the SSA number entry. Verify and enter the correct SSA No. in item 2 of the G-60.

- SURNAME BLNK, INITIALS PRESENT

The mechanical G-90 request contained the employee's first and middle initials, but the surname entry was blank. Verify and enter the employee's correct name, (up to 10 letters) in item 4 of the G-60.

- SURNAME PRESENT, 1ST INIT BLNK

The mechanical G-90 request contained an employee surname, however the first initial entry was blank. Enter the employee's name, including initials, in item 4 of the G-60.

- TYP REQ 01 MUST HAVE DLW RR

The mechanical G-90 request did not contain an RR date last worked. Enter the correct DLW (RR) in item 11 of the G-60.

- VESTING YR NOT 37 TO 74 OR 99

The mechanical G-90 contained an invalid vesting year. If the DF G-90 request is for a '37 Act case (item 13 of the G-60 is "13"), enter the correct vesting year in item 39 of the G-60. The item 39 entry must either be from "37" through "74", if a vesting year is displayed in item 10F of a previous file G-90; or "99", if no vesting year is displayed in item 10F of a previous file G-90. Leave this item blank in any '74 Act or later case. This message often results from missing G-90 information from the preceding award.

- WRNG EE ANN CD FOR TYPE OF REQ

The mechanical G-90 request contained a 1974 Act type of request code, however the request also contained a 1937 Act annuity code. Review and enter consistent codes in items 13 and 14 of the G-60.

9.3.41 Correction Of The Research Record In Mechanical G-90 Reject Situations

Once the manually requested G-90 is matched to the file, action must be taken to correct the Research record which caused the mechanical reject.

- A. If the manually requested G-90 date (item 3H of G-90) is less than 9 months old, take the following action:
 1. If award action is being taken, simply show the new G-90 date in item 18 of the G-357.
 2. If award action is not required, it will be necessary to send Form G-59 to BIS-DMG with the new G-90 date shown on the G59.
- B. If the manually requested G-90 date is more than 9 months old, take the following action:

See RCM 8.1.164 for complete instructions on handling of all G-90s more than 9 months old.

9.3.50 Category "B" Survivor G-90 Referrals

A FNOD or on-line SURGE request will generate a SEARCH G-90 wage record request. Category B (paper) Survivor G-90 referrals are routed to Operation's Claims Certification Unit (CCU).

CCU forwards certain category B survivor G-90 referrals immediately to the Survivor Benefits Division (SBD). CCU retains other referrals for manual review or calculation before release.

All category B referrals are listed on the B G-90 Database Program. SBD examiners can trace outstanding category B survivor G-90s directly with CCU using the Database program (see RCM 8.1 Appendix D.)

The referral messages along with the effect on the computation and handling by CCU/SBD are outlined below:

- **MANUAL COMPUTATION REQUIRED FOR BASIC AMOUNT**

No basic amount(s) are shown on the G-90. CCU forwards the G-90 to SBD. If SBD requires a basic amount calculation, attach a G-563 request to the paper G-90 and return to CCU.

- **MANUAL COMPUTATION REQUIRED FOR AMC'S 1A -37-50 OVERLAP (MS TR2 QUESTIONABLE)**

There is military service in the 1937-1950 period and one or more overlapping months. CCU forwards the G-90 to SBD.

In rare cases, Tier II could be overstated if the employee's high 60 months of creditable compensation (used to determine the Tier II AMC) are in the 37-50 period. In that case, attach a G-563 to the G-90 and return to CCU for a manual Tier II computation.

- **MANUAL COMPUTATION REQUIRED FOR PIA 1, 8, 9**

PIAs 1, 8, and 9 are not shown on the G-90. CCU forwards the G-90 to SBD. If SBD requires a PIA calculation, attach a G-563 to the G-90 and return to CCU.

- **SSA 794 PENDING**

SSA wage information, which could possibly increase the PIA, is outstanding. CCU photocopies the G-90 and forwards the original to SBD. SBD will use the original G-90 for payment. CCU traces with SSA for wage information. If the SSA 794 information is returned and affects the PIA computation, the corrected G-90 will be forwarded to SBD for handling.

- **INCORRECT ACCOUNT NUMBER INDICATION**

G-90 calculations could be understated or overstated. CCU photocopies the G-90 and forwards the original to SBD for payment. CCU will follow its' internal procedure for resolving this referral. The referral could take months, even years to resolve. When resolved, the G-90 will be forwarded to SBD.

- **OUT OF BALANCE INDICATION RRB/SSA**

G-90 calculations could be understated or overstated. CCU photocopies the G-90 and forwards the original to SBD for payment. CCU will follow its' internal procedure for resolving this referral. The referral could take months, even years to resolve. When resolved, the G-90 will be forwarded to SBD.

- **SERVICE AFTER DOD**

The Tier II shown on the G-90 is overstated. CCU will cutback service to the date of death, and manually compute the correct Tier II before forwarding the G-90 to SBD. Compensation posted to years after the year of death will be ignored.

- **MILITARY SERVICE AFTER 1956**

No basic amounts or Tier IIs are shown on the G-90. CCU will calculate Tier II with and without military service before forwarding the G-90 to SBD. If SBD requires a basic amount calculation, attach a G-563 to the G-90 and return to CCU.

- **QBD REQUESTED**

Quarters of coverage (QCs), 1937 through 1952, are needed to determine if the employee is vested. If the employee is vested, a possible VDB reduction could apply to the survivor Tier II. The CCU supervisor forwards the G-90 to the SBD Operations Analyst to determine if there is enough information in the claim folder to make a vesting determination.

If a determination cannot be made using the claim folder, SBD will pay the case with a VDB reduction using PIAs 4, 7 and D8 on the wage record. SBD will release a teletype to SSA for QC information. When that information is received, SBD will make a vesting determination. If the employee is not vested, SBD will recertify the survivor annuity.

Appendices

Appendix B - RASI Award Message Codes

When generating a final award, RASI will only print up to 20 lines of referral messages in the "Remarks" section of the award form. If more than 20 lines are needed, RASI will print numeric codes for the remaining messages. These numeric codes follow:

EMPLOYEE AWARD FORM MESSAGES

CODE	MESSAGE
003	O/M PAYABLE
004	POSSIBLE RECOMP IN YEAR AFTER 62
006	NO CC ASSUMED
007	REVIEW M/S
008	DUAL ENTITLEMENT CORRECT PREH RECORD FOR EE
009	RATE DECREASE
011	CHECK EE DATE OF BIRTH
012	ASSUMED NOT VESTED
013	FRZ INDICATED-CHECK FOR WF
016	M/S NOT USED-PROOF NOT IN FILE
018	SUBMIT 150 OR 954 - CHECK RR PENS ENTITLEMENT
021	PRIOR M/S NOT USED
029	CONTROL FOR SUP-CHECK DRR
030	G-90 MORE THAN 9 MONTHS OLD
031	POSSIBLE W/D INSURED STATUS
032	CHILD CARE DROP OUT MAY APPLY

033	RRA MAXIMUM
034	WORK DEDUCTION COMPUTED
036	TIER 1 W/D COMPONENT EXCEEDS T1 RATE
038	W/D INSURED STATUS QUESTIONABLE
040	W/D COMPUTED-EXCESS EARNINGS IN ABD MONTH ONLY
042	EXCESS EARNINGS NO ADJ REQUIRED
044	POSS. RESTORATION OF TIER 1 BENEFIT
046	ACCRUAL DUE OVER \$20,000
047	ASSUMED ABD FOR PURPOSE OF PARTIAL AWARD
048	M/S MOS - M/S COMP
050	M/S USED AS COMPENSATION REQ. FOR ELIGIBILITY
051	SEC 3(G) CUMULATIVE COL 4.6% + 3.6%
052	SEC 3(G) CUM. COL 3.2% + 4.6% + 3.6%
053	SEC 3(G) CUM. COL 2.1% + 3.2% + 4.6% + 3.6%
054	SEC 3(G) CUM. COL 1.9% + 2.1% + 3.2% + 4.6% + 3.6%
055	TERMINATION
057	O/M MAY APPLY - CHILDREN
059	O/M DOES NOT APPLY
062	O/M MAY APPLY - SPOUSE OVER 62
068	RUIA EXCEEDS ACCRUAL
069	PARTIAL EXCEEDS FINAL
071	DETERMINE IF MIN PIA APPLIES 072
072	ABD PRIOR TO EAR POSS ABD
076	M/S NOT USED - EE CLAIMED BENEFITS WITH OTHER AGENCY
077	EXCESS EARNINGS INDICATED FOR NEXT YEAR
082	ACTUAL PIA 2 AMOUNTS USED

083	APPLY PERMANENT WD FOR PRIOR YEAR
084	\$10.00 MINIMUM RULE APPLIES
085	NET TIER 1 DECREASE - ZERO T/B
086	NOT DISABLED - PAID AN A&S ANNUITY
087	DIS ONSET DTE USED FOR PIA'S-DIS FREEZE INDICATED AT SSA CHECK WF
088	DIS ONSET DTE USED FOR PIA'S-RECALCULATE USING ABD THEN CHECK WF
089	DIS ONSET DTE USED FOR PIA'S-RECALCULATE USING ABD
090	EE ATTAINS AGE 62 (YEAR) (MONTH)
091	ADJUST MANUALLY
092	TAX REFUND POSSIBLE-CHECK DF STATUS
094	SERVICE MONTH DEEMING APPLIED
096	WINDFALL CUTBACK APPLIED FROM DATE OF ENTITLEMENT-REVIEW
097	RRAMAX AMOUNT EXCEEDS SPOUSE TIER TWO
098	CHECK TWD FOR PERIOD BEFORE AGE 70
100	LAST NON-RAILROAD WORK WAS FEDERAL EMPLOYMENT
101	NEXT-TO-LAST NON-RAILROAD
102	POSSIBLE DEEMED CURRENT CONNECTION
103	PENSION DEVELOPMENT REQUIRED
104	SEP/PREMIUM SURCHARGE RELIEF CLAIMED - FWD TO MS
106	SUPPLEMENTAL ANNUITY AMOUNTS ARE BEFORE CUTBACK
107	DRC'S NOT ADDED - SPEC MIN PIA APPLIES
108	CHECK ABD - INJURY SETTLEMENT OR PAY FOR TIME LOST INVOLVED
109	LAG REQUIRED FOR ELIGIBILITY
111	LAG SERVICE MAY PROVIDE SUPP ELIGIBILITY RELEASE G-88A.2

112, 114	LAG YEAR ()
113, 115	LAG YEARS (,)
116	LPS WORK DEDUCTIONS WITHHELD
117	POSSIBLE 1988 AMENDMENT MS CASE, CONSIDER MS AS COMP.
118	POSSIBLE 1988 AMENDMENT MS CASE. G-90 RE-ENTRY DATE BEFORE 1988 AMEND COULD BE CONSIDERED
120	MS ACCOUNTING: MANUAL CALCULATION REQUIRED
122	SALSA CALCULATED - CONSIDER MANUAL AWARD
121	INTERVENING WAGES - USE 1948-50 MS AS WAGES ONLY
123	SALSA AMOUNT CALCULATED:
124	ADVANCE FILE CASE
125	POSSIBLE DUPLICATE EARNINGS INVOLVED. WAGES FOR SOME YEARS NOT USED IN PIA CALCULATION
126	SPOUSE PENDING - DO NOT SEND TO CLAIM FILES
127	DLW-LPE IS ____, REMOVE LPE WORK DEDUCTIONS
129	M/S USED AS WAGES - REQUIRED FOR VDB ELIGIBILITY
130	M/S NOT USED - REQUIRED FOR VDB ENTITLEMENT
131	CHECK PIA 1 - SPECIAL MINIMUM MAY APPLY
132	M/S AS WAGE'S REQ. FOR VDB ELG. BUT EE CLAIMED BENS. AT OTHER AGENCY
133	NET RECURRING RATE ZERO - COMPUTE ONLY
134	TRIC REPLY - MBR EARMARK REJECT
135	VDB DOE (mo/yr)
136	SS BENS CLAIMED - NO TIER 1 REDUCTION
137	NO EXCESS EARNINGS INDICATED FOR NEXT YEAR
138	PIA 17 EQUALS 9999
139	PIA 17 EQUALS 9999 - EE HAS WDIS

140	SERVICE BEGINNING DATE IS AFTER 8/83
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SPOUSE AWARD FORM MESSAGES

CODE	MESSAGE
503	POSSIBLE RECOMP YEAR AFTER EE AGE 62
504	REVIEW - DUAL SPOUSE
505	G-90 MORE THAN 9 MONTHS OLD
506	ADJUST MANUALLY WHEN SPOUSE AGE 62
507	WORKER'S COMP TERMINATED - CHECK ACCRUAL PERIOD
508	DUAL ENTITLEMENT CORRECT PREH RECORD FOR EE
509	CHILD ATTAINS AGE 18 - BENEFIT TERMINATES
512	SPOUSE PARTIAL RATE EXCEEDS FINAL RATE
600	ASSUMED ABD FOR PURPOSE OF PARTIAL AWARD
601	EE ALSO
602	TERMINATION REJECT
603	COST-OF-LIVING REJECT
604	TIER 2 REDUCED FOR RRA MAXIMUM
606	EE TIER 1 W/D COMPONENT
607	SPOUSE TIER 1 W/D COMPONENT EXCEEDS SP TIER 1 RATE
608	EXCESS EARNINGS IN ABD MONTH ONLY - W/D APPLIED
609	EXCESS EARNINGS NO ADJUSTMENT REQUIRED
610	POSSIBLE RESTORATION OF TIER 1 BENEFIT
611	ACCRUAL DUE OVER \$10,000
612	SEC 4(D) CUMULATIVE COL 4.6% + 3.6%
613	SEC 4(D)CUM COL 3.2% + 4.6% + 3.6%
614	SEC 4(D) CUM COL 2.1% + 3.2% + 4.6% + 3.6%

615	SEC 4(D) CUM COL 1.9% + 2.1% + 3.2% + 4.6% + 3.6%
616	SPOUSE PARTIAL EXCEEDS FINAL - COMP ONLY
617	SPOUSE PREVIOUS PAYMENTS EXCEED ACCRUAL
620	RATE DECREASE
621	ABD MORE THAN 1 YEAR PRIOR TO FILING DATE
622	EE C/O
623	ONE PAYMENT ONLY
624	MECHANICAL ZERO ANNUITY RATE - COMPUTE ONLY
626	PARTIAL EXCEEDS FINAL
630	RRA MAXIMUM APPLIES
633	ABD PRIOR TO EAR POSS ABD
634	TOO MANY RATE BREAKS
635	RRA MAX AMOUNT EXCEEDS SPOUSE TIER 2
637	EXCESS EARNINGS INDICATED FOR NEXT YEAR
640	REVIEW EE & SP FOR EARLIER ABD
643	NET TIER 1 DECREASE - ZERO T/B
644	REDUCED FOR PUBLIC SERVICE PENSION - REVIEW
646	SPOUSE ATTAINS AGE 65 (YR. MOS.)
647	NOW ENTITLED BASED ON AGE
650	CHECK FOR POSSIBLE ENTITLEMENT BASED ON MINOR CHILD PRIOR TO CURRENT ABD
652	ADJUST EE AND SP MANUALLY
653	NO AGE 62 RECALC FOR EE
654	PIA 1 ADJUSTED AT 62
655	TIER 1 BASED ON RED PIA 1
656	SP ATTAINS AGE 62
658	TIER 2 AFTER TAKEBACK LESS THAN \$10.00 - GUARANTY APPLIED

660	CHECK TWD FOR PERIOD BEFORE AGE 70
661	SEP/PREMIUM SURCHARGE RELIEF CLAIMED - FWD TO MS
663	LPS WORK DEDUCTIONS WITHHELD
666	WORK DEDUCTIONS COMPUTED
667	ACTUAL PIA 2 AMOUNTS USED
669	POSSIBLE LPS WD NEEDED DUE TO EE LPS
670	SPOUSE TIER 1 W/D FACTOR. SP W/D EFF DATE
671	ADVANCE FILE CASE
672	RELEASE RL-13G.1 WHEN G-88 RECEIVED
673	RELEASE RL-13G.1 FOR EE
674	APPLY PERMANENT WD FOR PRIOR YEAR
675	CHECK SPOUSE LAW YEAR
676	DLW-LPE IS ____, REMOVE LPE WORK DEDUCTIONS
677	ABD OR AWARD DATE AND CALCULATED ACCRUAL INCONSISTENT.
678	CHECK RRA MAX APPLICATION: PSP INVOLVED AFTER ABD
680	PSP EFFECTIVE DATE IS, APPLY REDUCTION.
681	EE POSSIBLE RAIL - CHECK SP DATA
682	TRIC REPLY - SP MBR EARMARK REJECT
683	TRIC REPLY - AUX MBR EARMARK REJECT
684	SP LWYR83 A/R 60/30: CONSIDER ABD RETROACTIVITY
685	SS BENS CLAIMED - NO TIER 1 REDUCTION
686	NO EXCESS EARNINGS INDICATED FOR NEXT YEAR
687	SERVICE BEGINNING DATE IS AFTER 8/83

Appendix C - Numeric List Of PAM Referral Messages

PAM can print up to eight messages on its output. If more than eight messages are necessary, the numeric codes will be printed for the remaining messages.

CODE	REJECT MESSAGES
500	SSA DATA EXCEPTION - RRBCAN
501	SSA DATA EXCEPTION - CAN
502	SSA DATA EXCEPTION - BIC
503	SSA DATA EXCEPTION - TOA
504	SSA DATA EXCEPTION - DOEC
505	SSA DATA EXCEPTION - DOEI
506	SSA DATA EXCEPTION - MBP
507	SSA DATA EXCEPTION - BENCD
508	SSA DATA EXCEPTION - BENNAME
509	RESERVED
510	SSA DATA EXCEPTION - BOAN
512	SSA DATA EXCEPTION - PNA
513	SSA DATA EXCEPTION - RRBBS
514	SSA DATA EXCEPTION - DOST
516	REP PAYEE CODE DISC
517	UNABLE TO PROCESS ON PREF OR BEN SYM SURV/PENS CASE
518	SEARCH REPLY REC'D - LESS THAN 120 MO OF SERV
519	RR ESTABLISHED - NOT "PURE"
520	CASE PAID OR DUMPED BY RASI
521	MORE THAN 8 PARCELS ON MASTER
522	UNABLE TO COMPUTER AMT PAYABLE. ACC AMT \$9999.99
523	CANNOT DETERMINE IF CHICO MATCHES PARCEL
524	9 PAYEE CODES USED
525	CANNOT DEVELOP UNIQUE BEN SYM/PAYEE CODE (DEVELOPED CODES ALREADY USED)
526	NO REINS REC'D ON DEF AWD - DEF DT MM/YY

527	TRANS MATCHED PARCEL - UNABLE TO PROCESS
528	PARCEL MATCHED CHICO - BEN STAT INCONSIST.
529	SSA DATA EXCEPTION - NO ACCRUAL
530	UNABLE TO PROCESS - SS BEN AMTS NOT EQUAL
531	RR RATES ON CHICO AND RASI UNEQUAL
532	PARCEL MATCHED CHICO WITH DUE PROC. IND
533	RR CLM NO. DISC. RASI 999999; PAM 999999
534	MANUAL DUMP REQUESTED
535	CHICO SS NUMBERS INCONSISTENT
536	UNABLE TO PROCESS ADJ
537	UNABLE TO PROCESS - NO COL RATE
538	COL MATCHED PAM - UNABLE TO PROCESS
539	NO RECORD ON CHICO
540	UNABLE TO PROCESS CPA - NO RR REDUCTION MADE
541	UNABLE TO PROCESS CPA - LAST ACTION NOT ON RASI
542	RASI REDUCTION/SS DATES AND RATES INCONSISTENT
543	DUAL ENTITLEMENT INVOLVED
544	CHECK JURIS OF BIC C - NOT ON RR EMP'S ACCT
545	UNABLE TO PROCESS - NO NEW HISTORY
546	LAF CODE C ON RR TYPE ACTIVITY
547	UNABLE TO PROCESS - G-96 T/S
548	SMIB RATE EXCEEDS RECURRING RATE
549	PREV NO NOT PAYABLE POSSIBLE O/P

CODE	REVIEW MESSAGES
600	ALERT - T-3WD REQUIRED
601	ALERT - JURIS DETERM REQUIRED

602	ALERT - EARMARK MBR WITH CORRECT RR CLAIM NO/PREFIX
603	ALERT - CHECK RRB'S USE OF MIL SERV
604	ALERT - DOB DISCREPANCY - CHECK CHICO/RASI/DPA
605	ALERT - MANUAL HI CLEARANCE REQ.
606	ALERT - POSSIBLE TRUST FUND CHANGE
607	ALERT - FORWARD CASE TO DB
608	ALERT - COA NOT PROCESSED - RR IN FORCE
609	ALERT - BENE'S OWN NUMBER EXTRACTED FROM CHICO
610	PAM ADJ PROCESSED EFF MM-YY SSA ADJUSTMENT EFF DT MM-YY
611	SSA ACCRUAL AMOUNT \$99999.99 RATE CORRECTED
612	ALERT - CHICO SS RATES INCONSISTENT
613	ALERT - CASE ON RASI
614	ALERT - CORRECT PART RATE BEGINNING DATE MO-YR
615	AWARD NOT BALANCED TO ACCRUAL SSA ACCRUAL \$9999.99 COMPUTED ACCRUAL \$9999.99 THRU (MO-YR)
616	ALERT - ESTABLISH SS ACCTS REC
617	CORRECT BIC ON CHICO
618	ALERT - CHECK FOR POSSIBLE SS COL REFERRAL
619	ALERT - RR ALREADY REDUCED
620	ALERT - RR IN FRCE/SUSP - LAF C CASE
621	POSSIBLE U/P CHECK OLD HISTORY
622	G-96 NOT PROCESSED TIMELY
623	SSA SHORT MONTH WITHHOLD \$999.99 RATE CORRECTED
624	RR INVOLVED
625	DOWNWARD ADJUSTMENT RATE CORRECTED
626	CHANGE PAYEE NAME
627	POSSIBLE INSTALLMENT PAYMENT
628	RR G-96 PROCESSED ON MM-DD-YY CAUSE CD 999 LTR CD 999

629	SSA DATA EXCEPTION - DOB
631	FORWARD CASES TO DB IF RR DIS INVOLVED
632	PARCEL MATCHED CHICO/NAME DOB DISCREPANCY
633	RREE IN PAY STATUS/CHECK O/M
636	POSSIBLE DUPLICATE EARNINGS BA NUMBER XXXX PREV XXXX
639	ALERT - DPA/SSA NAME DISCREPANCY
642	ALERT - COA INDICATOR
646	DOD IN DPA DATA/RR EE IN FORCE

CODE	NON-REVIEW MESSAGES
700	ALERT - ESTABLISH FOLDER
701	ALERT - ACTIVE RECORD ON PAM
702	ASSOCIATE AND FILE DOWN
703	MECHANICAL HI CLEARANCE GENERATED ON MM/DD/YY DOEHM MM/YY DOES MM/YY
704	ALERT - REP PAYEE CODE ASSUMED
705	ALERT - IMPACC PAYMENT MADE
706	SMIB BEING DEDUCTED
708	SS G-96 PROCESSED ON MM/DD/YY CAUSE CD 999 LTR CDE 999
709	RATE CORRECTED/TOLERANCE APPLIES
710	COA NOT PROCESSED - SS TERM
711	PNA ALERT

Appendix D - Processing Referrals

PAM AWARD LETTER CODE PARAGRAPHS

The following is a list of code paragraphs printed on the RL-130Z PAM award letter. The numbers of the code paragraphs used in a particular case will be printed in item 34 of the RR-1a award form.

- 005 Under the law, social security benefits for railroad retirement workers and their families are certified by the Social Security Administration to the U.S. Railroad Retirement Board for payment. This is true even if the individual is not entitled to current or future benefits under the Railroad Retirement Act. The Social Security Administration has notified you and the Board that you are entitled to the following social security benefit:
- 006 Under the law, social security benefits for railroad workers and their families are certified by the Social Security Administration to the U.S. Railroad Retirement Board for payment. The Social Security Administration has notified you and the Board that you are entitled to the following social security benefit:
- 007 If you have not received a check in the amount of \$ (amount of accrual due through the accrual month), you should receive one within the next two weeks. This check will cover the payment of your social security benefit through (date will be accrual month). (The accrual period is through the end of the month prior to the voucher month.)
- 008 Succeeding checks will be mailed to reach you during the first week of each month and will cover the amount due for the preceding month.
- 009 If you have any questions about your benefit, contact the nearest district office of the Social Security Administration or, if it is more convenient, the Railroad Retirement Board. If you call in person, please bring this notice and all other material you have about your claim.
- 010 Starting with your next payment, your social security benefit will be included in your railroad retirement check each month. The amount of each benefit payment will be shown on the check. Succeeding checks will be mailed to reach you during the first week of each month and will cover the combined amounts due in railroad retirement and social security benefits for the preceding month.
- 011 The Social Security Administration has requested the Railroad Retirement Board to adjust your social security payments.
- 012 The following headings will appear and the appropriate fill-ins will be furnished by the system:

Social Security Claim No.	Type of Benefit	Monthly Rate	Effective Date
------------------------------	--------------------	-----------------	-------------------

- 013 If you believe this determination is not correct, you may request that your case be re-examined. If you want this reconsideration, you must request it not later than 60 days from the date you receive this notice. You may make your request through any social security office.

- 017 The date of entitlement to monthly benefits for this case has been established as (DOEC).
- 018 This payment represents the difference between benefits already paid and those now payable on your claim.
- 019 They have also advised the Board to withhold your benefit for those months in which you were not entitled to payment.
- 025 The following line will appear and the appropriate benefit information will be supplied by the system in conjunction with code paragraph #12:
- Benefits will now be paid as follows:
- 026 This adjustment is due to a recalculation of your benefits.
- 027 Your social security benefit has been adjusted effective (RRB processing date). The Social Security Administration will contact you regarding the benefits paid prior to this adjustment.
- 028 An overpayment of social security benefits will be recovered by withholding part of the benefit due you.
- Your full social security benefit will be restored when the overpayment has been recovered.
- 029 This adjustment is due to a change in the earnings data of you or the person on whose social security record the benefits are payable.
- 066 Your monthly payment will be increase to \$_____ beginning with your next month's payment. This increase is based on the rise in cost-of-living.
- 069 The cost-of-living increase that became effective in the month of June has been considered in the computation of your monthly payment.
- 071 Part of your benefit continues to be withheld to recover an overpayment of social security benefits.
- 075 The Social Security Administration has requested the Railroad Retirement Board to pay you an amount due in addition to your regular social security monthly benefit amount.
- 123 You should have received a letter from the Social Security Administration regarding the overpayment which caused this action. If you have not received such a letter or need more information about the overpayment, contact the nearest Social Security district office. Most questions can be handled by telephone or mail. If you call in person, please bring this notice and any other material you have about your claim with you.

Appendix E - Duplicate Earnings Table

This table may be used as a reference when handling retirement referrals 096 (see RCM 9.3.13) and POSSIBLE DUPLICATE EARNINGS...NOT USED IN PIA CALCULATION (see RCM 9.3.14), survivor referral 0324 (see the STAR referral screen), or when the message "POSSIBLE DUPLICATE EARNINGS BA 9999" appears in the Remarks section of Form G-90 (see RCM 9.14.110). It duplicates the table in SEARCH containing the current listing of BAs with known reporting problems. If any of these referrals appear, refer to RCM 9.14.110, Possible Duplicate Earnings BA 9999, for handling instructions.

<u>BA#</u>	<u>FROM – TO</u>	<u>BA#</u>	<u>FROM – TO</u>	<u>BA#</u>	<u>FROM – TO</u>
1203	1987 – 1988	3378	1993 – 1994	4525	1990 – 1991
1222	1994 – 1994	3412	1987 – 1987	4650	2001 – 2003
2209	1989 – 1989	3533	1993 – 1993	4858	2001 – 2001
2247	1989 – 1989	3587	1989 – 1994	5508	1988 – 1988
2525	1992 – 2001	3602	1992 – 1992	5550	1997 – 1999
2592	1988 – 1988	3663	2002 – 2002	7531	1998 – 1999
2606	1993 – 1996	3743	2001 – 2003	8911	1990 – 1990
2644	1997 – 1997	3754	1990 – 1993	9228	1992 – 1994
2775	1991 – 1993	3759	1988 – 1988	9248	1998 – 2002
2789	2001 – 2003	3767	1990 – 1993	9345	1989 – 1991
2805	2001 – 2004	3772	1990 – 1993	9346	1998 – 1999
2807	1988 – 1990	3783	1994 – 1994	9523	1988 – 1993
2903	1988 – 1988	3818	1992 – 1992	9534	1996 – 1999
3119	1995 – 1997	3879	1997 – 1999	9619	1989 – 1989
3270	1990 – 1993	4115	1990 – 2002	9621	1987 – 1991
3345	2005 – 2005	4310	1980 – 1989	9631	1996 – 1998
3362	1989 – 1989	4398	1994 – 1996	9843	1992 – 1995

G-59 - Correction of the PREH/TAX Record

The G-59 is now available on RRAILS. Also, the G-59R has been incorporated into this form and is now obsolete.

Use

Examiners (example, Retirement, Survivor, etc.) should use the G-59 to notify BIS/DMG, P&S/RAC, and TCIS/TS of changes or new information affecting the PREH record or tax accounting system (TAX).

The PREH record can be corrected with a vouchered payment award, a PREH update award, the on-line PREH correction system, or a G-59.

The TAX record can be corrected with a vouchered payment award or a G-59. If you use a PREH update award, the PREH on-line correction system, or a G-59 to correct a social security number, a rate, or a date of birth, you **MUST** prepare a G-59 for TCIS/TS.

Examiners should use G-59MS for any changes to military service on EDM or PREH. This includes creating a military service record when one does not currently exist.

NOTE: Section 3 allows for correcting the survivor record when PSP information is used to reduce the tier 1 to zero. While some of these corrections can be made with the PREH On-Line Correction facility, not all can. Therefore, a G-59 should be used to make all changes in order to eliminate an extra action.

Completion

Section 1

After entering RRAILS, click #9, the Bene button, in the CASES area of the initial screen. Any fields you fill out in the client window will be pre-filled on the G-59. All identifying information in this section, except #6 Beneficiary Type, should always be completed. It is used by BIS/DMG, P&S/RAC, and TCIS/TS to ensure record changes are made on the correct beneficiary. The information is self-explanatory. Complete the Beneficiary Type for an IPI, a Twin, or SSA Only.

Section 2

Complete section 2 only if the information is changing. If the Beneficiary's SSA Number is changing, the current, incorrect, SSA number will pre-fill from section 1.

Section 3-Survivors Only

Complete Section 3 to remove PSP information that was entered into the record for the sole purpose of reducing tier 1 to zero.

Section 4-Retirement Data

Put a checkmark in the box in front of each piece of information that applies. If you need to enter a number, enter two digits (i.e., # of W/D DRCs: 03). If you are entering a date for 'Vested in the future', use the mm-dd-yyyy format. EXCEPTION: If the 'Vested in the future' date is three months or less in the future, control the case on USTAR and pay the VDB when the USTAR referral comes up.

Section 5-Other Corrections and Remarks

Enter any other information or comments in this space.

The examiner's name and the date will pre-fill. Type in the unit initials. Email the form to the RAC G-59 and TCIS-TS mailboxes, as necessary. Send the form to IMAGING through RRAILS.

G-96 - Termination or Suspension of Payments

(Original and one copy)

Use

This form is used for all of the following actions:

To suspend or terminate regular annuity payments and SUP ANN payments;

To suspend or terminate social security benefits paid by the Railroad Retirement Board (RRB);

To terminate suspended annuities;

To delete the checkwriting master record in order to correct the claim number, prefix, claim number symbol or payee code.

This form may be used to notify the annuitant of a suspension action by a computer-printed letter if the annuity will be reinstated in the same month, or when processing a timely termination (i.e., payment for the effective month of termination is stopped.) If termination is not timely, a special overpayment and/or adjustment notice must be prepared.

NOTE: This form is used when an annuitant record cannot be located on DATA-Q. If the annuitant record is on DATA-Q, process any suspension or termination activity via FAST-S/T (see RCM 9.7).

General Instructions

Multiple Payee Codes - If more than one person is receiving a monthly check based on the insured status of the same employee, prepare a separate G-96 to terminate or suspend each beneficiary's payments according to their respective payee codes.

Payee Receiving More Than One Type of RR Annuity - If a person is receiving an employee annuity and a supplemental annuity, one G-96 showing the regular RR annuity rate will suspend or terminate both annuities. However, if a person is receiving any other combination of two regular monthly RR annuities, for instance, an employee annuity and a widow's annuity, prepare a G-96 to terminate or suspend each payment, as appropriate.

Payee Receiving Railroad Retirement Annuity and a Social Security Benefit Is Also Being Paid by the RRB - Handle suspension or termination action on the RR annuity in the usual manner. However, if suspension or termination action is required on the SS benefit in other than death cases or SMI premium deduction cases, refer the case to the on-site representative.

Computer Rejects Of G-96

The computer rejects Form G-96, and does not suspend annuity payments in force if the payee code or reason code entry is omitted from item 5 or 7 or if the complete claim number or monthly rate does not match the same item on the checkwriting master file. If the G-96 rejects, the payment services group will return the unprocessed G-96 to the originator.

Regular Completion Of Form G-96

Item	Entry
1	Enter the beneficiary symbol, if any, and the prefix by entering an X in the appropriate handprint box.
2	Enter the claim number. In six-digit claim number cases, begin handprinting in the last six boxes (just below the blue shading). In terminal-digit claim number cases, begin handprinting in the first box.
3	Never Complete
4	Enter the payee's name and the annuitant's name, if other than the payee. This item may be handwritten but must be kept within the restraining margin.

5	<p>Handprint the payee code in the <u>right-hand box</u>. In all cases, enter the payee code as shown on the award form, EDP printout in file, or the microfilm of checks issued. This item must be completed in order to stop an in-force payment or to terminate a suspended annuity.</p>
6	<p><u>RR Annuities</u> - Enter the current monthly RR annuity rate (<u>after</u> any deduction for SMI) from the latest recurring award form EDP printout. Do this even though a check at that rate has not yet been released. <u>Do not</u> use the total check rate on the MOMS microfilm, because if an SS benefit is included in the total check rate, both the RR and SS amounts will be affected by the G-96 action. When terminating cases already in suspense, enter the last rate paid. It is not necessary to precede with insignificant zeroes but the rate must be entered so that the last digit appears in the last box. Suspension or termination of the RR annuity will not stop on SS benefit being paid by the RRB.</p> <p><u>SS Benefit Paid by the RRB</u> - The on-site representative must approve the suspension or termination of all SS benefits paid by the RRB in all cases other than death cases and SMI premium deduction cases. To suspend or terminate the SS benefit, enter the current monthly SS benefit (after any deduction for SMI, if only SS benefits are payable by the RRB. To terminate or suspend both the RR annuity and the SS benefit, enter the total check rate. The check rate can be obtained from the MOMS microfilm if it is not readily available in the folder.</p> <p>NOTE: <u>In death terminations only</u>, enter the last monthly rate shown in file, <u>and</u> the annuitant's date of birth in Item 8. The G-96 program will terminate payments if it matches either on the monthly rate or on the date of birth.</p>
7	<p><u>RR Annuities</u> - Select the reason for terminating or suspending payments to the beneficiary shown in item 4 from the codes printed on the G-96 or Exhibit 1 of this chapter.</p> <p><u>SS Benefit Paid by the RRB</u> - Use the SS benefit cause codes in Exhibit 1 of this chapter to suspend or terminate</p> <p>RR-certified SS benefits:</p> <p><u>Combined SS and RR payments</u> - One G-96 may be used to terminate or suspend both an RR annuity and SS benefit by entering the total check rate in item 6. Select the cause code from the ones printed on the G-96 (9-76) or Exhibit 1 of this chapter. Two G-96's must be prepared (use the RR cause codes for one form and the SS cause codes for the other</p> <p>G-96) if:</p> <ul style="list-style-type: none"> • The RR annuity cause code is "miscellaneous" but there is a specific cause code for the SS benefit, or,

	<ul style="list-style-type: none"> • The RR cause code does not correspond to the reason for stopping the SS benefit. (Example: the RR benefit is being suspended because of a return to employer service; the SS benefit is being stopped due to work and earnings, or) • The combined RR and SS rate is equal to the old RR annuity rate, or, • Combined RR and SS non-phaseout student benefits terminate effective August 1, 1982, or, • Combined RR and SS spouse benefits terminate and payment of spouse SS benefits is transferred to SSA, or, • Combined RR and SS young mother's/father's benefits terminate when the youngest child attains age 16.
	If two G-96's are used, do not use the combined check rate.
8	Enter the DOB on all suspension and terminations.
9	Never complete.
10	Never complete.
11	Never complete.
12	<p>Enter the month and year only. When payments are being suspended because a payee failed to respond to a questionnaire, enter the month in which the G-96 is prepared.</p> <p>If the G-96 is being prepared to terminate an earlier suspension, enter the month and year in which the termination is effective. (Also note the date of the suspension in the remarks section.)</p> <p>If the month of suspension or termination cannot be determined, enter the current month and year.</p>
13	Enter the appropriate letter code for release of an RL-176 suspension or termination notice to the annuitant. (See the section entitled "Generating Suspension or Termination Notices via Form G-96").
14	For EDP Control purposes.

Enter your name and unit in the spaces provided. In the "date" box, enter the date on which the G-96 is completed unless it will not be delivered to the control and services group until after noon of the G-96 cut-off date announced on the monthly cut-off calendar. In that case, or if it is intended to terminate an annuity in the month following

the month in which the G-96 is completed, enter the first day of the month in which the annuity is to be suspended. In the "remarks" section, enter any remarks necessary or appropriate to explain the action.

Terminating Annuity Entitlement In A Suspended Case

Prepare a G-96 to terminate the annuity record when a termination event occurs and the annuity was previously suspended. Complete all entries on the G-96 according to the instructions for terminating an annuity in force. The termination code and effective date will replace the suspension code and effective date on the master record. A termination notice will be released for the code shown in item 13, (if any). Do not make any entry in item 10.

Use Of Termination Code 62

Prepare a G-96 with code 62 in item 7 only when the benefit payment record needs a correction in one of the following items:

- Claim number
- Claim number symbol (M, W, WC, P, or J) NOTE: If only the symbol is being corrected on a survivor award, a G-96 is not necessary. See G-364 instructions located in RCM 8.9.
- Prefix (A, D, or H)
- Payee Code

Processing of the code 62 G-96 will delete the benefit payment record and must be followed by an award action. If the code 62 is being used to delete an incorrect claim number, prefix or symbol, an initial award must be processed on the correct claim number, prefix and symbol in cases where there was no previous award processed under the correct claim number, prefix and symbol. If an award had previously been processed under the correct claim number, prefix and symbol, a "reinstate-recert" award is used to process the award. If the code 62 is being used to change the payee code, the award on the "new" payee code must be processed as an initial award. See RCM 8.1.141 and 8.1.142 for further information on the use of code 62.

Effect Of G-96 On The MIRTEL Record

The MIRTEL system receives information from the checkwriting master (CHICO) file. If a change in payment status is shown on DATA-Q or MOMS; the MIRTEL and MOLI records will also change.

A G-96 which terminates or suspends an annuity has the following effect on the MIRTEL record:

- Death Codes 01, 41, and 51 - These codes terminate the MIRTEL record if the annuity is in current pay status or suspense.

NOTE: If a constructive award was made, or the beneficiary filed for Medicare only, or the date of death was over 16 months ago, a G-811 (activity code 50) is required to terminate the MIRTEL record. See RCM 3.3 for instructions on completing form G-811.

- Other Termination Codes - These codes change the record status on the MIRTEL record and may generate a referral "Termination - Check Jurisdiction" (See RCM 3.5 Exhibit 1 for handling.)
- Suspension Code - These codes change the record status code on MIRTEL to an "annuity in suspense" code which will generate quarterly or year end billing for SMI option codes 1 or 5.

If an annuity is suspended and reinstated in the same month, no change will be made in the MIRTEL record.

Generating Suspension Or Termination Notices Via Form G-96

When RR annuity or SS benefit payments will be reinstated in the month of suspension or when processing a timely termination (i.e., payment for the effective month of termination is stopped), an entry in item 12 will generate a computer-printed notice which will be released to the beneficiary.

Following are tables listing RR and SS code letters as they correspond to the suspension and termination codes. Following the tables, the text of each code letter is shown, as well as, instructions as to when the letter should be released. Before releasing any letter, be sure to review the instructions and the text of the letter.

RR Termination Code Letters

RR TERM CD	REASON	LTR CODE
01/41/51	Death	---
42	Survivor child attained age 18	503
45	Widow - child attaining 18 not FTS	501
45	Widow - child attaining 18 is FTS	502
45	Wid. - child 18 not FTS-future elig.	515
45	Surv. child 16 - future elig.	509

45	Surv. child 16 - no future elig.	510
47	Student ceased FTA	516
47	FTS attained age 19	513
47	FTS graduated	514
53	Sp. - child 18-sp. ent. red. 62 in future	505
53	Sp. - child 18-Sp. ent. full age 60 in future	506
53	Sp. - child 18-Sp. ent red. 60/30 in future	507

RR Suspension Code Letters

RR SUSP CD	REASON	LTR CODE
06/16/56	EE/Spouse/Surv. - other	
"	SMIB deductions	151
"	Estimated excess earnings	169
"	Miscellaneous RR/SS	197
"	Miscellaneous RR only	199
66	Susp. to recover overpayment - RR/SS	197
66	Susp. to recover overpayment - RR only	199
67	Susp. to begin garnishment	172
67	Susp. to adjust garnishment	173

SS Termination Code Letters

SS TERM CD	REASON	LAF/BIC	LTR CODE
01/41/51	Death	T1	---
03	Attainment age 18	T4/C	353

03	Attainment age 22	T4/C	355
03	Mother term. last chld 18	T4/Not C	354
03	Mother term. last chld 16	T4/Not C	394
08	Ben. no longer disab.	T8/A	359
08	Ben. no longer disab.	T8/C	360
08	Ben. no longer disab.	T8/Not A or C	361
10	Ent. to different benefit	T5	356
10	Ent. to different benefit	AD	365
13	Withdrawn/Canc. claim	TR,T+	363
14	Student ceased FTA	T6/C	357
14	Mother term. no chld in care	T6/Not C	358
15	Marriage/divorce/remarriage	T3	352
17	Primary benefit terminated	T2	351/390
17	Ben. term. - SS ben. to SSA	B/C	391
25	Other	T9/TP	362

SS Suspension Code Letters

SS SUSP	CD REASON	LAF/BIC	LTR CODE
26	Work and earnings	S2	374
26	Foreign work and earnings	S1	373
27	SS Primary suspended	S3	375
27	SS Prim. susp. (foreign wk.)	S5	377

28	Payee not determined	S8	379
30	Suspend for investigation	SO/A	370
30	Suspend for investigation	SO/C	371
30	Suspend for investigation	SO/Not A or C	372
31	Better address required	S6	---
50	Young mother no chld in care	S4	376
50	Other	S7, S9, SD, SF, SH, SJ, SK, SL, SM, SP, SW	380/198
67	Suspend to begin garnishment	-	172
67	Suspend to adjust garnishment	-	173
71	Work and earnings	D2	382
71	Foreign work and earnings	D1	381
72	SS Primary deferred	D3	383
72	SS Prim. def. foreign wk.	D5	385
73	Recovery of overpayment	D6	386
75	Young mother no chld in care	D4	384
75	Receipt of Public Assistance	DP	388
75	Receipt of Workman's Comp.	DW	389
75	Other	D9	387

- A. RR Suspension Code Letters - When payments will be reinstated in the month of suspension, an entry in Item 12 will generate a computer-printed RL-176 which will be released to the annuitant. RR suspension letters are detailed below:

Code Letters 151 and 169

A copy of the letter will be sent to the appropriate field office. The standard text of the letters is as follows:

YOUR MONTHLY BENEFITS MUST BE ADJUSTED BECAUSE...

(INSERT)

THIS ADJUSTMENT MAY CAUSE A DELAY IN THE RECEIPT OF YOUR NEXT PAYMENT. HOWEVER, A PAYMENT WILL BE SENT TO YOU AT THE EARLIEST POSSIBLE DATE. SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS ADJUSTMENT, CALL OR WRITE THE BOARD OFFICE NEAREST YOU. THERE IS AN OFFICE LOCATED AT (Address of field office).

The first sentence of the letter will be completed as follows:

Code 151 -MEDICARE PREMIUMS WILL BE DEDUCTED FROM YOUR BENEFITS.

Code 169 -YOUR EXPECTED EARNINGS FOR THIS YEAR WILL EXCEED THE EXEMPT AMOUNT.

Code Letter 172

Use this code letter when suspending an annuity to begin or adjust garnishment withholding. A copy of the letter will be released to the appropriate field office.

YOUR ANNUITY HAS BEEN SUSPENDED TO BEGIN OR ADJUST WITHHOLDING IN ACCORDANCE WITH A GARNISHMENT, ASSIGNMENT, OR COURT-ORDERED PROPERTY DIVISION. THIS MAY CAUSE A DELAY IN THE RECEIPT OF YOUR NEXT PAYMENT; HOWEVER, A PAYMENT WILL BE SENT TO YOU AT THE EARLIEST POSSIBLE DATE. SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS ADJUSTMENT, CONTACT THE NEAREST RAILROAD RETIREMENT BOARD OFFICE. MOST RAILROAD RETIREMENT BOARD OFFICES ARE OPEN TO THE PUBLIC FROM 9:00 A.M. TO 3:00 P.M. MONDAY THROUGH FRIDAY. IF YOU COME IN PERSON, TAKE THIS NOTICE WITH YOU.

THERE IS AN OFFICE LOCATED AT (Address of field office).

Code Letter 173

Use this code letter when suspending to adjust the amount of the annuity payment being sent to the third-party payee in a garnishment case. A copy of this letter will not be released to the field office.

DUE TO A REDUCTION IN THE AMOUNT OF THE PAYMENT, THERE WILL BE A DELAY IN THE NEXT PAYMENT TO BE MADE IN CONNECTION WITH ENFORCEMENT OF LEGAL PROCESS FOR SUPPORT.

Code Letter 197

Use this code letter whenever suspending the RR portion only of a combined RR-SS payment, and that portion will be reinstated in the month of suspension.

Be sure to include the reason for adjustment in the reinstatement award letter. The text of the letter is as follows:

YOUR MONTHLY RAILROAD RETIREMENT ANNUITY MUST BE ADJUSTED. THIS MAY CAUSE A DELAY IN THE RECEIPT OF THE RAILROAD RETIREMENT PORTION OF YOUR NEXT PAYMENT. THE SOCIAL SECURITY PORTION OF YOUR PAYMENT WILL BE RELEASED AS USUAL, WITHOUT DELAY. YOUR RAILROAD RETIREMENT PAYMENT AND AN EXPLANATION WILL BE FORWARDED TO YOU AT THE EARLIEST POSSIBLE DATE.

A copy is not sent to the servicing field office.

Code Letter 199

Use this code letter whenever suspending an RR only annuity, and the annuity will be reinstated in the month of suspension. Be sure to include the reason for adjustment in the reinstatement award letter. The text of the letter is as follows:

YOUR MONTHLY BENEFITS MUST BE ADJUSTED. THIS MAY CAUSE A DELAY IN THE RECEIPT OF YOUR NEXT PAYMENT. A PAYMENT AND AN EXPLANATION OF THE ADJUSTMENT WILL BE SENT AT THE EARLIEST POSSIBLE DATE.

A copy is not sent to the servicing field office.

B. SS Suspension Code Letters

Code Letter 198

Use this code letter when suspending the SS portion only of a combined RR-SS payment and that portion will be reinstated in the month of suspension. Be sure to include the reason for adjustment in the reinstatement award letter. The text of the letter is as follows:

YOUR MONTHLY SOCIAL SECURITY BENEFIT MUST BE ADJUSTED. THIS MAY CAUSE A DELAY IN THE RECEIPT OF THE SOCIAL SECURITY PORTION OF YOUR NEXT PAYMENT. THE RAILROAD RETIREMENT PORTION OF YOUR PAYMENT WILL BE SENT AS USUAL, WITHOUT DELAY. YOUR SOCIAL SECURITY PAYMENT AND AN EXPLANATION WILL BE SENT TO YOU AT THE EARLIEST POSSIBLE DATE.

A copy is not sent to the servicing field office.

SS Suspension Code Letters - (Continued) - Use the following code letters when suspending an RR certified SS benefit. A copy of the letter will be sent to the appropriate RRB field office. The code letter states:

THE SOCIAL SECURITY ADMINISTRATION HAS REQUESTED THE RAILROAD RETIREMENT BOARD TO SUSPEND YOUR BENEFITS (SEE REASONS LISTED BELOW)

IF YOU BELIEVE THAT THIS DETERMINATION IS NOT CORRECT, YOU MAY REQUEST THAT YOUR CLAIM BE RE-EXAMINED. IF YOU WANT THIS RECONSIDERATION, YOU MUST REQUEST IT NOT LATER THAN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. YOU MAY MAKE YOUR REQUEST THROUGH ANY SOCIAL SECURITY OFFICE. IF ADDITIONAL EVIDENCE IS AVAILABLE, YOU SHOULD SUBMIT IT WITH YOUR REQUEST.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, CONTACT THE NEAREST DISTRICT OFFICE OF THE SOCIAL SECURITY ADMINISTRATION. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE BRING THIS NOTICE AND ALL OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

The first sentence of the letter will be completed as follows:

LETTERSUSPSSA

CODE	CODE	LAF CODE	REASON FOR ADJUSTMENT
370	30	S0 (IF BIC=A)	PENDING ADDITIONAL INFORMATION WHICH IS NEEDED TO DETERMINE WHETHER YOU ARE STILL DISABLED.
371	30	S0 (IF BIC=C)	PENDING ADDITIONAL INFORMATION WHICH IS NEEDED TO DETERMINE WHETHER YOU,OR THE PERSON ON WHOSE RECORD YOU RECEIVE BENEFITS, IS STILL DISABLED.
372	30	S0 (IF BIC = A OR C)	PENDING ADDITIONAL INFORMATION WHICH IS NEEDED TO DETERMINE WHETHER THE PERSON ON WHOSE RECORD YOU RECEIVE BENEFITS IS STILL DISABLED
373	26	S1	BECAUSE YOU ARE WORKING OUTSIDE THE UNITED STATES ON 7 OR MORE DAYS DURING A MONTH. IF YOUR WORK PLANS CHANGE, PLEASE NOTIFY ANY SOCIAL SECURITY OFFICE PROMPTLY.

374	26	S2	BASED ON YOUR ESTIMATED EARNINGS FOR THIS YEAR. IF YOUR ESTIMATE OF EARNINGS FOR THE YEAR CHANGES, PLEASE NOTIFY ANY SOCIAL SECURITY OFFICE PROMPTLY.
375	27	S3	BASED ON THE ESTIMATED EARNINGS FOR THE PERSON ON WHOSE SOCIAL SECURITY RECORD YOU RECEIVE BENEFITS.
376	50	S4	BECAUSE YOU NO LONGER HAVE A CHILD IN YOUR CARE ENTITLED TO RECEIVE SOCIAL SECURITY BENEFITS.
377	27	S5	BECAUSE THE PERSON ON WHOSE SOCIAL SECURITY RECORD YOU RECEIVE BENEFITS IS WORKING OUTSIDE THE UNITED STATES ON 7 OR MORE DAYS DURING A MONTH.
379	28	S8	BECAUSE THE SSA IS REVIEWING THE QUESTION OF WHO SHOULD RECEIVE THE SOCIAL SECURITY BENEFITS PAYABLE ON THIS RECORD. A SOCIAL SECURITY REPRESENTATIVE MAY BE GETTING IN TOUCH WITH YOU ABOUT THIS IF THEY HAVE NOT ALREADY DONE SO. WHEN A DECISION HAS BEEN REACHED, THEY WILL CONTACT YOU.

Code Letter 380

If the reason for adjustment of an SS only case is other than the ones covered by code letters 370 through 379, use letter code 380. This is a miscellaneous code letter which is suitable for SS benefits suspended under LAF codes S7, S9, SD, SF, SH, SJ, SK, SL, SM, SP, or SW. (See RCM 7.4 Appendix B)

The letter states:

THE SOCIAL SECURITY ADMINISTRATION HAS REQUESTED THE
RAILROAD RETIREMENT BOARD TO SUSPEND YOUR BENEFITS. YOU

WILL BE NOTIFIED AT A LATER DATE AS TO WHEN YOUR BENEFITS CAN BE RESUMED.

IF YOU BELIEVE THAT THIS DETERMINATION IS NOT CORRECT, YOU MAY REQUEST THAT YOUR CLAIM BE REEXAMINED. IF YOU WANT THIS RECONSIDERATION, YOU MUST REQUEST IT NOT LATER THAN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. YOU MAY MAKE YOUR REQUEST THROUGH ANY SOCIAL SECURITY OFFICE. IF ADDITIONAL EVIDENCE IS AVAILABLE, YOU SHOULD SUBMIT IT WITH YOUR REQUEST.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, CONTACT THE NEAREST DISTRICT OFFICE OF THE SOCIAL SECURITY ADMINISTRATION. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE BRING THIS NOTICE AND ALL OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

Code Letters 381 through 389

Use these code letters when suspending an RR certified SS benefit that has been placed in a deferred status (LAF Code D). A copy is sent to the appropriate RRB field office.

The letter states:

THE SOCIAL SECURITY ADMINISTRATION HAS REQUESTED THE RAILROAD RETIREMENT BOARD TO TEMPORARILY WITHHOLD YOUR SOCIAL SECURITY BENEFITS.

(SEE REASONS BELOW)

YOUR NEXT PAYMENT WILL BE MADE AS SOON AS THE REQUIRED AMOUNT OF BENEFITS HAS BEEN WITHHELD.

IF YOU BELIEVE THAT THIS DETERMINATION IS NOT CORRECT, YOU MAY REQUEST THAT YOUR CLAIM BE REEXAMINED. IF YOU WANT THIS RECONSIDERATION, YOU MUST REQUEST IT NOT LATER THAN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. YOU MAY MAKE YOUR REQUEST THROUGH ANY SOCIAL SECURITY OFFICE. IF ADDITIONAL EVIDENCE IS AVAILABLE, YOU SHOULD SUBMIT IT WITH YOUR REQUEST.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, CONTACT THE NEAREST DISTRICT OFFICE OF THE SOCIAL SECURITY ADMINISTRATION. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE BRING THIS NOTICE AND ALL OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

Code Letter 386

Code letter 386 will close with the following paragraph instead of the one shown above:

YOU SHOULD HAVE RECEIVED A LETTER FROM THE SOCIAL SECURITY ADMINISTRATION REGARDING THE OVERPAYMENT WHICH CAUSED THIS ACTION. IF YOU HAVE NOT RECEIVED SUCH A LETTER OR NEED MORE INFORMATION ABOUT THE OVERPAYMENT, CONTACT THE NEAREST SOCIAL SECURITY DISTRICT OFFICE. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU CALL IN PERSON, PLEASE BRING THIS NOTICE AND ANY OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

LETTER CODE	SUSP CODE	SSA LAF CODE	REASON FOR ADJUSTMENT
381	71	D1	BECAUSE OF YOUR WORK AND EARNINGS OUTSIDE OF THE UNITED STATES.
382	71	D2	BECAUSE OF YOUR WORK AND EARNINGS.
383	72	D3	BECAUSE OF THE WORK AND EARNINGS OF THE PERSON ON WHOSE RECORD YOU ARE RECEIVING BENEFITS.
384	75	D4	SINCE YOU NO LONGER HAVE A CHILD WHO IS UNDER AGE 18, OR DISABLED, IN YOUR CARE.
385	72	D5	BECAUSE OF THE WORK AND EARNINGS OUTSIDE THE UNITED STATES OF THE PERSON ON WHOSE RECORD YOU ARE RECEIVING BENEFITS.
386	73	D6	TO RECOVER THE OVERPAYMENT DESCRIBED IN THEIR LETTER TO YOU.
387	75	D9	(NO REASON PRINTED.)
388	75	DP	BECAUSE OF YOUR RECEIPT OF PUBLIC ASSISTANCE.
389	75	DW	BECAUSE OF YOUR RECEIPT OF WORKMAN'S COMPENSATION.

- C. RR Termination Code Letters - Use the following code letters when terminating an RR annuity. Code paragraph 199 regarding reconsideration and appeals is included on all termination code letters. A copy of the letter will be sent to the appropriate field office.

Code Letter	Situation
501	<p>Use in manual termination of WCIA-last child attaining age 18 IS NOT an FTS; widow will be eligible in future.</p> <p>YOUR MOTHER'S/FATHER'S ANNUITY HAS ENDED BECAUSE YOUR CHILD IS ATTAINING AGE 18 THIS MONTH. THE CHILD SHOULD CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD IF HE (SHE) BECOMES:</p> <ul style="list-style-type: none"> • A FULL TIME STUDENT AT A HIGH SCHOOL OR ELEMENTARY SCHOOL BEFORE ATTAINING AGE 19 AND HAS NOT MARRIED, <u>OR</u> • DISABLED BEFORE ATTAINING AGE 22 AND HAS NOT MARRIED. <p>YOU MAY BE ELIGIBLE AGAIN FOR A MOTHER'S/FATHER'S ANNUITY IF THE CHILD BECOMES DISABLED BEFORE AGE 22, HAS NOT MARRIED AND IS IN YOUR CARE.</p> <p>YOU MAY BE ELIGIBLE FOR A WIDOW(ER)'S ANNUITY AT AGE 60 (AGE 50 IF DISABLED). AT THAT TIME YOU WILL HAVE TO FILE A NEW APPLICATION WITH THE RAILROAD RETIREMENT BOARD.</p> <p>IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.</p> <p>THERE IS AN OFFICE LOCATED AT (ADDRESS OF NEAREST FIELD OFFICE).</p>
502	<p>Use in manual termination of WCIA-last child attaining age 18 is an FTS; widow will be eligible in future.</p> <p>YOUR WIDOW'S CURRENT INSURANCE ANNUITY HAS ENDED BECAUSE YOUR CHILD IS ATTAINING AGE 18 THIS MONTH. ALTHOUGH THE CHILD IS ENTITLED TO AN ANNUITY AS A FULL-TIME STUDENT, A WIDOW UNDER AGE 60 CANNOT QUALIFY FOR AN ANNUITY ON THIS BASIS.</p>

	<p>YOU MAY BE ELIGIBLE AGAIN FOR A MOTHER'S/FATHER'S ANNUITY IF THE CHILD BECOMES DISABLED BEFORE AGE 22, HAS NOT MARRIED AND IS IN YOUR CARE.</p> <p>IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.</p> <p>THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u>.</p>
503	<p>Use in manual termination of a CIA when child attains age 18 this month.</p> <p>YOUR CHILD'S INSURANCE ANNUITY HAS ENDED BECAUSE THE CHILD HAS ATTAINED AGE 18 THIS MONTH.</p> <p>FURTHER BENEFITS MAY BECOME PAYABLE IF THE CHILD BECOMES:</p> <ul style="list-style-type: none"> • A FULL-TIME STUDENT AT A HIGH SCHOOL OR ELEMENTARY SCHOOL BEFORE ATTAINING AGE 19 AND HAS NOT MARRIED, <u>OR</u>, • DISABLED BEFORE ATTAINING AGE 22 AND HAS NOT MARRIED. <p>IF HE (SHE) BECOMES ELIGIBLE FOR FURTHER BENEFITS, OR IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER CONTACT THE NEAREST OFFICE OF THE BOARD.</p> <p>THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u>.</p>
505	<p>Use when terminating a spouse annuity based on minor children in her care--last child attaining age 18, spouse will qualify for unreduced annuity at age 60.</p> <p>YOUR ANNUITY ENDED THIS MONTH. YOU WERE PREVIOUSLY NOTIFIED THAT YOUR ANNUITY WOULD END WHEN YOUR CHILD ATTAINED AGE 18 UNLESS THE CHILD WAS TOTALLY AND PERMANENTLY DISABLED AND IN YOUR CARE.</p> <p>WHEN YOU REACH AGE 62, YOU MAY QUALIFY FOR A SPOUSE ANNUITY AT A REDUCED RATE. IF YOU DECIDE TO WAIT UNTIL AGE 65, YOU MAY QUALIFY FOR AN UNREDUCED ANNUITY AT THAT TIME.</p>

	<p>YOU MUST FILE AN APPLICATION BEFORE A SPOUSE ANNUITY CAN BE PAID AGAIN. YOU MAY DO SO AT ANY BOARD OFFICE WHEN YOU ARE QUALIFIED FOR AN ANNUITY. THE ENCLOSED FORM GIVES THE CONDITIONS UNDER WHICH YOU MAY QUALIFY FOR AN ANNUITY. IF YOU NEED FURTHER INFORMATION, CALL OR WRITE THE NEAREST DISTRICT OFFICE OF THE BOARD. PLEASE TAKE THIS LETTER WITH YOU IF YOU CALL IN PERSON.</p> <p>THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u>.</p> <p>ENCLOSURE</p> <p>G-177a</p>
515	<p>Use in 1981 Act case for manual termination of WCIA--last child attaining age 18 IS NOT an FTS; widow will be eligible in future.</p> <p>YOUR WIDOW'S CURRENT INSURANCE ANNUITY HAS ENDED BECAUSE YOUR CHILD IS ATTAINING AGE 18 THIS MONTH. IF THE CHILD BECOMES A FULL-TIME STUDENT, OR BECOMES DISABLED BEFORE ATTAINING AGE 22 AND HAS NOT MARRIED, HE (SHE) SHOULD CONTACT THE NEAREST OFFICE OF THE BOARD.</p> <p>YOU MAY BE ELIGIBLE FOR A WIDOW'S INSURANCE ANNUITY AT AGE 60 (AGE 50, IF DISABLED). AT THAT TIME, YOU WILL HAVE TO FILE A NEW APPLICATION WITH THE RAILROAD RETIREMENT BOARD.</p> <p>IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.</p> <p>THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u>.</p>
516	<p>Use when terminating a student who is no longer in full-time attendance; no overpayment involved.</p> <p>YOUR ANNUITY HAS BEEN TERMINATED BECAUSE YOU CEASED FULL-TIME SCHOOL ATTENDANCE THIS MONTH.</p> <p>IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.</p>

	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u> .
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- D. SS Termination Code Letters - Use the following code letters when terminating an RR certified SS benefit. A copy of the letter will be sent to the appropriate RRB field office.

The basic text of the letter is as follows:

THE SOCIAL SECURITY ADMINISTRATION HAS REQUESTED THE
RAILROAD RETIREMENT BOARD TO TERMINATE YOUR BENEFITS

(SEE REASONS LISTED BELOW)

IF YOU BELIEVE THAT THIS DETERMINATION IS NOT CORRECT, YOU MAY REQUEST THAT YOUR CLAIM BE RE-EXAMINED. IF YOU WANT THIS RECONSIDERATION, YOU MUST REQUEST IT NOT LATER THAN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. YOU MAY MAKE YOUR REQUEST THROUGH ANY SOCIAL SECURITY OFFICE. IF ADDITIONAL EVIDENCE IS AVAILABLE, YOU SHOULD SUBMIT IT WITH YOUR REQUEST.

(USED ON ALL BUT LETTER #363)

WHEN BENEFITS ARE TERMINATED DURING A YEAR AND A BENEFICIARY IS UNDER AGE 70, AN ANNUAL REPORT OF EARNINGS MUST BE FILED IF THE BENEFICIARY HAS INCOME FROM WORK EXCEEDING THE YEARLY LIMIT. THIS REPORT SHOULD INCLUDE THE BENEFICIARY'S EARNINGS FOR THE ENTIRE YEAR BOTH BEFORE AND AFTER THE BENEFITS WERE TERMINATED.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, CONTACT THE NEAREST DISTRICT OFFICE OF THE SOCIAL SECURITY ADMINISTRATION. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE, OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE BRING THIS NOTICE AND ALL OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

LETTER CODE	TERM CODE	SSA LAF CODE	BIC	REASON
351	17	T2		DUE TO THE DEATH OF THE PERSON ON WHOSE ACCOUNT YOU ARE RECEIVING BENEFITS.
352	15	T3		DUE TO YOUR CHANGE IN MARITAL STATUS.

353	03	T4	C(AGE 18)	SINCE YOU HAVE REACHED AGE 18.IF YOU ARE DISABLED OR ATTENDING SCHOOL FULL-TIME, PLEASE CONTACT ANY SOCIAL SECURITY OFFICE AS BENEFITS MAY AGAIN BE PAYABLE.
354	03	T4	C(CHILD AGE 18)	SINCE YOU NO LONGER HAVE A CHILD WHO IS UNDER AGE 18, OR DISABLED,IN YOUR CARE.
355	03	T4	C(AGE 19)	SINCE YOU HAVE REACHED AGE 19, OR ARE NO LONGER ATTENDING SCHOOL FULL-TIME.
356	10	T5		ON THIS SOCIAL SECURITY ACCOUNT NUMBER. IT HAS BEEN DETERMINED THAT YOU ARE ENTITLED TO AN EQUAL OR GREATER AMOUNT OF BENEFITS ON ANOTHER NUMBER. YOU SHOULD BE RECEIVING BENEFITS BASED UPON THAT NUMBER.
357	14	T6	C	BECAUSE YOU ARE NO LONGER ATTENDING SCHOOL FULL-TIME, OR ARE NO LONGER DISABLED.
358	14	T6	C	SINCE YOU NO LONGER HAVE A CHILD IN YOUR CARE ENTITLED TO RECEIVE SOCIAL SECURITY BENEFITS.
359	08	T8	A	SINCE YOU HAVE RECOVERED FROM YOUR DISABILITY.
360	08	T8	C	SINCE YOU, OR THE PERSON ON WHOSE ACCOUNT YOU ARE RECEIVING BENEFITS,HAS RECOVERED FROM DISABILITY.
361	08	T8	= C OR A	SINCE THE PERSON ON WHOSE ACCOUNT YOU ARE RECEIVING BENEFITS HAS RECOVERED FROM DISABILITY.
362	25	T9, TP		(NO REASON PRINTED)
363	13	TR, T+		SINCE YOU HAVE WITHDRAWN YOUR APPLICATION FOR SOCIAL SECURITY BENEFITS.
365	10	AD		BECAUSE ALL BENEFITS NOW

				PAYABLE HAVE BEEN COMBINED WITH YOUR OWN BENEFITS SO THAT ONE PAYMENT CAN BE MADE UNDER YOUR OWN NUMBER.
390	17	T2	B/C	DUE TO THE DEATH OF THE PERSON ON WHOSE ACCOUNT YOU ARE RECEIVING BENEFITS.
				<u>ADDITIONAL PARAGRAPHS:</u>
				SURVIVOR BENEFITS ARE PAYABLE BY EITHER THE RAILROAD RETIREMENT BOARD OR THE SOCIAL SECURITY ADMINISTRATION, BUT NOT BY BOTH, EVEN THOUGH THE EMPLOYEE MAY HAVE RECEIVED BENEFITS FROM BOTH AGENCIES WHILE HE WAS ALIVE. THE RAILROAD RETIREMENT BOARD HAS JURISDICTION OF YOUR SURVIVOR BENEFITS. NOTICE OF THE EMPLOYEE'S DEATH WAS RECEIVED TOO LATE TO PREVENT THE RELEASE OF SOCIAL SECURITY BENEFITS ISSUED AFTER THE MONTH OF DEATH. THESE OUTSTANDING AND NOT DUE BENEFITS WILL BE RECOVERED FROM YOUR SURVIVOR AWARD.

Disposition

The original copies of all Forms G-96 are to be accumulated by units and sections and forwarded to the control and services group by 11:00 a.m. on the cut-off date published on the monthly cut-off calendar. Carbon copies are to be filed the left side of the claim folder.

G-100 - Request to Enter or Delete Due Process Code

(Original and one copy)

Use

- Used by claims examiners to freeze an annuity rate or an RR-certified social security benefit rate and to prevent the mechanical increase of either during a due-process period.
- Used to delete previously entered due process code without going through the process of manually certifying an award or completing a G-96 for an annuity rate or an RR-certified social security benefit.

- Used to prevent a PAM adjustment in cases where manual certification of an RR-le is in progress.

General Instructions

A G-100 entered into the checkwriting system with codes "0" or "1" will freeze the annuity or RR-certified SS benefit for the payee designated on the form until:

- A manual award form, including an award certification for SSA, is processed; or
- Form G096 is prepared to suspend or terminate payments; or
- Another form G-100 with codes "2" or "3" is prepared to delete the previously entered due process code.

Preparation

You must complete a G-100 for each type of benefit for which you want to enter a due process code.

Cols. 1-3 - Enter beneficiary symbol and prefix. If the prefix is one character, use column 3.

Cols. 4-12 - Enter the numerals of the claim number. For a six-digit claim number, enter the numbers in cols. 7-12.

Cols. 13 - Enter the payee code of the annuitant for whom you wish to enter a due process code.

Record Changes

Enter the appropriate due process code as described below:

Code Situation

- | | |
|---|---|
| 0 | To freeze an annuity rate |
| 1 | To freeze an RR-certified SS benefit |
| 2 | To delete a previously entered due process code for an annuity rate |
| 3 | To delete a previously entered due process code for an RR certified SS benefit. |

Disposition

- Sign and date the form and enter the unit in which it was prepared in the space provided. File the carbon copy on the right side of the claim folder and put the original in the designated keypunch forwarding location.

- G-100's used to stop a mechanical increase to the RR annuity (code 100 in columns 16-18) are submitted to keypunch once a month on the same day as examiner/recert cut-off. The exact date will be specified on EFP calendar.

Miscellaneous

If you want to find out the G-100 was entered into CHICO, request a QUICKIE print-out.

G-143 - Master Benefit Adjustment Record Control

(For research use only)

Use

Research has the responsibility of post-editing and reconciling their files with the benefit payment records. When an error is found involving an award form, the correction is made on the award form in red. When an error not involving an award form is found and corrected, research inserts a Form G-143 in the folder to note the type of correction made and when the action took place. The form is used exclusively by research and can be disregarded by claims examiners and payment records personnel. A copy of the G-143 is shown below:

Sample Copy

(Printed on Pink Stock)

SEE EXHIBIT 1

G-607 PC- Record Correction Request Name-Address-Code

Use

Used to change or correct a payee's or beneficiary's name and/or address on the CHICO master benefit file, and to make certain other corrections on the file.

Program Access

To access the PC G-607 Program, double-click on the G-607 icon. The Online Form G-607 Program entry screen will appear.

Form Access

To access the online Form G-607, single click on the G-607 box. The online Form G-607 will appear with the cursor positioned in the RRB Claim No. "Sym" field.

Data Entry Procedure

Sym Box (Optional Entry) - If the RRB claim number symbol/prefix is MA, WA, WD, WCA or WCD, enter M, W, or WC as appropriate. After making the entry, press TAB or ENTER to move to the Prefix box. If the RRB claim number does not contain an M, W, or WC symbol, leave this field blank and press TAB or ENTER to move to the Prefix box.

Prefix Box (Mandatory Entry) - The Prefix box is prefilled with an A. If the claim number prefix is A, press TAB or ENTER to move to the Claim Number box. If the prefix is D, override the prefilled A with a D and press TAB or ENTER to move to the Claim Number box.

Claim Number Box (Mandatory Entry) - Enter the six or nine-digit RR claim number. Use preceding zeroes with six-digit claim numbers. Press TAB or ENTER to move to the Employee's Name box.

Employee's Name Box (Optional Entry) - Enter the employee's name. Press TAB or ENTER to move to the Payee's Name box.

Payee's Name Box (Optional Entry) - Enter the payee's name. Press TAB or ENTER to move to the Change Code box.

Change Code Box (Mandatory Entry) - Click on the applicable change code. The selected code will be highlighted. Press TAB or ENTER to move to the Payee Code box.

Payee Code Box (Mandatory Entry) - Enter the numeric payee code. Press TAB or ENTER to move to the First Five box.

First Five Box (Mandatory Entry) - The appropriate entry is based on the selected Change Code:

- If using Change Code 1,2,3,4,5,6,7,C, D or E, enter the first five letters of the *LAST WORD* on line 1 of the name/address block of the current payment record. Note: While this is usually the payee's surname, that is not always the case. Be sure to enter the first five letters of the *LAST WORD* on line 1 of the current name/address block.
- If using Change Code 8, the entry depends on the type of change being made. Use the following guidelines when using Change Code 8:

Entry to Correct SMIB Enrollment Code	Enter the new enrollment code followed by the letters "SMIB" to change the RR record, or "SMIS" to change the SS record, e.g., "9SMIB". Remember to enter the
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	payee's name on line 1 of the 5-line name/address block.
Entry to Correct Policing Code (Rep Payee Cases)	Enter the correct policing code (0,1, 2, 3, 4, 5, 6, 7, or 8 as described in RCM 5.10.3) followed by the letters "POLC", e.g. "0POLC". Remember to enter the payee's name on line 1 of the 5-line name/address block.
Entry to Correct the Family Code	Enter "FAMCD" in the First Five Box. Enter the two-digit Family Code (the first digit will always be zero) on Line 1 of the 5-line name/address block. Note: When deleting a Family Code, enter "00".
Entry to Correct the Twin Code on CHICO	Enter "TWIN" followed by the correct twin code (0,1,2) in the First Five box, e.g., "TWIN1". Enter the payee's name on Line 1 of the 5-line name/address block.
Entry to Correct the BA Number	Enter "B" followed by the railroad's 4-digit BA number in the First Five box, e.g. "B3724". Enter the payee's name on Line 1 of the 5-line name/address block.
Entry for Input of Collective Bargaining Code	Enter "1", followed by "CBCD" in the First Five box, e.g. "1CBCD". Enter the payee's name on Line 1 of the 5-line name/address block.
Entry to Correct the Geographic Code	Enter "GC", followed by the 3-digit geographic code in the First Five box, e.g., "GC223". Enter the payee's name on Line 1 of the 5-line name/address block.
Entry to Correct Date of Birth (RR or SS)	<p>Enter "DOB" in the First Five box to correct a RR DOB. Enter "DOBSS" in the First Five box to correct a SS DOB. Enter the correct DOB on Line 1 of the 5-line name/address block as an 8-digit date in century-year-month-date order.</p> <p>Examples:</p> <p>April 28, 1987 = 19870428</p> <p>October 12, 1995 = 19951012</p> <p>January 1, 2001 = 20010101</p>
Entry to Correct the Medicare Disability Code	Based on the type of case, enter the following in the First Five box:

	<p>“0DISA” to remove disability code,</p> <p>“1DISA” for a disabled Employee,</p> <p>“4DISA” for a disabled child,</p> <p>“6DISA” for a disabled spouse,</p> <p>“8DISA” for a disabled widow,</p> <p>“9DISA” for a disabled IPI.</p> <p>Enter the payee’s name on Line 1 of the 5-line name/address block.</p>
Entry to Correct the Sex Code	<p>Enter “1” for male, “2” for female, and “3” for unknown followed by “SXCD” in the First Five box, e.g. “2SXCD”. Enter the payee’s name on Line 1 of the 5-line name/address block.</p>
Entry to Correct Interim Widow Code	<p>To correct an erroneous interim widow code, enter “IWCD0” in the First Five box. Enter the payee’s name on Line 1 of the 5-line name/address block.</p>
Entry to Correct Type of Beneficiary Symbol	<p>Enter “TOB” followed by the appropriate 2-digit numeric code from RCM 6.9.13 in the First Five box, e.g., “TOB71”. Enter the payee’s name on Line 1 of the 5-line name/address block.</p>
Entry to Correct RRB COL Earmark Code	<p>Enter “RREM8” in the First Five box when all mass adjustments have been applied, but the master record still reflects pending status. Enter the payee’s name on Line 1 of the 5-line name/address block.</p>
Entry to Correct SSA COL Earmark Code	<p>Enter “SSEM8” in the First Five box when the most recent SS COL has been applied, but the master record still reflects pending status. Enter the payee’s name on Line 1 of the 5-line name/address block.</p>
Entry to Correct Employee’s SSA Number	<p>Enter “EMPSS” in the First Five box. Enter the correct SS number on Line 1 of the 5-line name/address block.</p>
Entry to Correct the SSA Claim Number	<p>Enter “CLMSS” in the First Five box. Enter the correct SSA claim number on Line 1 of the 5-line name/address block.</p>
Entry to Correct the SSA	<p>Enter “BIC” followed by the correct suffix in the First</p>

Claim Number Suffix	Five box, e.g. "BICC1". Enter the payee's name on Line 1 of the 5-line name/address block.
Entry to Correct The Beneficiary SS Account Number	Enter "BENSS" in the First Five box. Enter the correct account number on Line 1 of the 5-line name/address block.
Entry to Correct the SSA Trust Fund Indicator	Enter "SSATF" in the First Five box. Enter "OASI" or "DI" on Line 1 of the 5-line name/address block.
Entry to Correct SSA Partial Rate Code Data	Enter "PDATA" in the First Five box. Enter "N" on Line 1 of the 5-line name/address block if there is no partial rate. Enter "P" in the first box, the monthly rate in boxes 3-8 (\$\$\$\$cc) and the beginning date (MOYEAR) in boxes 10-15 on Line 1 of the 5-line name/address block.
Entry to Input RRA MAX Code (SUP ANN Cases)	Enter "3CBCD" if the EE receives a pension under a collective bargaining plan or "4CBCD" if the EE receives a pension under a non-collective bargaining code in the First Five box. Enter the payee's name on Line 1 of the 5-line name/address block.

Line 1 – Line 2 – Line 3 – Line 4 – Line 5 Boxes (Mandatory Entry) - Based on the selected change code in the Change Code box and the entry in the First Five box, make the appropriate entries on Lines 1 through 5.

Note: If entering an address (Change Code 2) or a name/address (Change Code 3), use an exclamation point ! for the group mark.

Note: If entering a Date of Birth, enter an 8-digit date in century-year-month-date order. For example, show September 29, 1984 as "19840929".

Press TAB or ENTER to move to the Prepared By box.

Prepared By Box (Mandatory Entry) - Enter your name. Press TAB or ENTER to move to the Unit box.

Unit Box (Mandatory Entry) - Enter your unit designation. This completes the data entry requirements unless the G-607 is being used to enter a foreign address. If the G-607 is being used for a change other than a foreign address, see the Disposition instructions below. If you are entering a foreign address (change code 2 or 3), press TAB or ENTER to move to the Geographic Code box.

Date Box (Prefilled Entry) - The current date is prefilled. No entry is necessary.

Geographic Code Box (Optional Entry) - Enter the appropriate 3-digit geographic code for the foreign country when entering a foreign address with change code 2 or 3. See RCM 10.2 Appendix B2 for the correct GEO code.

Auth For Rep Payee Change Box (Future Use)

Rep Payee Code Box (Future Use) - The PC G-607 program does not process Code R COA transactions at this time.

Disposition

UNDO RECORD BUTTON - Click on the UNDO RECORD BUTTON in the lower right corner of the G-607 screen to refresh the G-607 screen at anytime prior to establishing the record on the PC database. Any entries made on the G-607 will be erased and new or corrected entries can be made.

UPDATE RECORD BUTTON - After making the appropriate entries, click on the UPDATE RECORD BUTTON in the lower left corner of the G-607 screen to submit the transaction to the program database. To check on the submitted transaction, click on the scroll arrow in the Review Current G-607s box, also in the lower left corner of the screen. Scroll down through the listed cases to locate your transaction. Transactions are listed in ascending claim number order and the employee's name will be listed next to the claim number if the employee's name was entered on the G-607.

DELETE RECORD BUTTON - To delete a submitted G-607 transaction (prior to the DAISY upload), locate the record by scrolling through the records in the Review Current G-607s box. Click on the record to be deleted and the record will appear on the screen. Click on the DELETE RECORD BUTTON. A box insert will appear asking you if you want to delete the record. Click on the "YES" box to delete the record.

NEW G-607 BUTTON - After updating a record, the newly established record will remain on the G-607 screen. Click on the NEW G-607 BUTTON to refresh the screen. A new G-607 can now be entered.

PRINT G-607 BUTTON - Click on the PRINT G-607 BUTTON to create a screen-print of the G-607. The print will be made at your PC printer.

CLOSE FORM BUTTON - Click on the CLOSE FORM BUTTON to return to the PC G-607 Program entry screen.

Exit

To exit the PC G-607 program. Click on the "X" in the upper right hand corner of the program entry screen or click on the EXIT BUTTON (graphic) in the lower right corner of the program entry screen.

G-627 – Request for Information from Quality Control/Claims Specialist

Form G-627 is available on RRAILS. It replaces the BSB-111.

Use

The form is used by examiners to refer questions on specific case handling to lead examiners and Quality Analysts.

Examiner Form Completion:

- RRAILS completes the claim number, the examiner's name and the date.
- Enter the RCM reference(s) and AFCS charge.
- Under "Summary of Facts and/or Questions", briefly state the facts in the case, explain the problem and ask your question.
- DO NOT MAKE ANY ENTRIES IN THE "REQUIRED ACTION" section.

Lead Examiner/Quality Analysts Form Completion:

- If your name and the date prefill at the top of the form, delete these entries.
- Tab to the "REQUIRED ACTION" section and enter the action(s) to be taken.
- Enter your name and date at the bottom of the form.

Routing

Operation's management will determine how the form should be routed.

9.5.1 Scope Of Chapter

This chapter will familiarize you with the CRT (cathode ray tube) terminals used by this bureau. Information about operating CRT terminals is also in the manual, User's Guide. It contains information on resolving mechanical problems and problems with access. A copy of the manual is kept next to some CRT terminals. If a problem arises that cannot be resolved, contact the Help Desk through your unit supervisor.

The teleprocessing software system which displays data on the CRT terminals is called the Integrated Database Management System-Data Communications (IDMS-DC).

9.5.2 Terminology

The following terms are helpful in understanding the operation of CRT terminals:

- Teleprocessing is computer processing via remote terminals. The CRT terminals in use at the RRB are a teleprocessing device. Each terminal is connected to the RRB main computer; by entering input on the remote terminal keyboard, the user can access a particular computer system. Information accessed through the terminals will be displayed on the video screen.

There are three major applications of a teleprocessing system: 1) query processing, whereby the user can retrieve information from a computer system; 2) information updating, whereby the user can change the data in the computer's master record directly through the terminal keyboard; and 3) compiling, executing, and "debugging" computer programs.

- Database is a type of data storage, it is the storing of common data to eliminate the need for duplicate files. For instances, currently an annuitant's social security number is found in several computer files throughout the bureau and the RRB: CHICO, RASI, Research record, etc. In the database concept, one master record is established for each annuitant; common items such as social security number, date of birth, name and address, etc. are shown only once in the database record. Every individual system, such as CHICO, would retrieve the needed information from the database master record. Likewise, if one system makes a data change all other systems would have access to the new data.
- On-line processing occurs when data can be processed immediately. The bureau's CRT systems are on-line processing, since the user has immediate and direct response to his inquiries.
- On-line processing requires a computer system to have a random (or direct) access capability. Random access means the capability to go directly to a specified location to find a needed record in a file without searching the file from the beginning. For instances, the DATA-Q system can randomly access the necessary CHICO information for its display from the database.

9.5.3 Keyboard

The terminal keyboard is similar to a standard typewriter keyboard in appearance and arrangement of keys. Most keys perform the same function as the corresponding keys on a typewriter. The layout of the keyboard is shown in Exhibit 2.

The keyboard can generate and display 26 upper case letters, 10 numbers, and 26 symbols and punctuation marks. The character will be displayed when the corresponding key is pressed. The character is displayed on the screen in the position marked by the cursor, (the guideline or block that moves along as the characters are typed). The keyboard also includes control keys which are used to edit data and generate input messages to signal the computer.

Keys that have two designations on their faces can generate either character, depending upon the position of the SHIFT key. The lower character is generated when the key is pressed and the keyboard is in the unshifted mode. To generate the upper character, the SHIFT key must be held down while the selected key is pressed. The SHIFT keys and the SHIFT LOCK key function essentially the same as they do on any standard typewriter. To generate the front function of any of the control keys, the alternate shift key must be held down while the selected key is pressed.

The alphabetic, numeric, and special symbol key functions the same as they do on any standard typewriter.

Marking On Key	Name Of Key	Function
Alt	Alternate Shift	To activate the function on the front of a control key, the alternate shift key must be held down while the selected key is pressed.
Clear	Clear	Pressing the clear key will usually delete the current screen and move the system backward one screen level.
Enter	Enter	The ENTER key must be pressed after a data entry is typed onto the screen. The Enter key passes a data request from your terminal to the RRB computer, which in turn will generate a response. Do not press the ENTER key if you are typing information which is not a data request. For instance, do not press the ENTER key after typing in the routing designation for a printout.
Erase EOF	Erase to End of	When pressed, this key will delete any characters

	Field	that exist in a particular field from the point of and beyond the current position of the cursor. For instance, in the field 12 <u>3</u> 45, the ERASE EOF key would delete the 3, 4 and 5.
Er Inp	Erase Input	Pressing this key will erase all input fields and move the cursor to the first position in the first input field on the screen being displayed.
Ex Sel	Extended Select	Pressing the extended select key will alternately activate and deactivate the extended select functions (double speed cursor right or left, cursor home, and word delete.)
PA 1	Program Access Key #1	Pressing the PA1 key will usually delete the current screen and display the application. EXCEPTION: In DATA-Q, the PA1 key will page forward to the screen display of the next payee code in the family record.
PA 2	Program Access Key #2	Pressing the PA2 key will usually delete the current screen and display either an application or database menu or the ENTER NEXT TASK CODE message. EXCEPTION: In DATA-Q, the PA2 key will page backward to the screen display of the previous payee code in the family record.
PA 3	Program Access Key #3	Pressing the PA3 key (Shift and Page Down keys) will delete the current screen and display the NVi/TPX MENU or if you selected an application on another <i>RRAPID Advantage</i> session, it will take you to that application.
PF1-PF-24	Program Function Keys #1 - #24	Program function (PF) keys have functions unique to each application/system. Refer to individual application/system instructions to view a specific use for each PF key. Some PF keys have a general use available for most applications/systems. Functions for these PF keys, control keys, and screen management keys are explained below:
PF7	Program Function Key #7	In most systems, the key is used to page back.
PF8	Program Function Key #8	In most systems, the key is used to page forward.

PF22/ CrBnk	Program Function Key #22/Cursor Blink	Press the Alt and PF22 keys to make the cursor start or stop blinking.
PF23/ Alt Cr	Program Function Key #23/ Alternate Cursor	This key alternately makes the cursor a line or a box.
PF24/ Click	Program Function Key #24/ Click	Pressing the click key, while holding down the alternate shift key, will alternately activate and deactivate the click function. The click function provides audible verification of a keystroke.
PRINT	Print	Press the print key to request a printout of the display on the video element.
Reset/ DvCnl	Reset/ Device Cancel	The reset key will unlock the keyboard. This key will also cancel a print key request to a busy printer.
	Tab	This tab key will move the cursor to the next input field on the screen being displayed.
	Backtab	This tab key will move the cursor back to the first position of the input field. If the cursor is in the first position of a field, it moves the cursor to the previous input field on the screen being displayed.
	Backspace	The backspace key moves the cursor backward.
	Word Delete	Pressing the word delete key will delete any characters that exist in the input field where the cursor is currently located.
	Shift	To activate the upper character on a key, the shift key must be held down while the selected key is pressed.
	Shift Lock	The shift lock key functions are essentially the same as it would be on a standard typewriter. Repeated pressing of the shift lock key will alternately lock and unlock the key.
	Cursor Home	Pressing the cursor home key will move the cursor to the first position in the first input field on the screen being displayed.

	New Line	Pressing the new line key will move the cursor to the first position in the first input field in the next line on the screen being displayed.
	Insert	Pressing the insert key allows you to insert characters between others you have already typed. To stop inserting, press the reset key.
	Delete Character	Pressing the delete character key will delete the character at the cursor position in an input field.
	Cursor Up	Moves the cursor up.
	Cursor Down	Moves the cursor down.
	Cursor Left	Moves the cursor left.
	Cursor Right	Moves the cursor right.
	Double Speed Cursor Left	Moves the cursor to the left at double speed.
	Double Speed Cursor Right	Moves the cursor to the right at double speed.
None	Spacebar	The spacebar will move the cursor one space each time that it is pressed. If characters are already typed in a field, the spacebar will delete those characters.

9.5.4 Password Requests

Bureau personnel authorized to use the CRT terminals must be assigned a user ID and a password. These passwords are necessary to operate the on-line systems in accordance with the Privacy Act. Some passwords will not access every system. If access to a system is required, additional clearance may be requested on a G-455. An employee should never divulge his password to anyone for security reasons.

Form G-455 must be completed by a supervisor and submitted to the Evaluation, Security, and Control Section. This form is also used when an employee resigns, changes names, or forgets the password. When an employee is transferred, a G-455 must be completed. Usually a new password is not required, however, the user ID must be updated.

9.5.5 Terminal Operation

CRT terminals are continuously available for use 24 hours a day. A terminal should never be turned off. At the end of each regular business day the screen light knob should be turned down to dim the screen.

When most CRT terminals are not in use for several minutes, the RRB train logo will automatically disappear from the screen. Press the RESET key to display the RRB train logo and resume terminal operation.

At times it is necessary for computer services to shut down all terminals to change or move system data. When a scheduled shutdown occurs, you will be advised through your unit supervisor that terminal operations will be unavailable and when normal operations will resume.

Usually, if a CRT terminal is down, it will come up again momentarily. If it does not, notify your supervisor. Any major mechanical problems should be reported to the HELP desk through your supervisor.

9.5.6 Standard Sign-On And Sign-Off Procedures

1. Teleprocessing Activation

The teleprocessing software system which displays data on the CRT terminals is called IDMS-DC (Integrated Database Management System - Data Communications.)

The CRT is not operational unless the Power-On Light is on. The light is located below the screen either in the middle or on the right side. Consult the User's Guide if you believe there is a mechanical problem. If the problem cannot be resolved, contact the Help Desk through your unit supervisor.

2. Initial Sign-on Procedure

When the system comes up in the morning or after being down during the day, the screen will display the RRB train logo. This train also appears if an application/system is not used for ten minutes.

From the RRB train logo screen enter the name of the database to be accessed (DATABANK, RRAPID, etc.) and press the ENTER key. Refer to Exhibit 32 which shows a navigation chart of the systems contained in DATABANK and RRAPID.

NOTE: If the RRB logo screen is not present when the terminal is unlocked, enter the name of the database and press the ENTER key. When exiting the database, the RRB train logo screen will return.

If your database selection is successful, the next screen will have one of the following lines displayed:

V2 ENTER NEXT TASK CODE: (for DATABANK)

V6 ENTER NEXT TASK CODE: (for RRAPID)

Follow the sign-on procedure as explained in Section 4 below.

3. Problems

The following message indicates the database selected is currently not functional.

UNABLE TO ESTABLISH SESSION INIT FAILED WITH SENSE (TERMINAL #)

Wait five minutes and then try signing on again.

The following message should be reported per RCM 9.5.5.

SESSION NOT BOUND

The following messages indicate a particular system is unavailable.

APPLID PARAMETER INVALID

TASK OUT OF SERVICE

If you were not notified that the system would be down, report the problem per RCM 9.5.5.

4. Sign-on With User ID and Password

To access a database, you must have a USER ID and a password. If you need these, see RCM 9.5.4.

After the initial sign-on (see 2 above), the cursor will be positioned on the line after one of the following messages:

V2 ENTER NEXT TASK CODE

V6 ENTER NEXT TASK CODE

As part of the sign-on procedure, you must enter your USER ID. This code consists of an eight character code that has been assigned to you.

To complete the sign-on procedure, type the message: SIGNON (followed by the USER ID). For instance, type: SIGNON JONESJOC then press the ENTER key. Note that the hyphen is deleted from the spelling of SIGNON; a space

should be entered between the word, SIGNON, and your USER ID. If the USER ID has been entered correctly, a password prompt line appears:

ACFA 2032 ENTER PASSWORD

Type in your password and press the ENTER key. If the USER ID was incorrectly entered, the following message will be displayed.

ACFA 2041 INVALID INPUT RE-ENTER LOGONID

Reenter the word SIGNON and the correct USER ID.

For security reasons, the password does not appear as it is being typed. If the password is entered correctly, this message appears on the screen:

ACFA 2032 ENTER PASSWORD

ACFA 2050 SIGNON COMPLETE

ACFA 1137 LAST SYSTEM ACCESS 13 16-2/14/92 FROM 1441191C

On the third line of the password validation screen, the numbers before and immediately after the dot represent the Signon time, i.e., 13 16 is 1:16 p.m. After the dash, the sign-on date appears. The numbers after the word FROM represent the terminal number.

Do not enter any additional data on this screen. Press ENTER and the next screen will show:

ENTER NEXT TASK CODE:

You have now successfully accessed the database application. Refer to the appropriate section of RCM 9 or 16 for information on each database application. See Exhibit 32 which shows the systems in each database or how to view a system which must be accessed through the menu of another system.

Three chances are given to each user to enter his password. If the password is entered incorrectly, the following messages will appear:

ACFA 2032 ENTER PASSWORD -

ACFA 1012 PASSWORD NOT MATCHED

ACFA 2032 ENTER PASSWORD -

If the password continues to be entered incorrectly, the message will be repeated up to three times. If the password is entered incorrectly a third time, the following message appears:

ACFA 2047 MAXIMUM PASSWORD ATTEMPTS EXCEEDED

ACFA 2059 SIGNON TERMINATED

The system terminates access for the current USER ID. Contact the Administrative Operations Section - BDP to have your password reinstated.

If an incorrect entry has been made when trying to access a particular system, the message UNDEFINED TASK CODE appears on the screen. IDMS-DC displays the erroneous entry on the top line of the screen until a correct entry has been made.

If you attempt to access a system you are not authorized to use, or if you attempt to access a system without signing on, the following message will appear:

SECURITY VIOLATION ON TASK CODE: (Name of System)

ENTER NEXT TASK CODE:

If you failed to sign on, do so and then access the desired system.

If IDMS-DC is denying you access to a system that you should have access to, advise your supervisor to call the Administrative Operations Section - BDP to have this resolved.

5. Sign-off Procedure

Signing-Off RRAPID

After you are finished with one system within the Railroad Automated Processing Integrated Database (RRAPID), use the appropriate exit key for the system you have been using. This will return you to the RRAPID main menu. You have two options available:

You may enter a different system within RRAPID by selecting the assigned number and entering it next to the word, SELECTION. Then press ENTER, or

You may sign off by entering an X next to the word, SELECTION. Then press ENTER. The RRB train logo screen will appear. You can access another database by following the appropriate sign-on procedure in Section 2 above.

Signing-Off DATABANK

A somewhat different approach is taken when signing off DATABANK. On the last system screen, enter the letter E in the ACTION field and press ENTER. The next screen will show ENTER NEXT TASK CODE. From this screen you may either:

Select another system within DATABANK, or

Sign off by typing the word, BYE, then pressing ENTER. This will sign you off the system and bring up the RRB train logo screen.

Refer to RCM 9.10 for instructions on signing-on, moving through, and exiting the PAR system.

9.5.7 Requesting A Printout Of A CRT Screen

When you want to print the information that is currently displayed on the CRT screen, press the PRINT key.

Some systems allow for the entry of the requestor name and unit before the screen is printed. To do this from a DATA-Q or MOLI screen, press the PF-2 key. The following line will appear near the bottom of the screen:

> - - - - > ENTER NAME XXXXXXXXXXXX AND UNIT < - - - - <

At this point, enter your name and any routing designation decided upon in your office. Use the spacebar [or the ERASE EOF key] to blank out any X's in unused spaces.

To do this from a taxation system screen, move the cursor to the area next to the words, REQUESTOR'S NAME. Enter your name in this area and use the spacebar [or the ERASE EOF key] to blank out the X's in any unused spaces.

Once you have entered your name or your name and routing designation, press the PRINT key. The printer will then produce a printout, provided it has been turned on and is properly equipped with paper.

9.5.8 Accessing RRB System Applications

- A. Accessing the RRAPID Systems - The following is a list of the current systems in the Railroad Automated Processing Integrated Database (RRAPID), a brief description, and the point of reference for detailed information:

RATEH (ORIS)	On-line Rate History Inquiry System	16.2
PAM (POLO)	Pam On-line Operation	16.3
DATA-Q	Data Query	9.5
REQUEST	Retirement Adjudication System-Initial	9.5
MOLI	MIRTEL On-Line Inquiry	9.5

SURGE	Survivor G-90 Expeditor	9.11
PIENTRY	Payment Investigation Entry	9.7
PISTATUS	Payment Investigation Status	9.7
FTRACK	TRACK First Notice of Death	9.7
FTCHECK	TRACK Return of Check(s)	9.7
RRIC	Railroad Initial Claims	9.5
ALTA	Automated Award Letters to Annuitants	9.8
ONCORR	On-line Correction System	9.12
ROC	Retirement On-line Calculations	16.4
MAIS	Mass Adjustment Inquiry System	16.6
PAYBACK	On-Line Cancelled Payment Data	9.5
AFCS	Automated Folder Control System	AFCS Directory
EDMA	Employment Data Maintenance Inquiry	9.9
TAX	Taxation Accounting System	TOM Book I, Art. 3100
FOMF	Financial Organization Master File On-Line Inquiry System	9.5

The RRAPID main menu (see Exhibit 3) will appear with the message "NO HOTKEY SESSION." (See Section C below for an explanation of navigating between systems in RRAPID using the HOTKEY function). Select the number of the application you wish to view and enter it on the lower left side of the screen next to the caption, NEXT SELECTION. Press ENTER.

Depending on your screen selection, you will either view the first screen of the selected application or another menu for which the appropriate screen must be selected.

The systems having a number designation on the RRAPID main menu are available in RRAPID.

FTRACK, FTCHECK, and PISTATUS can also be accessed directly through DATA-Q. Refer to instructions for this in RCM 9.5.11 Section 2.

From any system screen of RRAPID, press the appropriate exit key to return to the RRAPID main menu. To exit from RRAPID, refer to sign-off instructions in RCM 9.5.6 section 5.

- B. Opening Multiple RRAPID Sessions – Please See FOM1 1525.15.3 for information on using the *RRAPID Advantage*
- C. Navigating Between Systems in RRAPID using the HOTKEY Function - The HOTKEY function allows you to more efficiently access information for a particular claim number or SSN from multiple application systems in RRAPID without re-keying the identifying information. A HOTKEY session is established whenever you sign on to RRAPID and continues as you move from system to system. The session ends when you sign off the RRAPID menu.
 - 1. Beginning a HOTKEY session - Sign on to RRAPID using the instructions in RCM 9.5.6. and 9.5.8A. The RRAPID menu will appear with the message "NO HOTKEY SESSION." Select the system you first wish to access. Enter the identifying information for that system (claim number, SSN, etc.) for the individual for whom you are retrieving information or creating a transaction. Complete your inquiry or transaction and exit the system in the normal manner (generally PA2). The system will return you to the RRAPID menu and retain the identifying information you were using.

Select another system and press ENTER. Additional identifying information for that individual will be retrieved from either RATEH or EDM (depending on the destination you select) and stored for use during your HOTKEY session. When you enter your next and subsequent destinations, the identifying information for each application will be prefilled on the first screen that requires them.

NOTE: It will be necessary to key over the prefilled data if the data retrieved from RATEH or EDM is discrepant or incorrect.

The identifying information in use is displayed on the message line at the bottom of the RRAPID menu as shown below.

```
HOTKEY IN FORCE FOR D000123456 1 BEN 123456789 EE 123456789
ER 1234
```

It includes the RR prefix, claim number and payee code, the beneficiary's SSN, the employee's SSN and, in a few circumstances, the employer number. The only identifying information displayed when you leave the first application you entered is the information used to access that

application. After additional applications are entered, the message will display all available identifying information. (The employer number is only displayed after leaving EDM or an RUIA application.)

NOTE: HOTKEY does NOT allow you to pause where you are, go to another system and return exactly to where you left. It facilitates movement between systems and decreases keystrokes. For example, if you are in the middle of a transaction in one system (e.g., creating an award in ROC) and you wish to retrieve some information from another system (e.g., a new mass adjustment rate from MAIS), you must finish storing the data for the screen you are on (usually by pressing ENTER) before you leave or you will have to re-key the data when you return.

2. Changing claims or individuals during a HOTKEY session - You may change identifying information during a HOTKEY session in three ways.

Press PF5 (REFRESH) while on the RRAPID menu. The HOTKEY IN FORCE message is replaced by the message NO HOTKEY SESSION. Go to the next application and enter the identifying information for the new claim or individual. When you exit this application, the HOTKEY session will again retrieve all possible identifying information from RATEH or EDM for the new claim/individual.

Return to the main screen for the application you are currently in and key in the new identifying information. The HOTKEY session knows when you change claims/individuals and retrieves the identifying information for the new claim/individual if you go to another application.

If you change beneficiaries within a claim, the HOTKEY session proceeds for whichever beneficiary is active when you leave the application. The HOTKEY session knows when you change beneficiaries and retrieves the identifying information for the new beneficiary if you go to another application.

3. Ending a HOTKEY session - The HOTKEY session is terminated when you EXIT the RRAPID menu.

NOTE: If your session terminates abnormally (i.e., you forget to sign off or the system goes down), your HOTKEY session will still be in force when you next sign on to RRAPID. The last claim number or SSN you were using will appear on the RRAPID menu. You may continue working with that number or you may refresh the menu (using PF5) and begin a new session.

- C. Accessing DATABANK Applications - See RCM 9.10 Sections 1 to 5 for an overview of the Program Accounts Receivable (PAR) System located in the DATABANK database. Other administrative systems such as Federal Financial

System (FFS) are accessed through DATABANK. Procedure for signing on to the PAR system to view available accounts receivable screens is located in RCM 9.10.50. To sign-off DATABANK refer to instructions in RCM 9.5.6 section 5.

9.5.9 DATA-Q

DATA-Q allows direct access to selected data in the checkwriting (CHICO) file through CRT terminals. DATA-Q may be used whenever there is need for current payment status information. Any new data entered into the CHICO system in a computer run between midnight and seven a.m. will appear on the DATA-Q screen at seven a.m.

9.5.10 DATA-Q Display

The following items will be shown on the DATA-Q terminal display: (See Exhibit 4 for a sample DATA-Q display.)

- CLAIM NO - The annuitant's beneficiary symbol, prefix and claim number.
- P/C - The payee code shown on the Master Record (usually from the latest annuity award form).
- PSEUDO/DUAL NO - This field is used for two purposes: To display a dual annuitant's other RRB claim number, or to display the annuitant's pseudo claim number when the annuitant has been assigned a pseudo claim number for Medicare purposes. If a pseudo claim number is displayed, the information was received from the MOLI database, and will be pink in color. If a dual number is displayed. The information was received from the DATAQ database and will be green in color.

NOTE: If a dual annuitant also has a pseudo claim number for Medicare purposes, the other RRB claim number will be the only number displayed in this field. In this situation, any information about the pseudo claim number can be found by viewing the MOLI screens (see RCM 9.5.20 through 9.5.22).

- RR/SS - The current status of the annuitant's railroad and social security benefits.
- IN FRC - In current pay status
- N APPL - No application processed
- SUSP - Suspended
- TERM - Terminated
- NAME/ADDRESS - The name and home or mailing address on our records.
- C/M - Combined Mailing.

- NO - No Combined Mailing.
- YES - Combined Mailing. The employee and spouse have the same home mailing address.
- GEO CODE - If the annuitant record contains a foreign address (foreign country or U.S. Possession) the geographical code is displayed in this field. If the record does not contain a foreign address, the geographical code is not displayed.
- DOB - Annuitant's date of birth. If both an RR annuity and SS benefit are being paid, DOB in the RR record is shown. In SS only cases, the DOB in the SS record is shown.
- SEX - Annuitant's sex is indicated. This field is filled with information from the DATAQ or MOLI database. If the information is from DATAQ, it will be in green. If the information is from MOLI, it will be in pink.
- RATE INFORMATION - The total current monthly check amount, and the individual regular annuity (after SMIB and tax withholdings, if applicable), SS benefit (after SMIB, if applicable), and supplemental annuity rates, if payable.

NOTE: To determine where the SMIB deduction occurs, see the SMIB CODE field.

- REP PAYEE - If a representative payee is involved, his status will be indicated as follows:

BLANK (No rep payee)

COURT (Court-appointed rep payee),

BOARD (Board-appointed rep payee),

PARENT (Parent-For-Child rep payee),

HRCRT (High Risk-Court Appointed without a Third Party Custodian),

HRBRD (High Risk-Board Appointed without a ThirdParty Custodian),

HRCRTC (High Risk-Court Appointed with a Third Party Custodian),

HRBRDC (High Risk-Board Appointed with a Third Party Custodian),

PRNTC (Parent for child with a Third Party Custodian).

- EARMARKS - Two codes are displayed in this field which will indicate the status of the record after each of the following mass adjustments:
- AERO - Automatic Earnings Recomputation Operation
- RAIL - Retirement Adjustment to Include Lag
- COL - Cost of Living

An acronym will be displayed for each of the mass adjustments described above. The acronyms are as follows:

- AE - AERO
- RL - RAIL
- CL - COL

Below each of these mass adjustment acronyms, a summary code which indicates the status of the record after each mass adjustment will be displayed as follows:

- OK - The record was successfully adjusted in each mass adjustment of this type.
- RE - Reject or Review

The record rejected from the mass adjustment, or the record requires review as a result of the mass adjustment.

If the record rejected, manual handling is required to apply the mass adjustment and to clear the earmark code.

If the record requires review, the record was adjusted, but manual handling is required to ensure the proper mass adjustment processing occurred and to clear the earmark code.

NOTE: RE will be displayed if the record rejected or was coded for review in the most recent or any previous mass adjustment of this type. After each mass adjustment is run, paper listings of the records that rejected or were coded for review are produced. These listings are used to determine the specific year the record was rejected or coded for review.

- BLANK -The record was not selected for the mass adjustment; no action is required.

NOTE: Records in suspense, other than code 35, 69, 88, or 98, are earmarked with reject code 03 by the mass adjustment operation, i.e., COLA, AERO or RAIL. The earmark will **only** be displayed on PREH, screen 3250, and **NOT** on DATAQ. Upon reinstatement remove the earmark by checking the box, 'Earmarks Considered' or submitting a G-607, if appropriate.

- FAMCD - FAMILY CODE

A single digit code appears when the entitlement of a young parent depends upon the entitlement of a minor or disabled child. The family code is the same as the payee code of the young parent.

- TWCD - TWIN CODE

A single digit code appears when:

- 1) more than one beneficiary entitled to benefits on the claim number has the same DOB; or
- 2) there are parent beneficiaries with beneficiary symbols of P and F, or of LP and LF.

Code

- 1 First beneficiary; or F or LF
- 2 Second beneficiary; or P or LP
- 3 Third beneficiary

- LAST COA - Date of the latest change of address.
- EE SSN - The railroad employee's social security number is displayed in this field.
- SMIB INFORMATION
- SMIB RATE - The monthly deduction for SMIB premiums.
- SMIB CODE - A separate code for both the latest RR and SS award; in combined benefit cases, this code will tell you from which benefit (RR or SS) SMIB is being deducted:

Code Condition

- 0 No benefit is being paid or SMIB is not being deducted from this benefit.
- 1 The beneficiary enrolled for SMIB and his first SMIB coverage has not been terminated.
- 2 No response.
- 3 The beneficiary filed a "No" election in his IEP or a GEP, or his "Yes" election was denied.
- 4 The beneficiary's first SMIB coverage has terminated, either at his request or for non-payment of premium, and he has not re-enrolled.
- 5 The beneficiary re-enrolled, following termination of his first SMIB coverage, and his second SMIB coverage has not terminated.
- 6 The beneficiary's second SMIB coverage has terminated, either at his request or for non-payment of premium.

7 RESERVED

8 The beneficiary is covered by a state buy-in agreement and premium deductions are not in effect because the welfare agency is paying the premium.

9 The beneficiary is entitled to an annuity (or is an IPI) under another RRB claim number and the enrollment (SMIB code) is shown under the other claim number.

- DISA CODE - This is an indication if the annuitant is entitled to Medicare based on disability. If he is not, the word "AGE" will appear. If the annuitant is entitled to Medicare based on disability, a code will appear indicating his (her) status; i.e., EMP, EMP 65, CHILD, CHILD 65, SP, SP 65, WIDOW, WIDOW 65.
 - HIB DATE/SMIB DATE - The month and year HIB/SMIB entitlement begins. These fields are filled with information from the MOLI database, and will be pink in color.
 - TABLE RATE - The current Medicare premium from the MOLI database. This information will be displayed in pink.
 - DIRECT DEPOSIT INFORMATION
 - DATE - The effective date of direct deposit.
 - ROUTE NO - The depositor's bank's routing number and check digit.
 - ACCOUNT TYPE/NO - The depositor's account number will be preceded by a "C" or "S" type of account designation.
 - PREVIOUS ACTIONS
 - ACCRUAL/OLD RATE/NEW RATE - The last rate of the RR annuity (after SMIB), the SS benefit payment, and/or the supplemental annuity, prior to the latest adjustment, is shown under "old rate." If the last award was an accrual award, this amount will also be shown. The latest rate is shown under "new rate" for comparison purposes. (This should be the same rate shown in "current rate information" above.)
 - VOU
 - TYPE is "AWD"
- The most recent activity was an award action. The date of the award action is shown under "ACC DATE." See RCM sec. 8.1, Exhibit 1 for a list of voucher number assignments.
- TYPE is "T/S"

The most recent activity was a suspension or termination. The date of the termination or suspension is shown under "ACC DATE." This should not be confused with the effective date, shown under "EFF DT".

Batch Number

011-299 T/S caused by G-96 or FAST-S/T

300-399 T/S caused by returned payment

- ACC DATE - If the most recent action was an award action, the date of the check is shown. If the most recent activity was a suspension or a termination, the date of the G-96 or the FAST-S/T batch date is shown.
- TYPE - The type of the last previous activity is indicated: award, suspension or termination. As mentioned above, an award will be shown as "AWD" and a suspension or termination will be indicated as "T/S".
- TERM/SUSP INFORMATION
- CAUSE - The termination or suspension code from the G-96, FAST-S/T, or cancelled payment is shown if either RR or SS benefits are not in current payment status.
- EFF/DT - The month and year of the RR or SS termination or suspension is shown, as indicated on the G-96 or FAST-S/T transaction. This field will be blank if a 00-00 effective date was present in the FAST-S/T or cancelled payment activity record or, the G-96 entry item was blank, at the time of processing.

NOTE: If the EFF/DT field is blank, develop for the actual suspension/termination effective date. When the month and year of the event is learned, process a new FAST-S/T transaction to update the record.

- RR PRE-TAX - The railroad annuity check rate before any tax withholding is displayed in this field.
- TAXES W/H
- RR ACC - Taxes withheld from the latest regular annuity accrual.
- SUP ACC - Taxes withheld from the latest supplemental annuity accrual.
- RECUR RR - Taxes being withheld from the recurring regular annuity.
- RECUR SUP - Taxes being withheld from the recurring supplemental annuity.

NOTE: Accrual tax withheld amounts shown after "RR ACC" or "SUP ACC" will be deleted if the amounts in "PREVIOUS ACTIONS" are deleted.

- SSA CLAIM NO - If the annuitant is claiming SS benefits, the claim number under which he is entitled is shown, followed by the appropriate suffix. ("0" indicates a blank space in the suffix.)
- BEN SSN - The annuitant's own SSA number is shown.
- SS ENTITLEMENT - The code "YES" indicates the RR annuity is reduced for entitlement to SS benefits. Code "NO" indicates the annuity is not being reduced.
- SUP EF DT - The effective date of the supplemental annuity.
- SUP RED - Amount of supplemental annuity reduction due to entitlement to a pension from railroad employer.
- BA NO - The BA number of the railroad paying the annuitant a pension.
- CB - A collective bargaining code "1" is shown if the employee is receiving a pension from his railroad employer which was negotiated through collective bargaining.
- DATE - The current display date is shown. This date will appear on any printouts made of the DATA-Q display.
- MESSAGES - DATA-Q will display a series of instructional messages on the bottom of the terminal screen. Follow these messages for correct input necessary for a DATA-Q display.

DATA-Q will also display a message on the bottom of the screen if a FAST S/T or FAST COA transaction is pending, i.e., the S/T or COA transaction has been entered on FAST but has not yet been processed.

9.5.11 Operating DATA-Q

After you have signed on to the RRAPID database (see RCM 9.5.6) access DATA-Q by selecting the appropriate number assigned to DATA-Q on the RRAPID Main Menu. Then press ENTER.

Note: DATA-Q is unavailable if the message PREVIOUS TASK ABENDED WITH ABEND CODE appears. Follow the instructions in RCM sec. 9.5.6.

- A. DATA-Q Display Selection - Once the DATA-Q system has been accessed, the screen will display the message:

"ENTER PREFIX X RRB# (9 DIGITS) XXXXXXXXX and PAY CODE X."

Press the appropriate keys on the terminal keyboard in the prefix, claim number and payee code order. Then press the ENTER key.

Prefixes may be punched as letter codes (A, D, H) or as number codes (A = 1, D = 4, H = 8).

Note that nine digits must be entered for the claim number. Precede a six-digit number by three zeros.

If an "A" is entered as a prefix for a nine digit number, but the claim number is on DATA-Q as a "D" record, the "D" record will be displayed.

EXCEPTION: In cases where there is a Pension Protection Act (PPA) 3rd-party payment in effect and a survivor benefit payment record with a 'D' prefix exists, the specific prefix ('D' for the survivor benefit record 'A' for the PPA payment record) **must** be entered in order for the DATA-Q record to be displayed for the specific payment record. If an error is made at any time before the ENTER key is pressed, move the cursor back to the incorrect entry and type in the correct entry. The cursor can be moved by pressing one of the "arrow" keys on the lower right hand side of the keyboard.

If an invalid prefix is entered, DATA-Q will display the message, INVALID PREFIX - TRY AGAIN. The cursor will return to the beginning of the claim number field. Enter the correct prefix.

If an invalid RRB claim number is entered, the message "INVALID RRB # TRY AGAIN" will appear. The cursor will return to the beginning of the claim number field. Enter the correct claim number.

If a claim number not on the database is entered, DATA-Q will display the message: NO RECORD FOUND - TRY AGAIN; OR PF14 FOR INITIAL DD. The cursor will move back to the prefix position. Enter a different claim number, depress PF14 to access IDDA, or depress the clear key and sign off. Although all terminals will show this message, only field office personnel and a limited number of Headquarters employees are authorized to input information to IDDA or view the screens.

Enter the payee code if you wish to have immediate access to a particular record. If you do not enter a payee code, DATA-Q will display the closest record on database. This is usually the last record put into pay status.

If an incorrect payee code is entered, the display will read: "NO RECORD FOUND - TRY AGAIN; OR PF14 FOR INITIAL DD." This means there is no record under that payee code. It does not mean there is no record under that claim number.

Once the necessary identifying information has been entered into DATA-Q, the requested payment record will be displayed on the DATA-Q screen.

- B. Viewing Additional Records on the Same Claim Number - If you wish to view additional screens after the initial screen is displayed, you have two options for selecting screens.
- After the requested screen has been displayed, a prompt line will appear: "SCREEN X DISPLAYED; NEXT? ____". Enter the number of the screen you wish to view and press the "ENTER" key. The screen you requested will then appear, along with a new prompt line.
- Note that the number is designated by the position a particular records holds on the CHICO family record. In most cases the number of the screen is the same as the payee code; for example, payee code 1 record = screen 1; payee code 2 record = screen 2, etc. However, in those cases where there is a gap in the payee code numbering of records on CHICO, this is not the case. For instance if the CHICO record contains payee codes 1 and 4, to display the payee code 4 record through the DATA-Q prompt line, you must request screen 2.
- If you wish to page through one screen at a time, (i.e., view all payee code records in order), use the PA 1 key. This key will move you forward through the family record, displaying each individual payee code in order. If you wish to page backward through the family record, use the PA 2 key.
 - If you are viewing the last screen in the family record and press the PA 1 key, the message "LAST SCREEN DISPLAYED" appears. Likewise, if you are viewing the first screen in the family record and press the PA 2 key, the message "FIRST SCREEN DISPLAYED" appears. If you request through the prompt line a screen that is not part of the family record on CHICO, the message "SCREEN NOT FOUND" appears.
- C. Accessing FAST - (Field Address-Suspension-Termination) is a database system that interacts with DATA-Q. The FAST system processes change of address, suspension/termination, non-receipt, reclamation, photocopy and first notice of death/returned check transactions through the CRT Terminal. FAST may be accessed after the record of the beneficiary on which the action is to be taken is displayed on DATA-Q. Press the PF-3 key to obtain a menu showing the following selections. Access the appropriate screen by pressing one of the PF keys shown.
- On-line Rate Verification Letters - PF6
 - FAST Suspension/Termination - PF7
 - FAST Change of Address - PF8
 - Payment Investigation - PF9

- FAST COA/Direct Deposit - PF10
- FAST Transaction Regarding Annuitant or Check - PF11
- Status of Payment Investigation - PF13

Refer to RCM 9.7 for further information on FAST.

- D. Viewing Additional Records on a New Claim Number - To clear the display in order to make a new request, press the PF1 key.

You will get the screen:

"ENTER PREFIX X RRB# (9 digits) XXXXXXXXX and PAYEE CODE X".

Press the appropriate keys on the terminal keyboard to enter the prefix, claim number, and payee code. Then press the ENTER key to view the record.

- E. How to Return to the RRAPID Main Menu - Press the CLEAR key to return to the RRAPID Main Menu. From the menu, you can select another application/system in RRAPID by entering the number assigned to the application/system and entering it next to the word, SELECTION. Then press ENTER. To sign off RRAPID enter an X next to the word, SELECTION. Then press ENTER.

9.5.12 DATA-Q Referrals

Any type of award activity will be reflected on the CHICO record. However, DATA-Q will not accept any new or changed records that are discrepant with records already on DATA-Q.

DATA-Q will reject any record with the following discrepancies:

- 1) Prefix - If DATA-Q already has a record with one prefix and nine digit claim number and an award activity with another prefix but the same claim number is processed, DATA-Q will reject the new activity. This problem frequently occurs in survivor awards; for example, a WA annuity in suspended status is reinstated as a WD award; DATA-Q will not accept the WD record.
- 2) Claim Numbers - Part of the CHICO record may be under one claim number and another part under a second number. For instance, if an RR annuity is being paid under a six digit number, and an SS benefit with the same employee SS number is processed under a nine digit number, DATA-Q will not accept the SS award.
- 3) Duplicate Payments - The same award may be processed under two different claim numbers. For example, two SS awards for the same person may be processed under two different claim numbers; first under a six digit number, then

under a nine digit number. DATA-Q will reject the second award processed under the nine digit number.

- 4) Employee SS Numbers - Two annuitants, paid under different claim numbers but both having the same employee SS number on the CHICO record, will also cause problems for DATA-Q. If one such case is already on CHICO and a second discrepant case is processed, DATA-Q will reject the second record.
- 5) Family Groups - In error, two claim numbers may be used for one family group, e.g., WA 631413 and WCA 631414. If one claim number is already on DATA-Q and a second award with a different claim number but with the same employee SS number is processed, DATA-Q will not accept the new award.

Note that in each of these cases, the discrepant award has been accepted by CHICO. Payments are being made under the discrepant numbers or the necessary data changes have been made in the CHICO record. The discrepant award, however, is not displayed by DATA-Q. (This occurs because the database file rejects such discrepancies.) Therefore, if a record does not appear on DATA-Q, it does not necessarily mean that an award has not been made. To insure that all cases that are on CHICO are reflected on DATA-Q, discrepant records rejected by DATA-Q should be given priority handling.

The bureau of data processing and accounts will send all DATA-Q referrals directly to the modules for handling. Check DATA-Q for those cases on DATA-Q and request QUICKIE printouts for those cases on Chico. Take the necessary action to resolve any discrepancies and return one copy of the referral, along with a new DATA-Q printout to verify the correction has been made, to the program analysis section. File the second copy of the referral in the claim folder.

If a correct prefix and claim number is already on DATA-Q, delete the record with the erroneous prefix and/or claim number with a Form G-96 completed with termination code 62. Reinstating the annuity under the correct prefix and claim number will correct the CHICO record and will cause the new record to be added to DATA-Q.

EXAMPLE: Employee is receiving an annuity under a six digit number and is on DATA-Q. Spouse is being paid erroneously under the employee's nine digit SS number. Delete the nine digit award with Form G-96, code 62. Prepare a current pay award under the six digit claim number. Spouse award will then appear on DATA-Q.

If an erroneous record is on DATA-Q, and a correct record is not, delete the erroneous record and reinstate the record under the correct claim number. The reinstatement activity will cause the new record as well as the payments already under the same prefix and claim number to be added to DATA-Q.

EXAMPLE: An RR annuity is being paid under an erroneous "D" prefix and is on DATA-Q; an SS benefit is being paid under the correct "A" prefix and is not on DATA-Q. Prepare Form G-96 with code 62 to delete the "D" record. Reinstate the RR annuity

under the "A" prefix; this action will bring both the annuity and SS payments onto DATA-Q.

If an erroneous, but suspended or terminated, record is on DATA-Q and the correct active record is not on DATA-Q, action must be taken to delete the erroneous record with Form G-96 code 62 and then to "force" the correct record onto DATA-Q. This is usually done by preparing Form G-607, since Form G-607 will generate CHICO activity and cause the record to be run against data-base. If the discrepant record has already been removed from data-base with Form G-96, Form 607 activity will not reject from data-base and will cause the correct record to be accepted by DATA-Q.

Prepare Form G-607 for any type of miscellaneous data entry. For instance, complete Form G-607 to change the date of birth, using the same date of birth already on the CHICO record. Even though the date of birth information is not being changed, the processing of Form G-607 will still bring the correct record onto DATA-Q. Form G-607 will also add to DATA-Q any other payments being made under the same prefix, claim number and payee code.

The timing of the above procedure is very important to insure that a case is accepted by DATA-Q. Do not prepare Form G-607 for the correct record until you are sure the Form G-96 deleting the erroneous record has cleared.

EXAMPLE: A suspended annuity with an erroneous "D" prefix is on DATA-Q. An active annuity with the correct prefix of "A" is on CHICO but not on DATA-Q; an SS payment under the same "A" prefix is also on CHICO but not on DATA-Q. Prepare Form G-96 with code 62 to delete the erroneous and suspended "D" record. Periodically check DATA-Q to determine when Form G-96 has cleared. After the erroneous record has been deleted, prepare a Form G-607 for the "A" annuity with the annuitant's date of birth as it is shown on CHICO. When Form G-607 is processed, both the annuity and SS payment will appear on DATA-Q under the "A" prefix.

In the case of discrepant employee SS numbers, no Form G-96 or award action is necessary. Instead, correct the erroneous SS number with Form G-607 and, if necessary, prepare a second Form G-607 to "force" the record with the correct SS number onto DATA-Q. The second Form G-607 should not be submitted until the first Form G-607 has processed.

EXAMPLE 1: Due to an error in the completion of their award forms, two widows, WA 999999 and WD 888888, have the same employee SS number on CHICO. WA 999999 is on DATA-Q; WD 888888 is not. Upon investigation, you discover that WD 888888 should have a different SS number. Prepare Form G-607 to correct the employee SS number. This will bring WD 888888 onto DATA-Q.

EXAMPLE 2: Two employees, A 999991, which is on DATA-Q, and A 999992, which is not, have the same SS number on CHICO. You learn that A 999991 has the incorrect SS number. Prepare Form G-607 to correct the SS number on CHICO and DATA-Q.

After that form has processed, prepare a second Form G-607 to "force" the record with the correct SS number, A 999991, onto DATA-Q.

See RCM 8.1.76 for further information on correcting claim numbers and prefixes and RCM 9.4 for Form G-607 instructions.

Be sure to notify MPS if SMIB is being deducted under the incorrect number. It may be necessary to make reimbursements and notify SSA of record consolidations.

When a particular record with an erroneous prefix is deleted with a code 62 and not reinstated, all records in the Research record with the same payee code are also deleted, since research ignores prefixes on payments under nine digit claim numbers. For instance, if you are deleting an erroneous "D" claim number payee code 1 that was previously suspended or terminated, and retaining the active "A" claim number payee code 1, both records will be deleted from the Research record when Form G-90 is processed. To keep the Research records accurate, prepare Form G-59, noting that the "A" claim number is being retained.

9.5.15 REQUEST System

REQUEST allows direct access to selected data on the RASI master file through CRT terminals. REQUEST may be used whenever there is need for current payment status information. Any new data entered into RASI during a nightly computer run will appear on the REQUEST screen the day after that run.

Cases paid by RASI and manually dropped cases are available on REQUEST for 90 days. Mechanically dropped cases are available on REQUEST for 10 days. Cases coded for immediate drop remain on REQUEST for one day only.

REQUEST displays information generated by RASI. At times, apparently inconsistent data may appear on REQUEST screens because of the nature of RASI processing. For example, if an employee and spouse file jointly, REQUEST will not display the spouse application until the day after the day on which the employee's is first displayed. This is because there must be an employee of record before RASI can accept a spouse application. Also, because of RASI's daily evaluation process, the FINAL ABD is not really "final" until the award occurs. In disability cases, REQUEST does not even show the final ABD until the award is made, in order to prevent confusion.

9.5.16 REQUEST

A. Screen 11 - Employee Information

- SSA # - Employee's social security claim number.
- RRB # - If an employee has a six digit claim number, that number will be displayed here. Otherwise, a series of nines will appear in this item.

- REQUEST UPDATED - The date of the last RASI run for which REQUEST has been updated, usually the last run.
- VIEW DT - The current date is shown.
- NAME AND ADDRESS - The name and home address or mailing address currently on the RASI record. The asterisk at the beginning of the address is equivalent to the RASI "group mark."
- TYPE ANNUITY - The type of annuity being processed is indicated: Full Age 65, Employee Health Insurance, SUP Only, Full Age 60, Reduced Age, Occupational Disability, Total Disability, or Spouse Only.
- STATUS - The status of the employee annuity is shown: PENDING is displayed until the annuity has paid final; PAID is shown when the final annuity rate is paid; DENIAL is indicated if the annuity claim is denied; MAN DROP is displayed for an examiner initiated drop from RASI; DUMP is shown if there is a computer generated drop from RASI; COMP ONLY is displayed if the annuity has been computed, but cannot be paid.
- NAME AND ADDRESS - The name and home or mailing address currently on the RASI record. The asterisk at the beginning of the address is equivalent to the RASI "group mark."
- TYPE ANNUITY - The type of annuity being processed is indicated: Full Age 65, Employee Health Insurance, SUP only, Full Age 60, Reduced Age, Occupational Disability, Total Disability, or Spouse Only.
- STATUS - The status of the employee annuity is shown: Pending is displayed until the annuity has paid final; PAID is shown when the final annuity rate is paid; DENIAL is indicated if the annuity claim is denied; MAN DROP is displayed for an examiner initiated drop from RASI; DUMP is shown if there is a computer generated drop from RASI; COMP ONLY is displayed if the annuity has been computed, but cannot be paid.
- TYPE CERT - The type of annuity payment most recently made. If no certification has been made, no entry is shown. PARTIAL is shown if an IMPACT rate has been paid; FINAL is displayed if a final annuity rate is paid and no partial rate has ever been paid; RECERT is indicated if a partial rate is recertified to a final rate.
- LAW YEAR - The year of the amendments which apply to the adjudication of the case. The law year can differ from the year of the application filing date.
- TYPE ACTION - An entry is made in this item if:
 - annuity payment is pending (PENDING, TRACE or CALC);

- some type of payment action has been taken by RASI (PARTIAL,FINAL,RECERT);
- the case has been dropped from RASI (MAN DROP for examiner initiated drop, MECH DROP for computer drop);
- if RASI is ready to make an annuity payment but cannot do so for some reason (FUTURE VOUCH, if RASI cannot make a payment until the next month's voucher; ESA INVEST, if the electronic systems analysis section is reviewing the case; INSUFF ACCRL, if the partial rate exceeds the final but the overpayment can be recovered from one more month's accrual; or RUIA EX ACCR, if RUIA recoverable amount exceeds the accrual and the overpayment can be recovered in the next month).
- NEXT ACTION DATE - The date of the next scheduled RASI processing activity for those cases pending payment.
- APP FILE DT - The filing date of the latest annuity or HI application.
- DOB - The employee's date of birth. If the annuity's DOB is verified, "VER" appears next to "DOB"; if the DOB is not verified, "CLM" appears to indicate claimed date of birth.
- PARTIAL ABD - If a partial payment has not been made, a Calculated ABD is shown. If a partial payment has been made, the partial ABD is shown.
- PART AWD DT - The date an award was processed by RASI. Check DATA-Q for date annuity check was processed.
- EE CALL UPS - The call-up codes, the type of data required, and the date of the next RASI trace for each type of pending data. Up to eight items of any of the following types of RASI call-up activity may be shown:

CALL-UP	TYPE OF INFORMATION PENDING
150-SUP	Supplemental annuity data to be submitted on a type code 150 "RASIFORM" screen.
900-EE POA	Employee's proof of age on a type code 900 "RASIFORM" screen.
906-POM/S	Employee's proof of military service on a type code 900 "RASIFORM" screen.
939-CHICO INQUIRY	If applicant claims to have filed for social security benefits, but TRIC indicates no MBR, RASI will

	check CHICO to determine if RRB is paying an SS benefit.
945-RUIA CLEARANCE	RUIA Clearance reply pending.
946-DCC SEARCH	RASI is searching DCC records for the employee's service and compensation record, or compensation is indicated in excess of three months after the claimed date last worked.
947-C/C	Current connection determination to be submitted on a type code 947 "RASIFORM" screen.
948-COMP/TRANS-R/C	A transfer or red cap determination to be submitted on a type code 948 "RASIFORM" screen.
949-RES FOR SUP	Research data required for payment of supplemental annuity is pending.
950-EE SS BEN	Employee social security benefit data to be submitted on a type code 950 "RASIFORM" screen.
954-SUPP PENS	Supplemental annuity pension information to be submitted on a type code 954 "RASIFORM" screen.
958-LAG:G-88A.2	Lag information found on Form G-88A.2 (Retirement Contact Form) to be submitted on a type code 958 "RASIFORM" screen.
960-EE TRIC	Employee TRIC reply pending.
970-DB RATING: G325	Disability determination required on Form G-325 (Disability Determination Sheet).
995-CLR MAN OP	Manual op code set to prevent annuity payments. Can be cleared with a type code 995 "RASIFORM" screen.
996-CLR MIS COR	A type code 996 "RASIFORM" screen needed to change the contents of a field in the RASI record.
997-NAME/ADDR	A name and/or address change or rep payee data to be submitted on a type code 997 "RASIFORM" screen.
998-P/S-AGE/SVC	Prior service data or HB data to be submitted on a type code 998 "RASIFORM" screen.

- FINAL ABD - If a final payment has not been made, a calculated ABD is shown. If an annuity has paid final or has been recertified, the final ABD is indicated. In a disability case, no ABD will be shown until all information has been processed to pay a final award.
- FINAL AWD DT - The date award was processed by RASI. Check DATA-Q for date annuity check was processed.
- RECUR RATE - The actual net annuity rate is displayed if an award has been made.
- CODE NAME - The first initial and first four letters of the applicant's surname.
- TIER I - The amount of the tier 1 component of the final annuity rate. (Before work deduction.)
- TIER II - The amount of the tier 2 component of the final annuity rate. (Before work deduction.)
- WF - The amount of the VDB component of the final annuity rate. (Before work deduction.)
- AGE RED - The amount of the final annuity rate age reduction, if applicable.
- SUP - The amount of the supplemental annuity after any LPS TWD but before cutback.
- SSA - If RASI reduced the retirement annuity for SS entitlement, the amount of the SS benefit appears.
- TRIC REQ DATE - The date of the TRIC request currently being processed. When a disability case has converted to an age and service case, or when RASI must initiate a new TRIC request for another reason, this is the date of that TRIC request. Compare this date with that of the referral message noting a change in the type of annuity being processed.
- INTO RASI - The date the application actually entered RASI. This can be different from the filing date or the APPLE transmittal date.

B. Screen 12 - Employee Status Words

The employee's SSA number and RRB claim number appear in the top left hand corner. The latest RASI processing date and current viewing date appear in the upper right hand corner of the screen.

Items of status information evaluated by RASI appear on this screen. Entries are made only for those items applicable to the particular case being reviewed. A

numeric code appears after each item; this code indicates the status of each item and is the same type of status word code that currently is found on the RASI referral. A narrative description of the particular item's status follows the numeric code. The employee status words shown on screen 12 are listed below.

- AGE
 - 0 - Not Applicable
 - 1 - Verified
 - 3 - DOB Accepted - Not Verified
 - 4 - Verification Required
 - 8 - Not Verified
- SERVICE
 - 0 - Not Applicable
 - 1 - Sufficient Service Established
 - 2,6 - 120 Months Required
 - 3,7 - 240 Months Required
 - 4,8 - 360 Months Required
 - 5 - Insufficient Service
- LAG
 - 0 - None
 - 1 - Verified
 - 2 - Requested for last employer
 - 3 - Requested for next to last employer
 - 4 - Requested for last two employers
- MILITARY SERVICE
 - 0 - Not Applicable
 - 2 - Claim Abandoned

- 5 - Proof Received
- 6 - Proof Required
- 8 - Creditable - Required for Eligibility
- 9 - Dumped - Other Federal Benefits
- FELONY
 - 0 - Not Applicable
 - 1 - OK, Continue processing
 - 2 - Manual drop
 - 4 - Verification required
- PRIOR SERVICE
 - 0 - Not Applicable
 - 1 - Verified
 - 5 - Verification Required
 - 6 - Prior Service Report Received - Lag Outstanding
- RED CAP
 - 0 - Not Applicable
 - 2 - Determination Required
 - 3 - Transfer Determination Required
 - 5 - Red Cap And Transfer Determination Required
- DATE LAST WORKED - RAILROAD
 - 0 - Not Applicable
 - 1 - Verified
 - 4 - Verification Required
- DATE RELINQUISHED RIGHTS - RAILROAD
 - 0 - Not Applicable

- 1 - Verified
- 4 - Verification Required
- 5 - G-88 Certification Required - Lag Received
- LAST EMPLOYER - OUTSIDE OR RAILROAD
 - 0 - Not Applicable
 - 1 - Last worked for railroad employer
 - 2 - Last worked outside; also worked for one railroad employer
 - 3 - Date last outside same as date last worked for railroad; had one railroad employer
 - 4 - No outside employment; had two railroad employers
 - 5 - Last worked outside; also worked for two railroad employers
 - 6 - Date last worked outside same as date last worked for railroad; had two railroad employers
- DATE LAST WORKED OUTSIDE
 - 0 - Not Applicable
 - 1 - Verified
 - 2 - Claimed date last worked outside accepted
 - 4 - Verification Required
- BEGINNING DATE
 - 0 - Not Applicable
 - 1 - Calculated
 - 4 - To be Determined
- CURRENT CONNECTION
 - 0 - Not Applicable
 - 1 - Yes
 - 2 - No

3 - No for Retirement, But Yes for Survivor

4 - Determination Required

- DISABILITY

0 - Not Applicable

1 - Grant

2 - Denial

3 - Decision Required

- TRIC REQUEST

0 - All Replies Received or Not Released

1 - Own SSA Number

2 - Alleged SS Claim Under Third Person's Number

5 - Claim on Own and Third Person's SS Number

8 - Examiner Determination Required

9 - No Request Received

- ALLEGED SS

0 - No answer to SS Entitlement question on annuity application

1 - Filed Under Own Account Number

2 - No Filing Alleged

3 - Filed on Third Person's Number

- SS BENEFITS

0 - Not Applicable

1 - Entitled

2 - Not Entitled

4 - Verification Required

9 - Manual Drop

- RUIA Clearance
 - 0 - Not Applicable
 - 1 - No Record
 - 2 - Requested - Computed Final
 - 3 - Requested - Computed Partial
 - 4 - Required
 - 5 - Received - Computed Final
 - 6 - Received - Computed Partial
 - 7 - Pre-Clearance Requested
- DUMP REASON
 - 0 - Not Applicable
 - 1 - Incorrect SSA Number
 - 2 - Notice of Death
 - 3 - Overpayment May Occur
 - 4 - Claims Abandoned
 - 5 - Application Cancelled
 - 6 - Manual Partial Award
 - 7,9 - Other
 - 8 - Computer Dump
- SUPPLEMENTAL ANNUITY
 - 0 - Not Applicable
 - 1 - Pending Computation
 - 3 - Recertification
 - 4 - Final Computation
 - 6 - Not Eligible

- 7 - Pension Information Required
- 8 - Supplemental Pension Information Received
- 9 - Supplemental Annuity Not Payable - Pension Applies
- SUPPLEMENTAL ANNUITY - PENSION
 - 0 - Not Applicable
 - 1 - Closing Date Involved-Eligible
 - 2 - No Pension
 - 3,4 - G-88p Required
 - 5,6 - G-88p and Closing Date Eligibility Determination Required
 - 7 - Closing Date Eligibility Determination Required
 - 8 - Closing Date Involved - Not Eligible
 - 9 - Handle Supplemental Annuity Manually
- SMIB OPTION
 - 0 - Not Applicable
 - 1 - First Enrollment
 - 2 - No Response
 - 3 - No Election on Application (Didn't Want SMIB)
 - 5 - GEP Enrollment - YES
- HIB
 - 0 - Not Applicable
 - 1 - Eligible
 - 6 - Not Eligible (Denied)
 - 7 - Employee not eligible, but spouse may be
- HIB SMIB
 - 0 - Not Applicable

- 1 - Clearance Sent
- 4 - Initial Clearance Required
- 5 - No Clearance Required
- SMIB DATE
 - 0 - Not Applicable or Actual Date Furnished
 - 1 - Assumed Date Furnished
- SEX
 - 1 - Male
 - 2 - Female
- MARRIAGE
 - 1 - Single
 - 2 - Married or Separated
 - 3 - Other
- SPOUSE
 - 0 - Not Applicable
 - 1 - No Spouse Application in File
 - 2 - Spouse Application Dumped; Employee Application Still Active
 - 3 - Spouse Application Attached to Pending Employee Application
 - 4 - Spouse Only Application - Employee Information Received
 - 5 - Spouse Only Application - Employee Information Required
- MANUAL OP CODE
 - 0 - Not Applicable
 - 2 - No Award Made - Manual Review Required
- REPRESENTATIVE PAYEE
 - 0 - Not Applicable

1,2,3 - Appointed

4 - Not Named

5 - Discharged

- WINDFALL

0 - Not Applicable

1 - Insured As of 12-31-84

2 - Insured As of Last Year Worked

3 - Not Vested

4 - Possible Vesting on Another's Wages

5 - Assumed Not Vested as of 12-31-74

6 - Assumed Not Vested as of Year Last Worked

- OVERALL MINIMUM

0 - Not Tested

1 - Does Not Apply

2 - Payable

3 - May Apply

4 - May Apply - Children

5 - May Apply - Self-Employment

6 - May Apply - Insured Status

7 - May Apply - Spouse Over 62

8 - O/M Payable - Children Included

9 - May Apply for Several Reasons

- GRANDFATHER OVERALL MINIMUM

0 - Not Tested

1 - Not Applicable

- 2 - Payable
- 3, 9 - May Apply
- 4 - May Apply - Children
- 5 - May Apply - Self-Employment
- 6 - May Apply - Insured Status
- 7 - May Apply - Spouse Over 62
- 8 - O/M Payable - Children Included
- 20-40 TEST
 - 0 - Not Applicable
 - 1 - Undetermined
 - 2 - Yes
 - 3 - No
 - 4 - Determination Required
- CERTIFICATION
 - 0 - Pending
 - 1 - Pending Final
 - 2 - Pending Partial
 - 3 - Recert
 - 4 - Final
 - 5 - Partial
 - 6 - Denial

C. Employee Miscellaneous Fields

Status and eligibility data appear on employee screens 13 and 14. Related items are grouped together for easy reference. Employee screen 13 and 14 contain "English" captions for RASI data. However, by pressing the PF3 Key, the captions change to mnemonic codes, which can be used when preparing RASI input forms.

Note that on the screen with "English" captions, dates appear in the month - day - year format. However, in the mnemonic display, dates are in the year - month - day order for use on RASI input forms.

The employee's SSA number and RRB claim number appear in the top left hand corner. The latest RASI processing date and current viewing date appear in the upper right hand corner of the screen.

The items displayed on screens 13 and 14, with both their English and mnemonic captions, are shown below. In some cases, numeric codes appear along with the displayed data.

C1. Screen 13 - EMPLOYEE MISC FIELDS

- Miscellaneous Data
- Field office (FLDOFF)
- Claimed DOB (DOBCLM)
- Marital Status (SWEMARR)
- Sex (SWESEX)
- Verified Lag Months (VERLAGMOS)
- Disability Effective Date (DISEFFDTE)
- Original RUIA Recovery Amount (RECOVBUSOC)
- Certified Through Date (CERTHRUDTE)
- Last Item Date (LSTITMDTE)
- Creditable Prior Service Months (CREDPSMOS)
- Other Benefits based on Military Service (EEOTHMSBEN)
- T1 WD: Amount of work deductions withheld from Tier 1 (EELSTT1WDAMT)
- T2 WD: Amount of LPS work deductions withheld from Tier 2 (EELSTT2WDAMT)
- Conversion Code: Code 6 indicates conversion from disability to age and service (EETYPAPP)
- Worker's Compensation (EEWCIND)
- Public Disability (EEPUBDISIND)

- ABD Information
- Earliest ABD: Did EE request earliest ABD allowed by law? (EEABDCDE)
- RASI Calculated ABD: In disability cases, remains blank until final payment (CALCABD)
- Employee Designated ABD - (EEDESABD)
- Supplemental Annuity ABD - (SUPABD)
- Children
- Does employee have minor children? "EEMINCHD" (1 = yes; 2 = no) - (AA1CHILDUND18)
- Total number of children employee has "EENOCHD"
- Impact
- Impact Tier 1 (IMPACTT1)
- Impact Tier 2 (IMPACTT2)
- Impact WF (IMPACTWF)
- Health Insurance Information
- Health Insurance Filing Date (HIFILDTE)
- Health Insurance Entitlement Date (HIENTDTE)
- Health Insurance Clearance Date (HICLRDTE)
- Supplemental Annuity Information
- SUP code indicating there is a SUP ANN adjustment; code 1 means RASI is processing the SUP ANN, code 9 indicates RASI has paid the SUP ANN (PAMCD)
- SUP ANN call-up date (PAMSUPTICKDTE)
- SUP ANN Type Code (PAMTYPE)
- SUP ANN Paid Date (PAMSUPPDDTE)
- SUP WD: The amount of the LPS TWD taken from the supplemental annuity (SUPPLSTWDAMT)

C2. Screen 14 - EMPLOYEE MISC FIELDS

- Railroad Employment Data
- BA number of last railroad employer (EELSTBA)
- BA number of previous railroad employer (EEPRVBA)
- Date last worked for last railroad employer (EEDLWRR)
- Date last worked for previous railroad employer (EEDLWPVRR)
- Verified date last worked for last railroad employer (ESTDLWRR)
- Date rights relinquished for last railroad employer (EEDRRLST)
- Date rights relinquished for previous railroad employer (EEDRRPRV)
- Does employee have rights to return to railroad employment? (EERGHTREL)
- Outside Employment Information
- Did employee work in outside employment during the last twelve months? (EEOUTLST12)
- Did employee work for federal agency after last railroad employment? (EEFEDEMPAFTDLW)
- Date employee last worked outside of railroad industry or "CONT" if still working (EELPSENDITI)
- Date employee last worked for second-last employer outside the railroad industry or "CONT" if still working (EELPSENDIT2)
- Previous Railroad Application
- Did employee previously file for an annuity? (EEPRVAPP)
- If so, what was annuity prefix? (EEPRVRRPRE)
- If so, what was previous annuity claim number? (EEPRVRRCLM)
- Self-Employment Information
- Was employee self-employed within the last twelve months? (EESELST12)
- Is employee self-employed now? (EESENOW)

NOTE: When the field office makes the determination that alleged SE is SE and no additional review by BRB required, REQUEST will display 2 or BLANK, as if the EE was not self-employed now or in the past 12 months. The field office determination is displayed on the remarks screen of APPLE (Pf-12) and transmittal.

When headquarters review is required, and the claimed SE is found to be LPE, these fields will not be changed. However, the applicable LPE fields will be changed.

- SSA Application Data
- Application: Has employee filed for SS benefit? (EESSAAPP)
- If so, under what SS number? (EESSANOFD)
- What is his claim suffix? (EECLMSUF)
- Alleged Filing: Is this his own claim number or another's? (SWEALGSSAFIL)

D. Screen 21 - Spouse Information

- SSA # - Employee's social security claim number.
- RRB # - If spouse has a six digit claim number, that number will be displayed here. Otherwise, a series of nines will appear.
- REQUEST UPDATED - The date of the last RASI run for which REQUEST has been updated, usually the last run.
- VIEW DT - The current date is shown.
- NAME AND ADDRESS - The name and home or mailing address on our records. The asterisk at the beginning of the address is equivalent to the RASI group mark.
- TYPE ANNUITY - The type of the spouse annuity being processed is indicated: Spouse Health Insurance, Full Age 65, Full Age 60-64, Reduced Age, Disabled Child, Minor Child.
- STATUS - The status of the spouse annuity is shown: PENDING is displayed until the annuity has paid final; PAID is shown when the final annuity rate is paid; DENIAL is indicated if the annuity claim is denied; MAN DROP is displayed for an examiner initiated drop from RASI; DUMP is shown if there is a computer generated drop from RASI; COMP ONLY is displayed if the annuity has been computed but cannot be paid.
- TYPE CERT - The type of annuity payment most recently made is indicated. If no certification has been made, no entry is shown. PARTIAL is indicated if a SPAR rate

has been paid; FINAL is displayed if a final annuity rate is paid and no partial rate has ever been paid; RECERT is shown if a partial rate is recertified to a final rate.

- LAW YEAR - The year of the amendments which apply to the adjudication of the case. The law year can differ from the year of the application filing date.
- TYPE ACTION - an entry is made in this item if:
 - annuity payment is pending (PENDING, TRACE, CALC);
 - some type of payment action has been taken by RASI (PARTIAL, FINAL, RECERT);
 - the case has been dropped from RASI (MAN DROP for examiner initiated drop; (MECH DROP for computer drop);
 - RASI is ready to make an annuity payment, but cannot do so for some reason (FUTURE VOUCHER, if RASI cannot make a payment until the next month's voucher; INSUFF ACCRL, if the partial rate exceeds the final but the overpayment can be recovered from one month's accrual.)
- NEXT ACTION DATE - The date of the next scheduled RASI processing activity for those cases pending payment.
- APP FILE DT - The filing date of the latest annuity or HI application.
- DOB - The spouse's date of birth. If the DOB is verified, "VER" appears next to "DOB"; if the DOB is not verified, "CLM" appears to indicate claimed date of birth.
- PARTIAL ABD - If a partial payment has been made, the partial ABD is shown.
- PART AWD DT - The date an award was processed by RASI. Check DATA-Q for date annuity check was vouchered.
- PARTIAL AMT - If a partial award has been made, the SPAR rate is indicated. This field can accommodate rates over \$999.99.
- INTO RASI - The date the application actually entered RASI. This can be different from the filing date or APPLE transmittal date.
- SP CALL-UPS - The call-up codes, the type of data required, and the date of the next RASI activity for each type of pending data. Up to eight items of any of the following types of RASI call-up activity may be shown.

CALL-UP	TYPE OF INFORMATION PENDING
901-SP POA	Spouse proof of age to be submitted on a type

	code 900 "RASIFORM" screen.
902-CHILD POA	Child proof of age to be submitted on a type code 900 "RASIFORM" screen.
904 POM	Proof of marriage to be submitted on a type code 900 "RASIFORM" screen.
932-RES FOR SP	Basic employee data from Research that is necessary before spouse annuity can be calculated.
933-ELIG INFO FOR SP	Miscellaneous spouse eligibility data required: "ELG" - eligibility determination based on child; "DIS" - disability eligibility determination based on disabled child; "PM" - validity of prior marriage determination (the field office has indicated via entries on the APPLE summary screen that examiner review is required); "DOM" - year of marriage eligibility determination. Each to be submitted on a type code 933 "RASIFORM" screen, coded for each applicable determination, as indicated in referral messages.
939 CHICO INQUIRY	If applicant claims (s)he filed for social security benefits, but TRIC indicates no MBR, RASI will check CHICO to determine if RRB is paying an SS benefit.
951-SP SS BEN	Spouse social security benefit data to be submitted on a type code 951 "RASIFORM" screen.
953-DUAL SPOUSE	Spouse also entitled to an employee annuity. Data to be submitted on a type code 953 "RASIFORM" screen.
957-PSP	Spouse indicates entitlement to a public service pension. Data to be submitted on a type code 957 "RASIFORM" screen.
961-SP TRIC	Spouse TRIC reply(ies) pending.
995-CLR MAN OP	Manual op code set, preventing annuity payments. Can be cleared with a type code 995 "RASIFORM" screen.

996-CLR MIS COR	Type code 996 "RASIFORM" screen needed to change the contents of a field in the RASI record.
997-NAME/ADDR	A name and/or address change or rep payee data to be submitted on a type code 997 "RASIFORM" screen.

- FINAL ABD - If an annuity has been paid final or recertified, the final ABD is indicated.
- FINAL AWD DT - The date an award was processed by RASI. Check DATA-Q for date annuity check was processed.
- RECUR RATE - The final net annuity rate is displayed.
- CODE NAME - The first initial and first four letters of the applicant's surname.
- TIER 1 - The amount of the Tier 1 component of the final annuity rate. (Before work deduction.)
- TIER 2 - The amount of the Tier 2 component of the final annuity rate. (Before work deduction.)
- AGE RED - The amount of the annuity age reduction, if applicable.
- SSA - If RASI reduced the retirement annuity for SS entitlement, the SS benefit amount appears.

E. Screen 22 - Spouse Status Words

The employee's SSA number and spouse's RRB claim number appear in the top left hand corner. The latest RASI processing date and current viewing date appear in the upper right hand corner of the screen.

Items of status information evaluated by RASI appear on this screen. Entries are made only for those items applicable to the particular case being reviewed. A numeric code appears after each item; this code indicates the status of each item and is the same type of status word code that currently is found on the RASI referral. A narrative description of the particular item's status follows the numeric code. The spouse status words shown on screen 22 are listed below.

- AGE

0 - Not Applicable

1 - Verified

4 - Verification required

- PROOF OF MARRIAGE

0 - Not applicable

1 - Verified

4 - Verification required

- DATE OF MARRIAGE

0 - Not applicable

1 - One year marriage requirement waived

2 - One year marriage requirement applies

4 - Determination required

- PREVIOUS MARRIAGE

0 - Not applicable

1 - Reconciled

2 - Not Reconciled

4 - Reconciliation required

NOTE: When the field office makes the determination that the spouse's previous marriage does not affect the validity of the current marriage, and no additional review by BRB examiner required, REQUEST will display 0, as if no previous marriage claimed on AA-3. The field office determination is entered and displayed on the IC G-230 screen and transmittal.

- FELONY

0 - Not applicable

1 - OK, continue processing

2 - Manual drop

4 - Verification required

- CHILD RELATIONSHIP

- 0 - Not applicable
 - 1 - OK
 - 2 - OK, proof of relationship required
 - 4 - Proof of age and relationship required.
- CHILD DISABLED
 - 0 - Not applicable
 - 1 - Disabled
 - 2 - Not disabled
 - 3 - Not required for spouse eligibility
 - 4 - Determination required
- CHILD QUALIFIES SPOUSE
 - 0 - Not applicable
 - 1 - Spouse eligible
 - 2 - Spouse ineligible
 - 4 - Determination required
- ALLEGED SS
 - 0 - No answer to SS entitlement question on application
 - 1 - Filed under own account number
 - 2 - No filing alleged
 - 3 - Filed on other account number
- SS BENEFITS
 - 0 - Not applicable
 - 1 - Entitled
 - 2 - Not entitled
 - 4 - Verification required

- 9 - Manual drop
- TRIC REQUEST
 - 0 - All replies received or Not Released
 - 1 - Sent under own SS number
 - 2 - Sent under employee's number
 - 3 - Sent under own and employee's number
 - 4 - Sent under third person's SS number
 - 5 - Sent under own and third person's SS number
 - 6 - Sent under employee's and third person's number
 - 7 - Sent under own number, employee's number, and third person's SS number
 - 8 - Examiner determination required
- SMIB OPTION
 - 0 - Not applicable
 - 1 - First enrollment
 - 2 - No response
 - 3 - No election (Sp doesn't want SMIB)
 - 5 - GEP Enrollment - (YES)
- HIB
 - 0 - Not applicable
 - 1 - Eligible
 - 4 - HI record created
 - 6 - Denied
- HIB SMIB
 - 0 - Not applicable

- 1 - RRB Jurisdiction
- 3 - Additional clearance required
- 4 - Initial clearance required
- 5 - None required
- 6 - Jurisdiction not determined
- HIB DATE
 - 0 - Not applicable
 - 1 - Based on marriage date
 - 2 - Based on employee eligibility
- HIB QUALIFICATION
 - 0 - Not applicable
 - 1 - Employee qualifies spouse
 - 2 - Spouse not qualified
 - 4 - Determination required
- SMIB DATE
 - 0 - Not applicable
 - 1 - Based on marriage date
 - 2 - Based on employee eligibility
- MANUAL OP
 - 0 - Not applicable
 - 2 - Manual examination required
- REP PAYEE
 - 0 - Not applicable
 - 1,2,3 - Appointed
 - 4 - Required

- 5 - Discharged
- DUMP REASON
 - 0 - Not applicable
 - 1 - Incorrect SSA number
 - 2 - Notice of death
 - 3 - Overpayment may occur
 - 4 - Claim abandoned
 - 5 - Application cancelled
 - 6 - Manual partial award
 - 7,9 - Other
 - 8 - Computer dump
- CERTIFICATION
 - 0,1 - Pending Final
 - 2 - Pending Partial
 - 3 - Recert
 - 4 - Final
 - 5 - Partial
 - 6 - Denial
- PUBLIC SERVICE PENSION
 - 0 - Does not apply
 - 1 - Entitled PSP (SSA tax deducted)
 - 2 - PSP withheld
 - 3 - Examiner requested dump
 - 4 - Verification required

F. Screen 23 - Spouse Miscellaneous Fields

The employee's SSA number and spouse's RRB claim number appear in the top left hand corner. The latest RASI processing date and current viewing date appear in the upper right hand corner of the screen.

Miscellaneous status and eligibility data appear on this screen. The information is displayed on the screen with "English" captions for easy reading. However, the PF 3 key will change the captions to mnemonic headings for use in preparing RASI input forms. Some items display numeric codes indicating their status, as well as actual data.

Note that on the screen with "English" captions, dates appear in the month-day-year format. However, in the mnemonic display, dates are in the year-month-day order for use on RASI input forms.

Similar items are grouped in categories for easy reference. The items shown on screen 23 are listed below with both "English" and mnemonic captions.

- Miscellaneous
- Spouse's own SSA number (SPSSANO)
- Claimed Date of Birth (SPDOBCLM)
- Date of Marriage (SPDOMARR)
- Previous Marriage (SPPRVMARR)
- Spouse's previous annuity claim number (SPPRVAPCLM)
- Last item date (SPLSTITMDTE)
- Sex (SPSEXCDE)
- T1 WD: Amount of work deductions withheld from Tier 1 (SPLSTT1WDAMT)
- T2 WD: Amount of LPE TWD withheld from Tier 2 (SPLSTT2WDAMT)
- Partial annuity rate (SPPRTLAMT)
- Health Insurance
- Health insurance filing date (SPHIFILDTE)
- Health insurance entitlement date (SPHIENTLDTE)
- Health insurance clearance date (SPHICLRDTE)
- SSA Application

- Has spouse filed SS application? (SPSSAAPP)
- If so, what is spouse's claim number? (SPSSACLMNO)
- Did spouse also file under a second number? (SPSSAOTHNO)
- Children
- Does spouse have minor children? (SPMINCHLD) (1 = yes; 2 = no)
- Does spouse have disabled children? (SPDISCHLD) (1 = yes; 2 = no)
- Verified date of birth of youngest child (SPYCVERDOB)
- Oldest child's date of birth (SPOLDDOB)
- Employment Information
- Was spouse employed in railroad industry? (SPEMPRR)
- Date last worked for railroad (SPDLWRR)
- Does spouse have rights to return to any RR employment? (SPRGHTREL)
- Was spouse employed outside of railroad industry? (SPEMPOUT)
- Date last worked in outside employment or "Cont" if still working (SPLPSENDT1)
- Date last worked in second-last outside employment or "CONT" if still working (SPLPSENDT2)
- Is spouse now self-employed? (SPSENOW)
- Has spouse been self-employed during last twelve months? (SPSE12)

NOTE: When the field office makes the determination that alleged SE is SE and no additional review by BRB required, REQUEST will display 2 or BLANK, as if the spouse was not self employed now or in the past 12 months. The field office determination is entered and displayed on the IC G-230 screen and transmittal.

When headquarters review is required, and the claimed SE is found to be LPE, these fields will not be changed. However, the applicable LPE fields will be changed.

- ABD Information
- Earliest ABD: Did spouse request earliest ABD allowed by law? (SPEARABD)

- ABD calculated by RASI (SPABD)
- ABE designated by spouse (SPDESABD)

9.5.17 Operating REQUEST

1. Sign-On Procedure - Access the REQUEST system as follows:

At This Screen	Type and Enter
Train logo	RRAPID
ENTER NEXT TASK CODE	SIGNON (plus your ID and password)
RRAPID MAIN MENU (NEXT SELECTION)	6

After these entries, the next screen to be displayed is the REQUEST DIRECTORY screen.

2. REQUEST DIRECTORY Screen - The DIRECTORY screen is a list of all the different screens available on REQUEST. A two digit numeric code is assigned to each screen and is also listed in the DIRECTORY. The first digit of the code is the payee code of the record you wish to view. The second digit is the sequential order of the screen in the REQUEST display format.

At the bottom of the DIRECTORY screen, REQUEST will display the message SSA# SCREEN# _____. Enter, in the spaces provided, the employee's SSA number and the number of the particular screen you wish to have displayed. Then press the enter key to register the information with the computer.

If an error is made at any time before hitting the ENTER key, move the cursor back to the incorrect entry and type in the correct entry. The cursor can be moved by hitting one of the arrow keys on the lower portion of the keyboard.

Note that the employee's SSA number, not his RRB claim number, must be entered to view a REQUEST display. (This procedure is used, since all claims in the RASI master record are in SSA number order, rather than claim number order.) The employee's SSA number must be used even if you wish to view a screen displaying spouse data.

If an invalid SSA number is entered, the message INVALID SSA # appears. The cursor will return to the beginning of the SSA number entry. Enter the correct SSA number.

If an invalid screen number is entered, REQUEST will display the message INVALID SCREEN NUMBER. The cursor will return to the beginning of the screen number entry. Correctly enter one of the screen codes listed in the REQUEST DIRECTORY.

If no record is found, the message RECORD NOT FOUND appears. No record for that particular SSA number can be found on REQUEST.

If REQUEST only has an employee record, and you request a spouse screen, the message NO SPOUSE FOUND - EMPLOYEE ONLY appears. Employee Screen 11 will then be displayed on the terminal.

Once the necessary identifying information has been entered into REQUEST, the requested RASI status information will be displayed on the CRT screen.

3. REQUEST Data Display

- A. On the bottom of each REQUEST data screen, the prompt line SCREEN X DISPLAYED; NEXT? ____ appears. To view additional REQUEST screens, type in the number of the next screen you wish to see. Then press the ENTER key. The new screen will then appear on the terminal.

If an incorrect screen number is entered in the prompt line, the message INVALID SCREEN NUMBER appears. Enter the correct screen number.

If REQUEST only has an employee record, the message NO SPOUSE appears on the bottom of each data screen. If a spouse screen is requested when the NO SPOUSE message is displayed, the message SCREEN NOT FOUND appears.

- B. To return to the DIRECTORY screen to request another record, hit the PF1 key.
 - C. Screens 13, 14 and 23 will display information with "English" captions. If you wish to view mnemonic captions, hit the PF3 key. This key displays the miscellaneous fields screen with RASI mnemonics. If you wish to return to the English captions, hit the PF3 key again.
4. Printout Request - If it is necessary to obtain a printout, press the PF2 key. The message ENTER NAME AND UNIT will appear. Type in your name (up to ten characters) and unit (no more than four characters). Do NOT press the enter key. This designation is important for distribution of printouts.
- Follow the printout request procedure as outlined in RCM 9.5.11.
5. Exiting REQUEST - You can return to the RRAPID menu by pressing PA1, PA2 or the Clear Key. To return to the train logo screen from the RRAPID menu, enter X at the NEXT SELECTION prompt.

9.5.20 MOLI

MOLI allows direct access to selected data in the MIRTEL file. MOLI may be used whenever there is a need for current Medicare status information. Any new data entered and processed into MIRTEL during a night computer run will appear on the MOLI screen the next morning.

See FOM-I-1540.5 for additional general information about MOLI.

9.5.21 MOLI Display

MOLI consists of six screens. The first screen is a menu/help screen that allows the user to enter identifying information for the beneficiary and to select the data screen needed. The MOLI screens and references for finding detailed information about the screens are shown in the following chart.

Screen ID Code	Description	Procedure References
	MOLI Help Screen (Menu)	FOM-I-1540.10 FOM-I-1540.15.1
GD	General Data Screen	FOM-I-1540.15.2
DB	Direct Bill Screen	FOM-I-1540.15.3
SB	State Buy-In Screen	FOM-I-1540.15.4
SC	Screening and Record Indicator Code Screen	FOM-I-1540.15.5
CP	Current Premium Screen	FOM-I-1540.15.6

9.5.22 Operating MOLI

MOLI is accessed from the RRAPID Main Menu. Refer to FOM-I-1540.10 for detailed instructions on how to access and operate MOLI.

9.5.23 Automated Folder Control System

For a detailed description of procedure and information about the Automated Folder Control System see the AFCS Folder Control Directory or Administrative Circular BSS-6 which is on Boardwalk under Bureau of Information Services.

9.5.40 PAYBACK

PAYBACK (On-line Cancelled Payment Data) is an inquiry only system that provides on-line viewing access of cancelled checks and returned direct deposit/EFT payments. PAYBACK gets its information from the cancelled payment files received from Treasury. Since RRB receives these files on a daily basis, PAYBACK is updated daily.

The system, which became operational in April 1993, was initially loaded with Treasury files containing RRA cancelled payments and limited payability cancellations received in March 1993. On July 5, 2000, Treasury began to include RUIA cancelled payments on the cancelled payment files; the RUIA data is available on PAYBACK.

Accessing PAYBACK

To access PAYBACK, enter the Railroad Automated Processing Integrated Database (RRAPID) using normal signon and password procedures. When the RRAPID menu is displayed, select option "23" and press the "Enter" key. This will access the claim number entry screen. The cursor will automatically position itself at the prefix/claim number field.

To view data on a particular claim number, enter the prefix (A, D or H) followed by the railroad claim number. If the claim number is a terminal number (employee's social security number) or you are checking for RUIA cancelled payment information, it is not necessary to enter a prefix; tab once and type in the social security number and then press the "Enter" key. If an error is made on the claim number entry screen, press the PF1 key to refresh the screen and re-enter the correct number.

9.5.42 Viewing PAYBACK

PAYBACK allows you to view returned/cancelled payment information for each beneficiary paid under the same claim number. The information is displayed in order of beneficiary and payee code.

9.5.43 PAYBACK Function Keys

TERMINAL KEY	FUNCTION	PC KEY
PA 2	Return to RRAPID menu	Page Down
PF 1	Return to the claim number entry screen	PF 1
PF 7	Move backwards to the previous screen	PF 7
PF 8	Move forwards to view additional data for the same claim number	PF8

Clear	Exit to RRAPID menu	Pause
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9.5.44 PAYBACK Screen Information

ITEM	INFORMATION
PFX	Prefix - A, D or H. This field is blank for RUIA claimants.
RRB CLM #	Self-explanatory.
BEN SYM	Beneficiary Symbol - This field is blank for RUIA claimants and employee annuitants. For RRA beneficiaries, the following symbols appear:
	M - all spouse type annuities
	W - all widow type annuities
	WC - survivor child/widow with child
	P - Parent
	J - Joint/Survivor
	L - Lump Sum
PAY CD	Payee Code - Numeric value 1 through 9 for RRA beneficiaries and 00 for RUIA claimants.
ISSUE DATE	The date (month, day and year) the payment was issued.
AMOUNT	The dollar amount of the payment.
CHECK SYM	3 or 4 digit Treasury code; direct deposit payment = 307 or 303, check = 2000 series number.
SERIAL NO.	Computer generated number assigned by Treasury used to identify each individual payment.
ACCTG DATE	RRA payments - The date the returned /cancelled payment was processed through the DAISY/CHICO system. This item is blank if the cancelled/returned payment information is received during the DAISY/CHICO post period.

	RUIA payments - The date Treasury cancelled the payment and credited the RRB.
RET RSN	The numeric code indicating why the payment was cancelled/returned (see 9.5.46).
EFF DATE	The effective date (month and year) of the susp/term
	Note: In rare instances the suspension/ termination action may reject. If the payment involves a RRA benefit, check DATA-Q to determine if payments were stopped.
PYMT TYPE	Identifies the type of payment: RR, RR/SS, RR/SUP, RR/SUP/SS, SS ONLY, LUMP SUM, SMIB REFUND, REPLACEMENT, or RUIA and payment frequency: ACCRUAL or MONTHLY

9.5.45 PAYBACK Messages

MESSAGE	MEANING
Claim Record Not Found	No data available for the claim number entered; Press PF1 to enter the next claim number
End of Data	Last screen displayed; no further information available for the claim number
Top Of Data	First screen displayed
Unacceptable Response. Please Try Again	Incorrect PF key used; see response list for acceptable PF keys
Prefix required for six-digit claim number	You must use the prefix A, D or H when entering a six-digit claim number; enter the correct prefix
Prefix must be A, D or H	An incorrect prefix was used; enter the correct prefix
Six-digit claim can be 1 but not greater than 991273	The claim number entered cannot be greater than the number 991273; press PF1 to refresh the screen and enter the correct claim number

9.5.46 PAYBACK Return Reason Codes

CODE	MEANING
01	Employee annuitant died
02	Employee annuitant returned to employer service
06	Employee - Other
08	Employee annuitant recovered from disability
09	Employee disability annuitant exceed monthly income
11	Survivor annuitant in employer service
12	Survivor annuitant exceeds yearly earnings
16	Survivor - Other
40	Limited Payability Cancellation Credit
41	Survivor annuitant died
42	Survivor child attained age 18, Survivor disabled child recovered, or Survivor student attained age 19
44	Child married or adopted or Widow or parent remarried
45	Widow does not have entitled child in care or Child attained age 18
46	Survivor annuitant entitled to equal or greater benefit
47	Student ceased FTA
51	Spouse annuitant died
52	Spouse annuitant in employer service
53	Spouse annuitant no longer has child in care
56	Spouse - Other
57	Spouse divorced
58	Spouse employee benefit suspended

59	Spouse termination - Employee benefit terminated
83	EFT Payment intercepted; payee not-entitled to payment
90	Reclamation Credit (Provisional; can be reversed)
91	EFT - Account Closed
92	EFT – Invalid account
93	EFT – Representative payee died
94	EFT – Account frozen
98	Undeliverable payment
99	Non-receipt credit (Provisional, can be reversed)

9.5.60 FOMF Overview

The Financial Organization Master File (FOMF) is a file furnished by the Treasury Department which the Railroad Retirement Board (RRB) uses to obtain the name and address of a financial organization based upon its routing number. Previously, the FOMF was contained on microfiche and viewed through a machine. However, the RRB developed an inquiry database which allows the FOMF to be accessed and viewed on-line. Access the FOMF from the RRAPID MAIN MENU as explained below.

9.5.61 Accessing The FOMF

To access the FOMF, select FOMF (31) from the RRAPID main menu. Enter the routing number (RTN) at the prompt on the FOMF entry screen. The route number has been expanded from eight digits to nine. The first eight fields encompass the previously entered eight digit RTNs and the ninth field position includes the check digit. If an incorrect RTN is entered, the system will show the message, "RTN NOT FOUND, PRESS PF1 TO ENTER NEW RTN".

9.5.62 FOMF Information Screen

The FOMF INFORMATION SCREEN will display the following data:

- Routing number
- Name of the Organization
- Address of the Organization, including City/Town and State

- ZIP+4
- Date the file was updated
- telephone number of the organization

To return to the FOMF Entry Screen to enter another RTN, press "PF1". To exit the FOMF inquiry system and return to the "RRAPID main menu", press the PA1 or PA2 key.

9.6.1 General

The Automated Stop Payment System is used to release mechanical SF-1184 "Unavailable Check Cancellation" requests to Treasury when:

Non-receipt Claim

- The payee or representative payee initiates a claim for the proceeds of a check which has not been received or which has been lost, stolen, mutilated or destroyed; or,
- The payee enrolled in direct deposit claims non-receipt.

NOTE: Occasionally, a Financial Institution (FI) will notify RRB of checks that were lost or stolen after being cashed by the payee. The FI may submit a non-receipt claim. When this occurs, secure the exact check symbol and check number of the check(s) from the Chicago Financial Center and advise the FI to file a "Holder In Due Course" claim or a "Lost/Stolen In Transit" claim with its servicing Federal Reserve Bank. Do not process the claim on the Automated Stop Payment System. If there is any doubt, refer the case to PP&PAS.

Non-entitlement

- The RRB determines that the payee is not entitled to the proceeds of a check that is not in the possession of either the RRB or the Treasury disbursing center (it is not known if the check has been paid (cashed) or if it is outstanding) and recovery cannot be made by any other means; or,
- The RRB determines that a payee enrolled in direct deposit is deceased or incompetent.

Status or Photocopy

- The RRB determines that a photocopy of a check or payment status information is needed for administrative purposes.

Requests to Treasury may be submitted using FAST-Payment Investigation or Form G-333. The information from the G-333 input document and FAST-Payment Investigation will be transferred to a computer tape by the Automated Stop Payment System for processing by Treasury. Complete Form G-333 in duplicate following the instructions in RCM 9.6, Appendix A. Enter a transaction on FAST according to RCM 9.7.

- A. Multiple Requests - Information for up to 24 payments in one case can be entered on FAST-Payment Investigation at one time. Additional requests must be entered using Form G-333. Information for up to five recurring payments in one case can be included on one G-333 as long as the claim number, symbol

and prefix, payee code, reason code, direct deposit information (if a DD/EFT payment) and name and address for the replacement check or photocopy are the same.

NOTE: CLAIMS FOR DD/EFT PAYMENTS AND REGULAR CHECKS CANNOT BE COMBINED ON ONE G-333.

- B. Accrual Check or One Payment Only - Requests for non-recurring payments (accruals or one payment only checks) require the first check number assigned by Treasury to the batch of checks in a voucher. This information is furnished on the confirmed copies of the SF-1166 Voucher and Schedule of Payments forms stored in PSG. Any G-333s prepared in the adjudication units for non-recurring payments must have this check number entered by PSG. Mark the complete voucher number (date and batch number) in the upper right corner of the G-333 and attach a copy of the SAMM tape. PSG will use this information to determine the first check number in the voucher and complete that item on the G-333.
- C. Courtesy Disbursement (Replacement Check) - Requests for Courtesy Disbursements released as a result of a B or C non-receipt claim require the exact check number of the Courtesy Disbursement check. This information is furnished by accessing Treasury's "TIE FILE". Any G-333s prepared in the adjudication units for Courtesy Disbursements (i.e. 9 shown in item 3) must have this check number entered by PSG. Mark the check symbol and check number of the original check in the upper right corner of the G-333. This information is found on the status of Non-Receipt Claims/Cancellation Requests listing. PSG will use this information to determine the exact check number and complete that item on the G-333.

9.6.2 Batching Forms G-333 And FAST Payment Investigation Transactions

G-333 forms will be prepared by both the adjudication units and the payment service group (PSG). Once a day, the central control group will collect all of the G-333s completed during that day, rubber band or paper clip the forms together in batches of one hundred or less and prepare a G-180, "Batch Control Sheet". Complete the items in Parts A and B as follows:

PART A

- TYPE OF FORMS SUBMITTED - enter G-333
- REQUESTING BUREAU - enter ORSP.
- PREPARED BY - enter the name of the person preparing the batch.
- UNIT - enter CSU.

- EXTENSION - enter the unit telephone extension.
- RETURN DOCUMENTS TO - enter CSU.

PART B

- DATE - enter the date the G-180 is being prepared.
- BATCH CONTROL NUMBER - enter the last digit of the current year in the first box followed by the Julian Calendar date in the last three boxes. If the Julian Calendar date is less than three digits, zero-fill the second and/or third box. The Julian Calendar date corresponds to the current month, date and year. It can be found in the left-hand corner of most standard desk calendars.
- NUMBER OF DOCUMENTS SUBMITTED - enter the number of G-333s. This total item count cannot exceed 100.
- DOCUMENT TYPE CODE - leave blank.
- CLAIM/SSA NUMBER OF FIRST INPUT DOCUMENT - enter the claim number from the first G-333 of the batch, if it is a six-digit claim number, zero-fill the first three boxes in this item.
- CLAIM/SSA NUMBER OF LAST INPUT DOCUMENT - enter the claim number from the last G-333 of the batch. If it is a six digit claim number, zero-fill the first three boxes in this item.
- BATCH CONTROL TOTAL - leave blank.
- HASH TOTAL - leave blank.

After the G-333s have been keypunched, the central control group will forward the batch and the G-180 to PSG. The batches should be kept for two months and then destroyed.

FAST-Payment Investigation transactions are mechanically batched and entered to the Automated Stop Payment System which runs twice weekly.

9.6.3 Transmitting Non-Receipt Reports, Photocopy Requests, Status Inquiries And Reclamation Requests To Treasury

The information from the G-333 and FAST-Payment Investigation is used to prepare a computer tape which is sent to the Chicago Financial Center (CFC) to initiate reclamation, payment investigation and/or the photocopy request. CFC processing is discussed further in section 9.6.10.

9.6.4 Initial System Output

During the processing of the information from the G-333s and FAST-Payment Investigation transactions the computer will prepare up to three types of output in addition to the computer tape for CFC. The output types are:

- letter of acknowledgment for non-receipt claims
- status line
- rejects

- A. Letter of Acknowledgment - With the processing of the G-333 and FAST input data, the computer will prepare one of the following three letters to acknowledge the non-receipt claim and notify the claimant that the matter has been referred to the Treasury Department.
- RL-37 - When direct deposit information is shown on the G-333 or FAST transaction and the reason code is either B, or C, an RL-37 will be released to the name and address shown on the G-333 or FAST transaction. See exhibit 3 for a sample of the RL-37.
 - RL-38 - When direct deposit information is not shown on the G-333 or FAST transaction and the reason code is either B, or C, an RL-38 will be released to the name and address shown on the G-333 or FAST transaction. See exhibit 4 for a sample of the RL-38.
 - RL-39 - When direct deposit information is not shown on the G-333 or FAST transaction and the reason code is G, an RL-39 will be released to the name and address shown on the G-333 or FAST transaction. See exhibit 5 for a sample of the RL-39.

The letters will be delivered directly to the mailroom for release. The computer will prepare an original only of each letter. There will not be a copy for the field office or for the folder. If the above situations occur in a case, assume the letter was sent to the claimant. If the field office specifically requests acknowledgment, respond by memo or electronic mail.

- B. Status List - A Status of Non-Receipt Claims/Cancellation Requests listing will be produced by the computer and will show the claim number, date of payment, amount of payment, type of payment, reason code, reclamation amount and name and address shown on the G-333 or FAST transaction. (See exhibit 6). Direct deposit information will be shown if applicable. If the transaction was entered on FAST, the signon and unit ID will also be shown. The list will be updated to include the information processed during the last computer run. The information for a specific claim or request will be maintained on the list for 6 months.

The status list will show one of three different types of messages under the caption STATUS depending on what action has been completed at the time the list is prepared.

1. If the claim or request has been transmitted to CFC, but we have not yet received the disposition (response) tape showing CFC's actions, the status shown will be "SENT TO TREASURY". If no reply is received from CFC within 30 days, the system will release a second request and the status shown will be changed to "SENT TO TREASURY - SECOND REQUEST". The date on which the RRB's tape is transmitted to CFC will be shown to the right of STATUS DT.
2. After CFC has processed our tape, they will return a disposition tape with information showing the action taken at CFC. When the disposition tape is processed by the automated stop payment system, the STATUS will change to reflect CFC's action. The check number or EFT trace number (CK NO), check symbol (CK SYM) and CFC processing date (PROC DT) will be added to the status list. In addition, the STATUS DT will be changed to show the date the disposition tape was processed at RRB. The CFC disposition status messages are explained in section 9.6.11.
3. In check cases, Treasury's Check Payment and Reconciliation System (CP&R) will provide the status of the original payment and notice of the initial CP&R action via the Daily Advice of Status tape. When this tape is processed by CFC they will return a disposition tape to us. After we process the tape, STATUS will change to reflect CP&R action and the STATUS DT will be changed to show the date the disposition tape was processed at RRB. The CP&R status messages are explained in section 9.6.24.

The status list can be used to answer correspondence from the claimant or the field without requesting the folder.

- C. Rejects - A G-333 may reject from the Automated Stop Payment system for any number of reasons (a box which should be completed is blank, an erroneous reason code, keypunch error, etc.) The computer will print out a Form G-333 Edit Reject Sheet (see exhibit 7). This form is in the same format as the G-333 and will show all the information which was keypunched from the original G-333. The reason(s) for the reject will be printed on the bottom of the form.

The Form G-333 Edit Reject sheets will be delivered to the payment services group (PSG) to be returned to the originating unit for correction. Corrections can be made directly on the Form G-333 Edit Reject Sheet. If necessary, consult the MOMS/SAMM/QUICKIE/DATA-Q and/or the folder to make the corrections. If the reject was caused by missing information, enter the information in the appropriate spot in the reject sheet. If the reject was caused by erroneous information, draw a line through the entire entry and clearly print the correct entry

to the right of the incorrect item. If it is determined that the reject was caused by a keypunch error, either correct the erroneous entry in the same manner as above, or enter the omitted information in the appropriate spot. The central control group will batch the corrected Form G-333 Edit Reject sheets with the regular G-333s completed during the day. CORRECT AND RESUBMIT G-333 EDIT REJECTS AS QUICKLY AS POSSIBLE.

9.6.10 Chicago Financial Center Processing

When the Chicago Financial Center (CFC) receives a computer tape of Automated Stop Payment system input, they will take the following actions:

- Screen their records to determine whether or not the payment in question was issued.
- Confirm that the payment amount on the request equals the issue amount.
- Search the returned checks to determine if the check is in the possession of the financial center.
- Search other files (previous SF-1184s, previous non-receipt claims) to determine if a previous action was taken.
- Complete the check description by entering the specific check symbol and serial number of the check in question.

If CFC has no record of the payment being issued (e.g., payment date and/or amount on the request does not match CFC's records) or if their records show a previous action (e.g., the check was returned or a non-receipt claim or a previous SF-1184 was filed) a Payment Investigation Referral will be generated.

- A. Check Cases - If the check was issued and CFC records show no previous action, they will notate their records that an SF-1184 was received and forwarded to the CP&R system in Washington D.C. for further handling. A record of the CFC disposition will be returned to the RRB.
- B. Direct Deposit Cases - If the payment was directed to a financial organization, CFC will check the representative payee and/or beneficiary information and depositor account number against the financial center microfilm and take the following actions:
 - 1) Reclamation - CFC will verify that the reason for the transmission of the request was either death or legal incapacitation and prepare and release a Form FMS-133 Notice of Reclamation to the financial organization.
 - 2) Non-receipt - CFC will verify the payment, prepare and release a FMS-150 DD/EFT Tracer to the financial organization.

9.6.11 Processing CFC Replies

After CFC processes our tape, they will return a disposition tape to the RRB notifying us of the action taken on each claim or request. This notification will either be in the form of a confirmation or a referral. A confirmation indicates that all necessary RRB action has been completed and Treasury is processing the claim or request. A referral indicates that the RRB should re-examine the case to verify that the request is valid and resubmit the claim with the corrected information. As each Chicago Financial Center disposition tape is processed, the Status of Non-Receipt Claims/Cancellation Requests listing and PI STATUS will be updated.

- A. Confirmations - When RRB receives a confirmation on a claim, PI STATUS and the status list will always be updated, however, a computer printed folder record will only be produced when direct deposit is involved or if the request is for a photocopy/certified photocopy. The Payment Investigation Folder Record (see exhibit 8), will show the information which was entered from the G-333 or FAST, the date the claim or request was processed by CFC and the action taken by the financial center. If the claim involves a check and the request is other than photocopy/certified photocopy, no folder record will be produced at this time. The only record of the financial center's handling on these claims will be the status list and PI STATUS.

The following messages will appear on PI STATUS, the status list and on the folder records produced at this time:

- CHECK PREV CANCELLED

The check or payment has been cancelled. The Cancelled Check Listings should be checked to verify this information. The folder record will show the date of the cancellation.

- DUPLICATE CLAIM SUBMITTED

Treasury will follow-up on a previous request. The folder record and status list will show the date of the previous action.

- EFT PAYMENT TRACE PROCESSED

CFC has released a DD/EFT payment tracer, FMS-150, to the financial organization to investigate the claim of non-receipt.

- PREV SF-1184 PROCESSED

The RRB has already entered a non-receipt claim or requested that reclamation action be taken on the payment. The referral notice and the status list will show the date the SF-1184 was processed.

- SF-1184 PROCESSED

The request for reclamation action or non-receipt claim has been sent to the CP&R system (Treasury in Washington) for handling.

The Payment Investigation Folder Records will be marked "ASSOCIATE AND FILE DOWN". They will be delivered to claim files.

- B. Referrals - When CFC is unable to process a request as submitted, they will provide the referral reason on the disposition tape. A computer printed Payment Investigation Referral will be generated. PI STATUS and the status list will be updated for each request containing a referral code. The Payment Investigation Referral (see exhibit 9) will show the information which had been entered from the G-333 or FAST, the date the claim or request was handled by CFC and the reason for the referral.

The referral notices will be delivered directly to PSG where they will be routed to the requester. All referrals should be investigated and corrective action should be taken as necessary.

The following messages will appear on the referral notices, PI STATUS and the status list:

- AMOUNT DIFFERENCE

Check the referral and if necessary the MOMS/SAMM or the folder to see whether the amount or possibly the date entered on the G-333, or FAST does not match with the claimed or requested check or payment. Resubmit a corrected G-333 or FAST transaction.

- CFC WILL REPROCESS - REASON CHANGED FROM C TO D

CFC was unable to process the non-receipt claim within 4 business days. The referral should be filed in the claim folder. Pend the case 45 days for Treasury's reply. If the payment is outstanding, Treasury will forward a code 99 Non-Receipt Credit (see section 9.6.56 for handling code 99 credits). If the payment was cashed, Treasury will forward a photocopy of the check and a claim form (TFS-1133) to RRB for completion by the payee.

- EFT PROOF OF PAYMENT PROCESSED

A non-entitlement reclamation action, or photocopy/status request on an EFT payment has been validated by CFC.

- INVALID DIRECT DEPOSIT INFO

Resubmit a corrected G-333 or FAST transaction.

- **INVALID RECORD OF ISSUE**

Resubmit a corrected G-333 or FAST transaction.

- **NO RECORD OF ISSUE**

The described check or payment was not issued. Recheck the data entered on the G-333 or FAST. Recheck MOMS/SAMM. If no payment was issued, refer the case to the appropriate adjudication unit.

- **UNKNOWN DISP REASON - XX**

Locate the claim folder. Send the folder and referral notice to PP&PAS.

- **UNMATCHED DISP - REFER TO RCA**

Send the referral notice directly to PP&PAS.

If the investigation of the referral shows that a FAST transaction or G-333 was submitted with erroneous data, prepare a corrected G-333 as shown in section 9.6, Appendix A or enter a payment investigation transaction on FAST. Attach the referral notice to the copy of the corrected G-333 or FAST print-out and file in the claim folder or mark the package "ASSOCIATE AND FILE DOWN" and release it to claim files.

9.6.20 Initial Editing And Review By The Check Payment And Reconciliation System (CP&R)

The Chicago Financial Center (CFC) sends all stop payment (non-receipt and reclamation) and photocopy requests for check cases to the CP&R System in Washington for further handling. Upon receipt in CP&R, the mechanical SF-1184s are again edited for missing data and/or inappropriate reason codes. A computer printed Payment Investigation Referral will be generated and PI STATUS and the status list will be updated for each request containing a CP&R edit reject message. The Payment Investigation Referral will show the information from the G-333 or FAST transaction, the date the claim or request was handled by CFC, the status date supplied by CP&R and the reason for the referral.

The referral notices will be delivered directly to BSU where they will be routed to the requester. All referrals should be investigated and corrective action should be taken as necessary.

The following messages will appear on the referral notices and status list:

A. Initial Stop

- **REJECT - CP&R UNABLE TO PROCESS.**

CFC passed erroneous data to CP&R. Resubmit the transaction on FAST or Form G-333 and notify PP&PAS.

- REJECT - DATE OF EVENT AFTER DATE OF PAYMENT.

Resubmit the claim via a new G-333 or FAST with either the correct date of death or the non-entitlement reason code (F).

- REJECT - DECEDENT/PAYEE NAME DISAGREE.

Resubmit the claim via a new G-333 or FAST with either the correct deceased name or the non-entitlement reason code (F).

- REJECTED - INVALID CHECK DATE FIELD.

Resubmit the claim via a new G-333 or FAST, correcting the check date.

- REJECTED - NON-NUMERIC DATA IN NUMERIC ONLY FIELD.

Resubmit the claim via a new G-333 or FAST.

- REJECTED - UNACCEPTABLE USE OF DECEASED REASON CODE: RESUBMIT NONENTITLEMENT STOP IF REPRESENTATIVE PAYEE DID NOT RECEIVE CHECK.

Resubmit the claim via a new G-333 or FAST with either the correct deceased name or the non-entitlement reason code (F).

B. Subsequent Stop

- DUPLICATE STOP

Review the case. If the original request has a reply, no further action is necessary. If there is no reply to the first request, trace with Treasury. See section 9.6.57 for instructions on tracing stop payments.

- REJECTED-OUTSTANDING CHECK NOT CANCELLED - NO ISSUE REPORTED - CONTACT DC.

CFC did not update their issue file. Send referral to PP&PAS.

- REJECTED - UNACCEPTABLE USE OF STOP REASON CODE.

Review the case. Submit a new G-333 or FAST transaction with the correct reason code.

If the investigation of the referral shows that a G-333 or FAST transaction was submitted with erroneous data, prepare a corrected G-333 as shown in section

9.6 Appendix A or enter a payment investigation transaction on FAST. Attach the referral notice to the copy of the corrected G-333 or FAST print-out and file in the claim folder, or mark the package "ASSOCIATE AND FILE DOWN" and release it to claim files.

9.6.21 Initial Stop Payment Processing By CP&R

Mechanical SF-1184s accepted by Treasury will be processed by the CP&R System. CP&R will examine its records to see if the check has been negotiated. (See section 9.6.24).

9.6.22 CP&R Action Taken When The Check Has Not Been Paid

If the CP&R System determines that the check is still outstanding (uncashed), Treasury will take the following actions based upon the reason code entered by RRB on the G-333 or FAST transaction:

- A - entitlement agency recertified before status - Treasury will cancel the original check and forward credit to RRB.
- B - entitlement-issue Courtesy Disbursement before status - Treasury will notify RRB that the check was outstanding and a Courtesy Disbursement (replacement check) was issued as a part of mass loss processing.
- C - entitlement - issue Courtesy Disbursement after status - Treasury will issue a Courtesy Disbursement (replacement check) bearing a unique check symbol and check serial number and notify RRB of their action.
- D - entitlement - agency will recertify after status - Treasury will cancel the original check and forward credit to RRB.
- E - deceased - Treasury will cancel the original check and forward credit to RRB.
- F - non-entitlement - Treasury will cancel the original check and forward credit to RRB.
- G - lost/stolen - endorsed - Treasury will cancel the original check and forward credit to RRB.
- K - photocopy - Treasury will notify RRB that the check is outstanding and no photocopy can be issued.
- L - certified photocopy - Treasury will notify RRB that the check is outstanding and no photocopy can be issued.
- M - status - no photocopy - Treasury will notify RRB that the check is outstanding. No further action will be taken by Treasury.

- S - agency match - non-entitlement - Treasury will cancel the original check and forward credit to RRB.
- T - agency match - deceased - Treasury will cancel the original check and forward credit to RRB.
- U - legal incapacitation - Treasury will cancel the original check and forward credit to RRB.

RCM 9.6.43 describes what action should be taken when the agency credit is received at RRB.

9.6.23 CP&R Action When The Check Status Shows Paid

If Treasury determines that the check has been negotiated, no credit is given. A photocopy of the paid check will be secured in all cases except reason code "M - Status - no photocopy." Treasury has agreed to provide photocopies for stop payment claims actions within 60 days. If the original check cannot be located and photocopy produced within that time frame, Treasury has established special procedures (see section B).

- A. Photocopy Available - When the Check Claims Group (CCG) has obtained the photocopy, they will take the following actions based upon the reason code entered by RRB on the G-333 or FAST transaction:
- A - entitlement - agency recertified before status - Treasury will notify RRB that the original check was paid. The photocopy and FMS-1133 will be forwarded to RRB.
 - B - entitlement - issue Courtesy Disbursement before status - Treasury will notify RRB that the original check was paid but a replacement check was issued (as a result of mass loss processing) before the paid status was known. If the replacement check is also paid, Treasury will notify RRB (see Interim Procedure A-95-03).
 - C - entitlement - issue Courtesy Disbursement after status - The photocopy and FMS-1133 claim form will be sent to the payee. A replacement check will not be prepared until the claim form is completed and returned to CCG for processing.
 - D - entitlement - agency will recertify after status - Treasury will notify RRB that the original check was paid. The photocopy and FMS-1133 will be forwarded to RRB.
 - E - deceased - Treasury will use the photocopy to seek recovery of the "amount to be reclaimed" from the banking system and credit the agency if the amount is recovered.

- F - non-entitlement - Treasury will send the photocopy and a FMS-1133 claim form to the RRB for completion by the payee. If the payee claims non-involvement, Treasury will seek recovery from the bank.
- G - lost/stolen - endorsed - Treasury will notify RRB that the check was paid and that the fact that it was endorsed when lost or stolen may prevent claims action. The photocopy and FMS-1133 claim form will be sent to the payee. In some cases, this will be done through the RRB.
- K - photocopy - Treasury will forward the photocopy to the name and address shown in the NAME/ADDRESS block of the G-333 or FAST transaction.
- L - certified photocopy - Treasury will send a certified photocopy to the name and address shown in the NAME/ADDRESS block of the G-333 or FAST transaction.
- M - status - no photocopy - Treasury will notify RRB that the check is paid. No further action will be taken by CP&R.
- S - agency match - non-entitlement - Treasury will send the photocopy and a FMS-1133 claim form to the RRB for completion by the payee. If the payee claims non-involvement, Treasury will seek recovery from the bank.
- T - agency match - deceased - Treasury will use the photocopy to seek recovery of the "amount to be reclaimed" from the banking system and credit the agency if the amount is recovered.
- U - legal incapacitation - Treasury will send the photocopy and FMS-1133 claim form to the RRB for completion by the payee. If the payee claims non-involvement, Treasury will seek recovery from the bank.

B. Photocopy Not Available Within 60 Days - When the photocopy of the paid check is unavailable after 60 days, release an FMS-3864 to trace with Treasury (see RCM 9.6 Appendix C). When Treasury receives the FMS-3864 they will either forward the photocopy or take the following actions:

1. Payee claiming non-receipt - CCG will send a modified FMS-1133 claim form (see exhibit 10) to either RRB for release to the payee or directly to the payee if RRB requested release of a replacement check. If the payee continues to claim non-involvement in cashing the check, the payee must complete the modified FMS-1133 claim form and return it to CCG.

CCG will adjudicate the claim and either credit RRB or settle with the payee. CCG will continue to attempt to retrieve the photocopy of the paid check. If they are successful, they will either reverse the credit to RRB or notify RRB that the duplicate payment must be recovered from the payee.

2. Requests other than non-receipt - In situations other than claims of non-receipt (deceased payee, non-entitlement, lost or stolen endorsed check, photocopy or status requests) the unavailability of a photocopy of the paid check will not result in credit being passed to RRB. CCG will notify RRB that no further action can be taken. If an overpayment exists, take the necessary or appropriate recovery actions.

9.6.24 Processing CP&R Status Replies

After CP&R investigates the payment status of a check, they will transmit a Daily Advice of Status file to CFC showing payment status and the action they will take on each claim or request. CFC will process the status file and transmit a disposition file to RRB. As each disposition file is processed at RRB, the Automated Stop Payment system will update the message on PI STATUS and the Status of Non-Receipt Claims/Cancellation Requests listing and produce Payment Investigation Folder Records.

The following messages will appear on PI STATUS, the status list and on the folder records produced at this time:

A. Paid Status

- PAID - CERTIFIED PHOTOCOPY TO FOLLOW.

Control case for the certified photocopy. Send to the requester when received. Treasury will use this status message for requests coded "L - certified photocopy".

- PAID - CCG RECLAMATION; NO PHOTOCOPY TO AGENCY.

Control for credit. Treasury will use this status message for request code "E - deceased" and "T - agency match - deceased".

- PAID - COURTESY DISBURSEMENT ISSUED BEFORE STATUS; PHOTOCOPY AND CLAIM TO FOLLOW.

Treasury will only use this status message for request reason code "B - entitlement - issue Courtesy Disbursement before status." This status message confirms that a replacement check was issued by CFC as a result of mass loss processing but the original check was paid (cashed). There is a strong possibility that an overpayment will occur. If both the original and replacement check are subsequently paid, Treasury will notify RRB (see Interim Procedure A-95-03).

- PAID - ENDORSEMENT MAY PROHIBIT CLAIMS ACTION; PHOTOCOPY AND CLAIM TO FOLLOW.

Treasury will only use this status message for requests coded "G - lost/stolen - endorsed." Treasury will send the claim form and photocopy to RRB for completion by the payee (see Interim Procedure A-95-03).

- PAID - PHOTOCOPY AND CLAIM TO FOLLOW.

Treasury will use this status message for request codes "A" - entitlement - agency recertified before status, "C" - entitlement - issue Courtesy Disbursement after Status, "D" - entitlement - agency will recertify after status, "F" - non-entitlement, "S" - agency match - non-entitlement and "U" - legal incapacitation. If the request reason code was "C" - entitlement - issue Courtesy Disbursement after status, Treasury will send the claim form and photocopy directly to the payee. In the remaining request codes, control the case for receipt of the claim form and photocopy. Send both to the payee when received (see section 9.6.31).

- PAID - PHOTOCOPY TO FOLLOW.

Control case for photocopy. Send to requester when received. Treasury will only use this status message for request code "K - photocopy."

- PAID STATUS.

No claim action pending. Use check payment status for the reason it was requested. Treasury will use this status message for request code "M - status - no photocopy."

- PAID - NO PHOTOCOPY AVAILABLE.

Treasury will use this status message for request code K - Photocopy and code L - certified photocopy for any check dated before November 7, 1986. This message will also appear for checks issued after November 7, 1986 that have aged 78 months. If an overpayment exists, take the necessary or appropriate recovery actions.

B. Outstanding Status

- OUTSTANDING - CHECK CANCELLED; AGENCY CREDIT TO FOLLOW.

Control case for receipt of the agency credit. When credit is received, reissue the check or close the accounts receivable and tickler call-up as necessary. Treasury will use this status message for request codes "A" - entitlement - agency recertified before status, "D" - entitlement - agency will recertify after status, "E" - deceased, "F" - non-entitlement, "G" - lost/stolen - endorsed, "S" - agency match - non-entitlement, "T" - agency match - deceased, "U" - legal incapacitation and in certain cases, "C" - entitlement - issue Courtesy Disbursement after status."

- OUTSTANDING - NO PHOTOCOPY.

No photocopy can be sent because the check has not been paid. If credit is necessary and the check issue date is less than a year old, submit a new G-333 or FAST transaction with a stop reason code (see exhibit 1 for acceptable codes). Treasury will use this status message for request codes "K - photocopy" and "L - certified photocopy."

- OUTSTANDING STATUS.

The check has not been presented for payment. No claim action is pending. Use the payment status information for the reason it was requested. Treasury will use this status message only for request code "M - status - no photocopy."

- OUTSTANDING - COURTESY DISBURSEMENT ISSUED.

Treasury issued a replacement check to the payee according to our request. Treasury will use this status message for request code "C - entitlement - issued Courtesy Disbursement after status."

- OUTSTANDING - COURTESY DISBURSEMENT ISSUED BEFORE STATUS.

Treasury issued a replacement check to the payee according to our request for mass loss processing. Treasury will only use this status message for request codes "B - entitlement - issue Courtesy Disbursement before status".

- LIMITED PAYABILITY CANCELLATION.

A check is at least 12 months old and has not been presented for payment. Treasury has cancelled the check. Reissue the check if entitlement to the payment exists or close the accounts receivable record and tickler call-up if necessary. Treasury will use this status message for request codes "K- Photocopy," "L-Certified Photocopy" and "M-Status -No Photocopy."

C. Miscellaneous Stops Exceptions

- PAYMENT EXCEPTION - CCG WILL INVESTIGATE AND ADVISE.

Control for the results of CCG's investigation. Treasury will use this status message for all request codes.

- STATUTE OF LIMITATIONS EXPIRED.

Treasury is unable to take any claims action because of the age of the check. Resubmit the claim using code M for the status of the payment or code K if a photocopy is needed.

9.6.25 Courtesy Disbursements

Treasury will provide Courtesy Disbursement replacement services as explained below:

- A. Mass Loss Claims - Replacement checks for mass loss claims will be produced by the Chicago Financial Center upon receipt of the claims tape. Checks will be issued immediately without the ten day delay for processing current month check replacements. If an overpayment occurs as a result of the Courtesy Disbursement being issued, it will be charged to the RRB (see Interim Procedure A-95-03).
- B. Non-receipt Claims - If the original check has not been negotiated, CP&R authorizes the Chicago Financial Center to issue a replacement check. The Courtesy Disbursement is clearly identified with the statement "REPLACES PAYMENT DATED MM/DD/YY." No further action will be taken by the Check Claims Group (CCG) unless both checks are later received negotiated.

NOTE: Treasury will not issue replacement checks for mass loss claims and non-receipt claims if 13 months have lapsed since the check issue date of the original check. The Limited Payability Cancellation listing should be checked to see if credit has been received for the payment.

9.6.26 Processing Code 90 Notice Of Cancelled Check Credits And Code 99 Non-Receipt Claim Credits

Treasury will forward credits to RRB in response to reclamation requests and non-receipt claims, on the cancelled check file using cause code 90 and cause code 99, respectively. These codes will not cause a suspension or termination, so code 90 and code 99 will not show up on DATA-Q under TERM/SUSP CAUSE. Notices of Cancelled Checks (Cause Code 90) and Non-Receipt Claim Credit notices (Cause Code 99) should be matched to the claim folder and handled as follows:

- A. Reclamations - Treasury will forward code 90 credits in response to reclamation requests when the check has been found to be outstanding. After determining that a reclamation request was processed for the payment returned as a code 90 credit, use the credit to reduce the outstanding overpayment balance.
- B. Non-Receipt Claims - The majority of non-receipt claims released to Treasury are reason code "C" claims. Normally, when the check is found to be outstanding, Treasury will use the credit from the outstanding check to release a replacement check. However, in a number of situations, Treasury will forward a code 99 credit to RRB for reissuance. Refer to RCM 9.6.56 for instructions on the release of a replacement check.

9.6.27 Processing Code 40 Limited Payability Cancellation Credits

Treasury will forward credit to RRB for all checks issued October 1, 1989, and later, that remain uncashed after the 12th month from the check issue date using cause code 40. A code 40 will not cause a suspension or termination, so a code 40 will not show up on DATA-Q under TERM/SUSP CAUSE. Limited Payability Cancellation Credit notices (Cause Code 40) should be matched to the claim folder and handled as follows:

- A. Check Covers A Period of Non-Entitlement - If the check covers a period of non-entitlement, any overpayment caused by the payment should be removed. Close out the accounts receivable record using action out code 12F and tickler call-up if necessary.
- B. Check Covers A Period of Entitlement - If the check covers a period of entitlement and a request for reissuance is received, reissue the payment to the annuitant. Refer to section 9.6.56B for instructions on the release of a replacement check to the annuitant. Otherwise, file down the Limited Payability Cancellation notice and forward the folder to claim files. If the annuitant is deceased, develop for accrued annuities and issue the payment to the eligible survivor(s).

NOTE: If the check covers a period of entitlement and an overpayment exists on the annuitant's record, use the amount of the check to offset the overpayment. If the check is a combined RR/SS payment, only the RR portion of the check can be used to offset the RR overpayment. Reissue the SS portion of the check to the annuitant. Prepare Form G-206 to modify the accounts receivable balance using action out code 12F. Notify the annuitant of the action and if an overpayment balance still remains, the new overpayment recovery date.

If the date of the check is 10/1/89 or later and, the check is reissued, used to offset an overpayment, or if there is no entitlement to the check, the bureau of fiscal operations (BFO) must be notified in order to properly credit funds. Access HSL to get to the Limited Payability Cancellation Reversals program so that a transfer of funds can be made. See RCM 9.6 Appendix D for instructions on using the HSL program.

Also, if the payment is reissued as an accrued annuity, or if the check was for a period of non-entitlement, send the claim folder to TAX-IAS after all examiner action.

9.6.28 Processing Non-Receipt Claims After Expiration Of The Claimability Period

When an annuitant claims non-receipt of a check that is a year or older, the Beneficiary Services Unit (BSU) will investigate the claim by checking the Administrative Cancellation listing, PAYBACK, the Limited Payability Cancellation listing, and/or the Cancelled Check listing to see if the check was previously cancelled. If the check is not found, BSU will check PI STATUS or the Status of Non-Receipt Claims/Cancellation

Requests listing to see if a previous non-receipt claim was processed. If no previous claim was processed, PSG will initiate a photocopy request via FAST-PI using stop reason code K.

- A. Check Previously Cancelled - If the check appears on PAYBACK or one of the cancellation lists or, PI STATUS indicates that the check was previously cancelled, BSU will prepare a G-696 and forward it to the appropriate unit for handling as described in section 9.6.27.
- B. Previous Stop Payment Processed
 1. If the check appears on the Status of Non-Receipt Claims/Cancellation Requests list or PI STATUS and the Treasury reply message is "OUTSTANDING--COURTESY DISBURSEMENT ISSUED" or "OUTSTANDING--DISBURSEMENT ISSUED BEFORE STATUS", BSU will access the Treasury Tie File to get the date that the replacement check was issued and release an RL-77 letter to the payee advising him/her that no further action will be taken on his/her claim.
 2. If the check appears on the Status of Non-Receipt Claims/Cancellation Requests listing or PI STATUS and the Treasury reply message is "OUTSTANDING--CHECK CANCELLED; AGENCY CREDIT TO FOLLOW", BSU will forward the case to the appropriate unit for handling. Examine the claim folder to determine if a replacement check was issued. If a replacement check was issued, release an RL-77 letter to the payee advising him/her that no further action will be taken on his/her claim. If a replacement check was not issued, and the payee is entitled to the check, prepare an OPO award as described in section 9.6.56.
- C. Check Not Previously Cancelled And No Previous Stop Payment Processed - If the check does not appear on PAYBACK, any of the cancellation listings, the Status of Non-Receipt Claims/Cancellation Requests listing or PI STATUS, process a photocopy request via FAST-PI using stop reason code K and pend the case 45 days for Treasury's reply.

IMPORTANT: Avoid processing unnecessary photocopy requests. Treasury charges RRB for each photocopy received. While initially providing the annuitant with the photocopy could minimize additional handling of the case, whenever possible process a status request using stop reason code M.

1. If the status message shows "PAID-PHOTOCOPY TO FOLLOW", BSU will release an RL-77 letter along with the photocopy to the payee advising him/her that no further action can be taken on his/her claim.
2. If the status messages shows "PAID-NO PHOTOCOPY AVAILABLE" or "PAID", BSU will release an RL-77 letter to the payee advising him/her

that no due to the Statute of Limitations, no further action can be taken on his/her claim.

3. If the status message shows "Limited Payability Cancellation," BSU will refer the case to the appropriate unit for handling, as described in section 9.6.27.

9.6.30 Claims Processing On A Paid Check

After the paid status is determined and RRB is advised, Treasury's computer will produce a two page Claims Document (see exhibit 11). This Claims Document contains all of the appropriate stop information and the appropriate mailing information. The FMS-3858 Claims Document, is now the first two pages of a four page forms set. Page three is a set of instructions to the payee/claimant on how to complete the TFS-1133 Claim Form and page four is the TFS-1133 Claim Form.

In some cases, the RRB will be responsible for contacting the payee for completion of the TFS-1133 claim form (see exhibit 12). The Claims Document will be used to transmit photocopies and TFS-1133 claim forms to the RRB for forwarding to the payee.

In cases where RRB asked Treasury to release a replacement check ("B-entitlement-issue Courtesy Disbursement before status" and "C-entitlement-issue Courtesy Disbursement after status"), Treasury will be responsible for releasing the claim forms to the payee. The Claims Documents will be destroyed if Treasury releases the claim forms.

9.6.31 ORSP Claims Document Processing

Treasury produced Claims Documents will be received in the payment services group (PSG). Folders charged to claim files or non-adjudication units will be requested through the Automated Folder Control System (AFCS). When the folder is charged to an adjudication unit, the Claims Document and photocopy will be routed to that unit for handling. NEVER SEND UNPROCESSED CLAIMS DOCUMENTS AND PHOTOCOPIES TO CLAIM FILES FOR MATCHING WITH THE FOLDER - ALWAYS USE AFCS.

Note: When the reason code shown on the Claims Document is A, F, S, or U and the folder is charged to claim files or a non-adjudication unit, PSG will request the folder through AFCS, match the Claims Document package and forward the folder to the appropriate adjudication unit.

Treasury will forward Claims Documents in both non-receipt and some reclamation requests. When the Claims Document is matched to the claim folder, check the reason code and take the following action:

- A. Reason Code "A - Entitlement - Agency Recertified Before Status" - If Treasury sends a Claims Document to the RRB for forwarding to the payee, and the

original request was for reason code "A", file the Claims Document package (pages 1 through 4 and photocopy) in the claim folder, and check the folder to determine if the replacement payment issued by the RRB was returned.

1. Payment Returned

Notate the Claims Document that the replacement payment was returned and take no further action.

2. Payment Not Returned

- Prepare Form G-333 or FAST transaction using reason code "F", for the replacement payment, enter the amount of the payment to accounts receivable, and establish a six-month 16-09 call-up for Treasury's response.
- If Treasury finds that the payment is outstanding (uncashed) the payment will be cancelled and credit forwarded to RRB on the cancelled check tape (Code 90). When the Notice of Cancelled Check (green sheet) is matched to the folder, close out the open accounts receivable balance. No further action is necessary.
- If Treasury finds that the payment is paid (cash) a Claims Document package will be forwarded to the RRB. When the package is matched to the folder, handle according to RCM 9.6.54.

B. Reason Code "B - Entitlement - Courtesy Disbursement Before Status" and "C - Entitlement Issue Courtesy Disbursement After Status"

Treasury should release claim forms and photocopies directly to the payee in these cases. Treasury will notify the payee directly on the disposition of his claim. If any claim forms are received in these cases, release the claim forms directly to the payee and send the folder to claim files. No further action is necessary.

C. Reason Code "D - Entitlement - Agency Will Recertify After Status" - If Treasury sends a Claims Document to the RRB for forwarding to the payee, and the original request was for reason code "D", take the following action:

- File both copies of the Claims Document (pages 1 & 2) in the claim folder.
- Release the TFS-1133 instructions and claim form (pages 3 & 4), along with the photocopy, to the payee.
- Notate page 1 of the Claims Document with the date of release and send the folder to claim files. No further action is necessary.

D. Reason Code "F - Non-Entitlement", "S - Agency Match-Non-Entitlement" and "U - Reclamation - Legal Incapacitation" - If Treasury sends a Claims Document to the RRB for forwarding to the payee and the original request was for either "F", "S", or "U", take the following action:

- File both copies of the Claims Document (pages 1 & 2) in the claim folder.
- Make a copy of the check for the folder for possible overpayment recovery action.
- Release the TFS-1133 instructions and claim form (pages 3 & 4), along with the photocopy, to the payee through the appropriate field office.
- Enter the amount of the payment to accounts receivable.
- Establish a tickler call-up, reason code 01 followed by the unit code (e.g. RPS would use "01-01"), for 90 days to control for receipt of the completed TFS-1133.

NOTE: Do not trace for the completed claim form when the call-up expires, see section 9.6.34.

E. Reason Code "G - Lost/Stolen - Endorsed" - Treasury will send a Claims Document to the RRB for forwarding to the payee.

- File both copies of the Claims Document (pages 1 & 2) in the claim folder.
- Release the TFS-1133 instructions and claim form (pages 3 & 4), along with the photocopy, to the payee.
- Notate page 1 of the Claim Document with the date of release and send the folder to claim files. No further action is necessary.

9.6.32 Reviewing Completed Claim Forms

When the completed TFS-1133 claim form is returned by the payee, request the claim folder through AFCS. Do not send the TFS-1133 to claim files for the folder. Review the claim form for completeness. Verify that:

- all of the questions on the front and back of the form have been answered; and
- the payee or representative payee has signed the claim in the required places (if the check is drawn jointly, both payees must sign); and
- the payee's signature, if made by mark, has been witnessed.

- A. Properly Completed Claim Forms - Send properly completed forms to: Financial Management Service, Adjudication Division - Check Claims, Room 800 D, P.O. Box 1849, Hyattsville, MD 20788. Attach both the CCG copy of the Claims Document (page 2) and the photocopy of the check to the completed claim form (page 4). File the RRB copy of the Claims Document (page 1) on the right side of the claim folder. Note the date the package was returned to Treasury and establish a new (16-09) tickler call-up for 6 months.
- B. Payee Admits Negotiating the Check - In cases where the payee admits negotiating the check or authorizing its negotiation, or where the payee does not return the claim form, Treasury will not take further action. If the accounts receivable record has been established in the case, route the folder to the appropriate adjudicating unit for recovery of the overpayment.
- C. Payee Claims Address Error - If the payee claims to have never lived or received mail at the check address, review the case to determine when and why the address was changed. If it appears that the wrong address was changed (the check was mailed to and received by a person of the same name residing at the check address), send the case to PP & PAS.

If the check address appears correct according to our records, attach a photocopy of the change of address request to the TFS-1133 claim form and return it to the address shown in section A on the previous page. Attach both the CCG copy of the Claims Document (page 2) and the photocopy of the check to the completed claims form. File the RRB copy of the Claims Document (page 1) on the right side of the claim folder. Note the date the package was returned to Treasury and establish a new (16-09) tickler call-up for 6 months.

9.6.33 Adjudicating TFS-1133 Claims On Paid Checks

Treasury will continue to have the responsibility to finally adjudicate paid check claims, referring apparent forgeries to Secret Service to investigate the circumstances surrounding negotiation of the check and reclaiming against the bank that presented the check.

The adjudication process at Treasury begins when CCG receives the completed TFS-1133 claim form, the CCG copy of the Claims Document and the photocopy of the check. CCG will analyze the payee's signature and other information from the TFS-1133 to determine the validity of the claim.

- A. Payee Involved in Negotiation of the Check - If Treasury determines that the endorsement was not forged (i.e., the intended recipient actually negotiated the check) the claim will be denied. Treasury will notify RRB of this denial. If this denial results in an overpayment (payee was not entitled to the check, RRB issued a replacement check, etc.) RRB must recover the overpayment. In cases where Treasury has been in direct contact with the payee/claimant, a denial notice will also be sent directly to the payee.

- B. Payee Was Not Involved in the Negotiation of the Check-Forgery - Upon receipt of the completed TFS-1133, Treasury will conduct a forgery investigation. Where they determine that the payee does not appear to have been involved in the negotiation of the check and he was entitled to the check, Treasury will seek to recover the amount of the original check through the banking system and issue a settlement check directly to the payee or forward the credit to RRB for reissuance of a replacement check.

In some involved cases, Treasury will advise that further investigation is necessary. Because of the length of time required for Treasury to complete a forgery investigation, it may take as long as two years from the date the stop payment request was processed to resolve the case and send the credit to RRB.

9.6.34 Action When The Erroneous Payments Tickler Call-Up Expires

When the tickler call-up expires, the adjudication unit examiner will review the case to determine if the completed TFS-1133 has been matched to the folder. If the completed TFS-1133 has been matched to the folder, see section 9.6.32.

If the claim form is not returned to the RRB, assume the payee negotiated the check or authorized its negotiation. Request recovery of the existing overpayment if an overpayment letter was never released, (see section 9.6.54 if double payments are involved and section 9.6.55 if there is a payment over cancellation). If reclamation was initiated after normal overpayment recovery methods were exhausted, refer the claim to OPR.

9.6.40 Treasury Receivable, Accounting And Collection System (TRACS)

The Treasury Receivable, Accounting and Collection System (TRACS) handles all accounting, billing and collection activities associated with the check claims process; initiating automated credits and charges to the RRB Budget Clearing Account. The credits received from TRACS are for Unavailable Check Cancellations (UCCs) from paper SF-1184s, Limited Payability Cancellations and Reclamation Credits on not-due checks paid (cashed) after the death of an annuitant. The charges are for Payments-Over-Cancellations (POCs).

All credit/charge detail information is received on magnetic tape and all credit/charge summary information is received over the Government On-Line Accounting Link System/On-Line Payment and Collection System (GOALS/OPAC). The Bureau of Fiscal Operations (BFO) is responsible for balancing and distributing the money to the correct RRB appropriation account.

9.6.41 ORSP Processing Of TRACS Transactions

Treasury will forward a separate tape for each TRACS transaction; Unavailable Check Cancellation (UCC) credits, Payment-Over-Cancellation (POC) Reclamation Credits and Limited Payability Cancellations. The Limited Payability Cancellation tape is processed through the DAISY/CHICO system (see section 9.6.27). The tape containing UCCs, POCs and Reclamation Credits is processed through the Automated Stop Payment System. Three types of output are then generated; the credit/charge folder notice (see exhibit 13), the credit/charge status listing (see exhibit 14) and a separate detail listing of each transaction type (see exhibit 15).

- A. Folder Notice - A folder notice will be produced for every item on a transaction tape. It will contain the schedule number, the transaction date and all of the detail information; the claim number, payee code, payee name, check number and symbol, check date and the credit or charge amount. A status message and a reason code will only be provided for UCCs and POCs. See section 9.6.43 for an explanation of the status messages.
- B. Status List - The information from each TRACS transaction will be accumulated on a credit/charge status listing. This listing is kept in PSG. It will contain the schedule number, the transaction date and all of the detail information; the claim number, payee code, payee name, check number and symbol, check date and the credit or charge amount. A status message and a reason code will only be provided for UCCs and POCs. See section 9.6.43 for an explanation of the status messages.
- C. Detail Listing - A detail listing showing all credits/charges will be produced for each TRACS transaction type; UCCs, POCs and Reclamation Credits. These listings are kept in PSG. Each list will contain the schedule number, the transaction date, the claim number, payee code, payee name, check number and symbol, check date and the credit or charge amount.

9.6.42 Distributing Automated Stop Payment Credit/Charge Folder Notices

The Credit/Charge folder notices will be received in the payment services group (PSG). PSG personnel will take the following actions:

- Sort the folder notices by stop reason code, and match them to the appropriate form FMS-3858 forwarded from Treasury. Form FMS-3858 will be produced for charges only; any credit folder notices should be forwarded to the appropriate unit with Form G-98. If a folder notice or FMS-3858 is received for the bureau of unemployment and sickness insurance or for the bureau of fiscal operations, it is to be forwarded to the respective bureau.

- Request the claim folder for all FMS-3858s received with stop reason code B or C. Access the Treasury Tie File to obtain a printout of the replacement check data. Review the claim folder for the return of the replacement check. If not found, check the cancelled check listing. If the replacement check was returned, no further action is necessary. If the replacement check was not returned, follow the instructions in section 9.6.55A.
- Route folder notices and associated forms FMS-3858 according to the beneficiary symbol and prefix (BSP) shown on the folder notice or the check copy attached to the FMS-3858. BSP of A or MA should be routed to the retirement post section (RPS). All others should be routed to SPS.

Instructions for the handling of these charges in the adjudication units and PSG are found in sections 9.6.55 and 9.6.56.

9.6.43 Processing Credits And Charges

In addition to identifying the credits and charges, Treasury will send the following status messages via TRACS on the Unavailable Check Cancellation (UCC) tape and the Payment-Over-Cancellation (POC) tape. These messages will appear on the folder notice and the status list.

A. Credits

- OUTSTANDING - CHECK CANCELLED; AGENCY CREDIT TO FOLLOW.

This is the only credit message. The check requested has not been cashed. The credit can be used to reduce an open accounts receivable balance, issue a replacement check, or pay the accrued annuity to a survivor, as necessary. Treasury will use this message for requests coded "A - entitlement - agency recertified before status", "D" - entitlement - agency will recertify after status, "E-deceased", "F-non-entitlement", "G-lost/stolen-endorsed", "S-agency match-non-entitlement", "T-agency match-deceased" and "U-legal incapacitation."

NOTE: This code is used infrequently. Credits are normally received at RRB on the cancellation tape as code 90 or code 99.

B. Charges

- BOTH CHECKS PAID - CHARGE TO AGENCY; PHOTOCOPIES AND CLAIM ATTACHED.

Treasury will use this message with a charge item when both the original and replacement check have been cashed. This code will only be sent when Treasury released the replacement check (request codes "B-entitlement-issue

Courtesy Disbursement before status" and "C-entitlement-issue Courtesy Disbursement after status"). See section 9.6.54 for further instructions.

- PAYMENT-OVER-CANCELLATION-REVERSAL OF PREVIOUS AGENCY CREDIT TO RFC BY SF-215 PHOTOCOPY AND CLAIM ATTACHED.

Treasury will use this charge message when they previously returned credit to the RRB for a check and it has now been processed for payment. This message will also be used when Treasury issued a replacement check and the original check is subsequently processed for payment. This code will be used for requests coded "A-entitlement-agency recertified before status" "B-entitlement - issue Courtesy Disbursement before status", "C-entitlement - issue Courtesy Disbursement after status", "D-entitlement -agency will recertify after status", "F-non-entitlement", "S-agency match-non-entitlement" and "U-legal incapacitation". See section 9.6.55 for further instructions.

- PAYMENT-OVER-CANCELLATION-REVERSAL OF PREVIOUS AGENCY CREDIT TO RFC BY SF-215 PHOTOCOPY AND CLAIM ATTACHED; ENDORSEMENT MAY PROHIBIT CLAIMS ACTION.

Treasury will use this charge message when they previously returned credit to the RRB for a check and now it has been processed for payment. This code will only be used for requests coded "G-lost/stolen-endorsed." See section 9.6.55 for further instructions.

- PAYMENT-OVER-CANCELLATION-REVERSAL OF PREVIOUS AGENCY CREDIT TO RFC BY SF-215; PHOTOCOPY USED FOR CCG RECLAMATION ON DECEASED STOP.

Treasury will use this charge message when they previously returned credit to the RRB for a check and now it has been processed for payment. Treasury's check claims group (CCG) will seek to recover the check through the banking system. If successful, credit will be sent to the RRB with the regular reclamation credits via TRACS. This code will be used for requests coded "E-deceased" and "T-agency match-deceased".

- THIRD PAYMENT AGAINST CHECK; CHARGE TO AGENCY WITH PHOTOCOPIES AND CLAIM ATTACHED. PREVIOUS AGENCY CREDIT TO RFC BY SF-215.

Treasury will use this code when both the original and the replacement checks have been paid after credit for the original check was returned to RRB. This code will be sent when RRB sent a request "C-entitlement-issue Courtesy Disbursement after status" for the replacement check and received credit because the original and replacement checks had not been paid (cashed). There should be a previous Automated Stop Payment Credit/Charge folder notice in file showing either "PAYMENT-OVER-

CANCELLATION REVERSAL OF PREVIOUS AGENCY CREDIT TO RFC BY SF-215; PHOTOCOPY AND CLAIM ATTACHED." or "BOTH CHECKS PAID-CHARGE TO AGENCY; PHOTOCOPIES AND CLAIMS ATTACHED." See section 9.6.55 for further instructions.

9.6.44 Updating The Accounts Receivable Record

When an Unavailable Check Cancellation (UCC) credit or a reclamation credit is received via TRACS or, a TFS-133 or TFS-135 is received from Treasury or, a cash refund is received via LOCK BOX, PSG will update the accounts receivable record. Claims examiners and/or development clerks must update the accounts receivable record in the situations described below.

- A. Establishing An Accounts Receivable Balance - Create an open accounts receivable record whenever:
 - An Automated Stop Payment Credit/Charge folder notice is received showing that the check was paid over a cancellation (credit was previously given to RRB).
 - An Automated Stop Payment Credit/Charge folder notice of a double payment is received (payee cashed both the original and replacement checks).
- B. Clearing an Accounts Receivable Balance - Update the accounts receivable record whenever:
 - A Notice of Cancelled Check (green sheet) is received or the outstanding check appears on the Cancelled Check listing.
 - The overpayment is written-off to uncollectible (this can only be done by OPR).
 - The overpayment is recovered from due benefits (annuity withholding, LSDP or accrued annuities).

NOTE: Refer to RCM 9.10 for instructions on establishing, clearing and modifying an accounts receivable balance.

9.6.50 Cancelling A Stop Payment Request

There will be instances where the RRB must request the Treasury Department to abandon the stop payment action. This situation usually occurs if the examiner submits a G-333 or FAST-PI request and any of the following occur:

- A refund is received from the estate or financial organization, or
- The stop payment request was prepared in error, or

- The incorrect date of the missing check was reported, or
- The original check was located.

Requests to terminate a stop payment request must be made in writing and include: the reason for abandoning the stop payment action, the date of the payment, the amount of the payment, the name of payee, the check number and check symbol. The completed check description information can be obtained from either PI STATUS, the Payment Investigation Folder Record or the Status of Non-Receipt Claims/Cancellation Requests list. The request to terminate a stop payment request should also show the "date of referral", use the processing date (PROC DT) from PI STATUS the status list or folder record.

- A. Direct Deposit/EFT Payment - If the stop payment request was submitted for a DD/EFT payment, the processing will be done by the Chicago Financial Center. Notice to terminate the stop payment action for a DD/EFT request must be sent to the Chicago Financial Center (CFC). Prepare an RL-78d; complete the payment identification section, mark the appropriate box, and release the letter.
- B. Check Cases - If the stop payment request was submitted for a check case, the processing will be done by the check claims group (CCG) in Hyattsville, MD. Notice to terminate the stop payment action for a check request must be sent to CCG. Prepare an RL-78; complete the check identification section, mark the appropriate box and release the letter to Treasury.

9.6.51 Non-Receipt Of A Courtesy Disbursement (Replacement Check)

When a claimant reports that he still has not received a replacement check for a check previously reported as missing, the payment services unit (PSU) will take the following action: Check the status of Non-Receipt Claims/Cancellation Requests listing for the request. Verify that the request was correctly submitted and that a replacement check was requested, reason code "B-entitlement-issue Courtesy Disbursement before status" or "C-entitlement - issue Courtesy Disbursement after status."

- A. Request Incorrectly Submitted - If the G-333 request or FAST transaction was submitted with incorrect information (wrong check date or wrong reason code), submit a new G-333 or FAST transaction with the correct information.
- B. Status Reply Not Received - If a status reply from Washington has not been received on the request and more than 30 days have elapsed since the processing date (PROC DT), release an RL-78 to Treasury. If less than 30 days have elapsed, release an RL-77 to the claimant showing that Treasury has been requested to investigate and he can expect to hear from that office.
- C. Status Shows Check Paid - If the status of the check shows "PAID-PHOTOCOPY AND CLAIM TO FOLLOW", release an RL-77 to the claimant advising that Treasury is handling the claim.

- D. Status Shows Check is Outstanding - If the status of the check shows either "OUTSTANDING-COURTESY DISBURSEMENT ISSUED" or "OUTSTANDING-COURTESY DISBURSEMENT ISSUED BEFORE STATUS", access Treasury's Tie File for the exact check number and check issue date of the Courtesy Disbursement. If the date of the claimant's inquiry is more than one week from the check issue date of the Courtesy Disbursement, prepare a new G-333 or FAST transaction using reason code C. If the date of the claimant's inquiry is less than one week from the check issue date of the Courtesy Disbursement, release an RL-77 to the claimant advising that Treasury is handling the claim.

9.6.52 Courtesy Disbursement Or Replacement Checks Returned

Courtesy Disbursement or Replacement checks issued as a result of non-receipt processing, should be routed to the Chicago Financial Center (CFC) in the same manner as regular checks. After CFC processing, these checks will appear on the Cancelled Check Listing showing the word REPLACE in the TYPE PAYMENT column. Processing of a replacement check in the DAISY system will not cause suspension or termination unless the check is returned as undeliverable (98), or because the payee died (01, 41, 51).

9.6.53 Original Check Returned To The RRB - Stop Payment Request Pending

A payee might return the original check when he has submitted a request for a replacement check. If an original check is returned, route the check to Chicago Financial Center in the same manner as regular checks.

9.6.54 Double Payments - Original And Replacement Cashed

A double payment occurs when:

- Treasury authorizes and issues a settlement (replacement) check to a payee based on the payee submitting a completed claim form (FMS-1133) and Treasury later determines that the payee cashed both the original and the replacement checks; or,
- The RRB authorizes Treasury to issue a replacement check based on a non-receipt claim filed by the payee (stop reason code C processing) and the payee receives and cash both the original and the replacement checks. At the time a replacement check is issued, the payee is advised not to cash both the original and replacement checks. The payee may still receive and cash both checks even though the stop payment request was processed.

These double payment overpayments require due process and must be recovered by full withholding, credit card payment or cash refund. The RRB is responsible for recovering the overpayment from the payee.

- A. Treasury Authorized Replacement Check - Treasury will use an SF-1081 Voucher and Schedule of Withdrawals and Credits to notify RRB of double payments on cases where they have determine that the payee has cashed both the original and the replacement checks. The amount of the duplicate payment will have been charged to the RRB. The SF-1081 will be accompanied by photocopies of both checks. Since the overpayment resulted from a false claim submitted by the payee, a claim form will not accompany the photocopies. The SF-1081 will be received in the payment services group (PSU) and sent to the appropriate adjudication unit for handling.

The examiner should take the following action:

- Prepare code letter 1855. Show the name and phone number of the appropriate field office on the letter. Release the letter to the payee.
- Enter the amount of the overpayment to the accounts receivable.
- Authorize and recover the overpayment in the usual manner.

- B. RRB Authorized Replacement Check--If Treasury notified the RRB of a double payment via TRACS, an Automated Stop Payment Credit/Charge folder notice will be generated. The amount of the duplicate payment will have been charged to the RRB. Treasury will furnish copies of both checks with a claim form to the RRB. PSU will send the credit/charge folder notice, photocopies and claim form to the appropriate unit for handling.

The examiner should take the following action:

- Prepare code letter 1855. Show the name and phone number of the appropriate field office on the letter.
- Prepare a memorandum modeled after Exhibit 16 to the appropriate field office.

NOTE: If the check is more than a year old, modify the memorandum to the field advising them to return the completed claim form and photocopies to headquarters and not to Treasury. Upon receipt, forward the completed claim form and photocopies to RRA PAS for further handling.

- Attach the Claims Document package and photocopies, along with a copy of the overpayment letter, to the field office memorandum.
- Enter the amount of the overpayment to the accounts receivable.
- Authorize and recover the overpayment in the usual manner.

- C. When SS Benefits Are Involved - When Treasury reports that a payee cashed both his original and replacement RR/SS BEN check, recover the RR portion of

the overpayment according to the applicable instructions described above in sections A or B (do not apply tolerance to the RR amount if the amount is at/below the tolerance rate) and prepare and release Form RR-3pc to the SSA Program Service Center that has jurisdiction of the SSA claim number (see RCM 10.5). File a copy of the RR-3pc in the folder.

Set a 90 day call-up for a reply from SSA. If no reply to the RR-3pc has been received when the call-up expires, release a second RR-3pc to the program service center.

D. Processing Returned G-66's - Form G-66 is an enclosure with the code letter 1855 overpayment notice. Process the returned G-66's in the following manner:

1. Review of the Facts - In reviewing the facts, consider as evidence the photocopies of the paid checks, provided by Treasury. Also consider the fact that the payee either neglected to complete the claim form or that Treasury determined that the annuitant signed both checks. If the claim form is not completed and returned to RRB until this time, send it to Treasury according to section 9.6.32.
2. Waiver Consideration - In considering waiver, keep in mind that since Treasury determined that the annuitant signed both checks, the annuitant is considered to be at fault. The photocopies of the paid checks serve as evidence of this. If the claim form is not completed and returned to RRB until the waiver consideration was requested, route the completed claim form to Treasury according to section 9.6.32.
3. Personal Conference - Be sure that the evidence presented at the personal conference includes the photocopies of the paid checks provided by Treasury. If after viewing the photocopies, the payee disputes the fact that he signed both checks, the payee must complete the claim forms to be referred back to Treasury for resolution of the disagreement.

NOTE: If the check is more than a year old and the payee denies negotiating the check, the payee must complete the claim form. Forward the completed claim form and photocopies to RRA PAS for further handling.

E. Original Check Endorsed Prior to Being Lost or Stolen - If the check was endorsed by the claimant prior to being lost or stolen, the beneficiary is liable for the amount of the check. If the original check, and the replacement check are both cashed, the beneficiary is liable for the amount of the overpayment since the original check bears the genuine endorsement of the payee.

9.6.55 Payment Made Over Cancellation

After a payment has been cancelled and credit passed to the agency, it is possible that the check will be subsequently presented for payment. If a check does come in for payment after a cancellation, Treasury will honor the check and reverse the cancellation. They will debit the RRB account, send notice via TRACS and send a photocopy of the check. Take the following actions:

- A. RRB Must Recover the Overpayment - Treasury will use one of the following status messages when they expect RRB to recover the amount of an overpayment caused by payment of a check over cancellation. PSU will send the credit/charge folder notice, photocopies and claim form to the appropriate unit for handling, after determining that an overpayment exists, as explained below.
 1. PAYMENT-OVER-CANCELLATION-REVERSAL OF PREVIOUS AGENCY CREDIT TO RFC BY SF-215; PHOTOCOPY AND CLAIM ATTACHED - Treasury will use this message when the original request was prepared using any of the following reason codes:
 - A - Entitlement - RRB Recertified Before Status
 - B - Entitlement - Issue Courtesy Disbursement Before Status
 - C - Entitlement - Issue Courtesy Disbursement After Status
 - D - Entitlement - RRB will Recertify After Status
 - F - Non-Entitlement
 - S - Agency Match - Non-Entitlement
 - U - Legal Incapacitation
 - a. Non-Receipt Claims - Reason Codes A, B, C or D - When Treasury reverses a cancellation credit previously forwarded to the RRB in response to a non-receipt claim, the status of the replacement check must be determined. File the Claims Document package (pages 1 through 4 and photocopy) in the claim folder, and check the folder and the cancelled check listings to determine if the replacement check was returned.
 - If the replacement check was returned, notate the Claims Document accordingly and take no further action.
 - If the replacement check was issued by RRB (see RCM 9.6.56), and there is no record that the replacement check has been

returned, prepare Form G-333 or FAST-PI transaction, reason code F, for the replacement check.

Note: If this reversal is received before RRB released a replacement check, the previous cancellation credit balances this charge. Clear the open accounts receivable amount using action out code 88A and send the case to claim files.

- If the replacement check was issued by Treasury (reason codes B or C), and there is no record that the replacement check has been returned, enter a FAST-Payment Investigation transaction, reason code F, according to RCM 9.7.82. Enter a 9 in the PAYMENT TYPE field, and the replacement check number in the FIRST CHECK NO field. The replacement check number is listed as the NEW SERIAL NUMBER on the COURTESY DISBURSEMENT TIE FILE INQUIRY printout attached to the claims document package.
- Enter the amount of the payment to accounts receivable and control the case for Treasury's response.
- If Treasury finds that the replacement check is outstanding (uncashed) the payment will be cancelled and credit forwarded to RRB on the cancelled check tape (Code 90). When the Notice of Cancelled Check (green sheet) is matched to the folder, modify the open accounts receivable balance (see RCM 9.10 for PAR instructions). No further action is necessary.
- If Treasury finds that the replacement check is paid (cash) a Claims Document package will be forwarded to the RRB. When the package is matched to the file, prepare code letter 1855 and a memorandum, to the appropriate field office, modeled after Exhibit 16. Show the name and phone number of the field office on the letter. Attach the Claims Document packages and photocopies of original and replacement checks, along with a copy of the overpayment letter, to the field office memorandum. Authorize and recover the overpayment in the usual manner.

Exception: When the annuitant is residing in a foreign country, modify code letter 1855 and release the claim forms and photocopies with the letter.

- b. Reclamation - Reason Codes F, S, or U - When Treasury reverses a cancellation credit previously forwarded to the RRB in response to a reclamation action (reason codes F, S, or U), forward the claim form (pages 3 and 4) and photocopy to the payee according to RCM 9.6.31 and take the following action:

- If the payee completes the claim form, refer to RCM 9.6.32 for further instructions.
- If the tickler call-up expires and the claim form has not been returned, the overpayment must be recovered from the annuitant by full withholding. Due process must be given. Prepare and release an overpayment letter based upon code letter 1855.

If there is no source of recovery, refer the case to DRD for a decision on write-off to uncollectible.

2. **PAYMENT-OVER-CANCELLATION-REVERSAL OF PREVIOUS AGENCY CREDIT TO RFC BY SF-215. PHOTOCOPY AND CLAIM ATTACHED; ENDORSEMENT MAY PROHIBIT CLAIM ACTION -** Treasury will only use this message when the original request was coded "G-lost/stolen-endorsed." If it was not done, enter the amount of the charge to accounts receivable. The examiner should release the claim form and photocopies to the payee according to section 9.6.31. If the payee completes the claim form, refer to section 9.6.32 for further instruction. If the tickler call-up expires and the claim form has not been returned, the overpayment must be recovered from the annuitant by full withholding. Due process must be given. The examiner should prepare and release an overpayment letter based upon code letter 1855. If the RRB issued the replacement check, change the reference to a Treasury issued substitute check.

Note: If this reversal is received before RRB released a replacement check, the previous cancellation credit balances this charge. Clear the open accounts receivable amount using action out code 88A and send the case to claim files.

If the payee is no longer entitled and there is no source of recovery, refer the case to DRD for a decision on write-off to uncollectible.

3. **THIRD PAYMENT AGAINST CHECK; CHARGE TO AGENCY WITH PHOTOCOPIES AND CLAIM ATTACHED. PREVIOUS AGENCY REVERSAL TO RFC BY SF-215 -** Treasury will use the message when:
 - The RRB sent a request code "C-entitlement-issue-Courtesy Disbursement after status to trace a previous "B-entitlement-issue Courtesy Disbursement before status" or "C-entitlement-issue Courtesy Disbursement after status" requests; and
 - Treasury sent credit for the check because the original and replacement checks were not paid when the non-receipt request for the replacement check was processed; and

- Both the original and the replacement checks have been cashed.

Treasury considers the three payments to be: the original check, the replacement check and the cancellation credit. The payee is only overpaid twice and if the cancellation credit was never used to issue a replacement check or reduce an overpayment, only one check must be recovered from the payee.

When the Credit/Charge folder notice is matched to the claim file, the examiner should enter the amount of the charge to accounts receivable. There should be a previous Automated Stop Payment Credit/Charge folder notice in file showing either "PAYMENT-OVER-CANCELLATION-REVERSAL OF PREVIOUS AGENCY CREDIT TO RFC BY SF-215; PHOTOCOPY AND CLAIM ATTACHED" or "BOTH CHECKS PAID-CHARGE TO AGENCY; PHOTOCOPIES AND CLAIMS ATTACHED." Check the status of the overpayment recovery on the previous charge.

- Recovery Is Complete - If recovery of the previous overpayment is complete, release the new claim form and photocopies to the payee according to section 9.6.54B. If the tickler call-up expires and the claim form has not been returned, the overpayment must be recovered from the annuitant by full withholding.
- First Overpayment Notice Never Released - If the overpayment letter for the first Treasury charge was never released, release the new claim form and photocopies to the payee according to section 9.6.54B before continuing to recover the first overpayment. If the tickler call-up expires and the claim form has not been returned, the entire overpayment must be recovered from the annuitant by full withholding.
- Overpayment Letter Released - No Recovery - If the overpayment letter for the first Treasury charge was released but the recovery has not begun, prepare a new overpayment letter based upon code letter 1855 and describing both payments. Release the letter according to RCM 9.6.54B. If the tickler call-up expires and the claim form has not been returned, the entire overpayment must be recovered from the annuitant by full withholding.

Note: If this third payment charge is received before RRB released a replacement check and the cancellation credit was never used to reduce an overpayment, the cancellation credit can be used to recover this charge. Clear the open accounts receivable using action out code 88A. If there is any doubt, refer the case to RRA PAS.

If the payee is no longer entitled and there is no source of recovery, refer the case to DRD for a decision on write-off to uncollectible.

- B. Treasury Will Attempt Recovery - When the original request was coded either "E-deceased" or "T-agency match-deceased", Treasury will use the photocopies to seek recovery of the overpayment through the banking system. Treasury will send the status message, "PAYMENT-OVER-CANCELLATION-REVERSAL OF PREVIOUS AGENCY CREDIT TO RFC BY SF-215; PHOTOCOPY USED FOR CCG RECLAMATION ON DECEASED STOP." PSU will send the Credit/Charge folder notice to the appropriate unit for handling.

If it was not done, enter the amount of the charge to accounts receivable. Set a six month tickler call-up (16-09) and handle the case like a regular reclamation. If Treasury is successful in recovering the money, credit will be sent to the RRB with the regular reclamation credits via TRACS.

9.6.56 RRB Issued Replacement Checks

There are instances where Treasury will not issue a replacement check even if the payee is entitled and check status is unpaid in their system.

- A. Requests coded "A-entitlement - agency recertified before status" "D-entitlement - agency will recertify after status", "G-lost/stolen-endorsed" and in certain instances "C-Entitlement - issue Courtesy Disbursement after status" - If Treasury is unable, for any reason, to process a reason code "C" entitlement (non-receipt) claim within 4 business days, the reason code will be converted to "D - entitlement-agency will Recertify After Status". When this is the case, Treasury will transfer credit to RRB on the cancelled check tape if the original payment is determined to be outstanding (uncashed).

If an Automated Stop Payment Credit/Charge folder notice showing "OUTSTANDING-CHECK CANCELLED; AGENCY CREDIT TO FOLLOW", or a Non-Receipt Claim Credit notice showing Cause Code 99 is matched to the file, the RRB may have to release a replacement check to the payee. Determine if the payee is entitled to the proceeds of the cancelled check. If so, prepare an OPO award for the replacement check. Treat the payment as a non-taxable amount. If the credit includes a supp amount, prepare a separate award to transfer the supp amount, paid out in the OPO, back to the RR fund. In the remarks section of the award form show "REPLACES CHECK DATED (date of the original check)." Prepare an ALTA letter to the payee explaining the replacement check and warning the payee not to cash both the original and replacement checks.

Note: If an inquiry is received on a non-receipt claim, check the status of the claim on the "Non-Receipt Claims/Cancellation Requests" listing or PI STATUS. If the status message shows "OUTSTANDING-CHECK CANCELLED; AGENCY CREDIT TO FOLLOW", release a replacement payment according to the above

guidelines. Control the case until the Non-Receipt Claim Credit notice - Cause Code 99 (green sheet) is matched to the folder.

- B. Limited Payability Applies - Public Law 100-86 limits the negotiability of U.S. Government checks to a one year period from the check issue date. In cases where a check is cancelled due to limited payability, the issuing agency will reissue the check.

If a Limited Payability Cancellation Notice (green sheet) showing Cause Code 40 is matched to the file or if the PI STATUS message shows "LIMITED PAYABILITY CANCELLATION", determine if the payee is entitled to the proceeds of the cancelled check. If so, prepare an OPO award for the replacement check. Treat the payment as a non-taxable amount including the supp amount, if any. If the credit includes a social security benefit amount, pay the social security amount on SOLAR. In the remarks section of the award show "Code 40-Replaces Check Dated (date of the original check)." Prepare an ALTA letter. Explain to the annuitant that the check must be cashed within a year.

NOTE: Remember to access the Limited Payability Funds Transfer Program so that notification can be sent to BFO.

9.6.57 Tracing Stop Payments

If acknowledgement of a stop payment request is not received from the Chicago Financial Center within thirty days, the Automated Stop Payment system will mechanically generate a duplicate request. The status message will be changed to show "SENT TO TREASURY - SECOND REQUEST."

A. Non-receipt Claims

1. Check Case - When the original request was coded for Treasury to release a replacement check (reason code either "B" or "C"), refer to section 9.6.51 if the payee claims non-receipt of the replacement check. If the payee reports that he never received any reply to his non-receipt claim, check PI STATUS or the Status of Non-Receipt Claims/Cancellation Requests listing. If Treasury fails to advise the RRB of the payment status of the original check for any non-receipt claim ("B"-entitlement-issue Courtesy Disbursement before status" or "G-lost/stolen endorsed") and at least 30 days have elapsed since the processing date (PROC DT), a "NON-RECEIPT FOLLOW UP NEEDED" referral will be produced. Refer to file to RRA PAS.

Note: If the status message on either the Payment Investigation Referral, the Status of Non-Receipt Claims/Cancellation Requests list or PI STATUS shows "DUPLICATE STOP", the payment services unit (PSU) should follow up by releasing Form FMS-3864, Agency Recertification follow up.

2. DD/EFT Payment - When the original request was coded for Treasury to investigate non-receipt of a DD/EFT payment (reason code either "B" or "C"), the Chicago Financial Center (CFC) will release a DD/EFT payment tracer form, FMS-150 to the financial organization. When Treasury and the financial organization resolve the non-receipt issue, the financial organization will send a copy of the complete FMS-150 to the payee. If the payee reports that he has not received either a credit to his account or a copy of the FMS-150, check the Status of Non-Receipt Claims/Cancellation Requests listing or PI STATUS. If the message shown is "EFT PAYMENT TRACED" and at least 45 days have elapsed since the processing date (PROC DT), release a second G-333 or FAST transaction coded with the original reason code. Treasury will process a follow up request with the financial organization. If the payee reports no response to the follow up, PSU should phone the Claims Branch at the Chicago Financial Center to secure status on the case.

Note: If the payment trace number on the second non-receipt claim is different from the payment trace number on the first request, CFC will not have processed a follow up. If the payment numbers are different, do not phone CFC, release another G-333 or FAST transaction to generate follow up action.

B. Reclamation Requests

1. Check Case - When the six month call-up expires for cases in which reclamation has been requested and Treasury has still not credited the RR account with the amount of the check, release an RL-78 to Treasury requesting the status of the credit. Show the processing date (PROC DT) from the status list or folder record or PI STATUS for the "date of referral." Establish a new call-up for 60 days. When the call-up for tracing the RL-78 expires and Treasury still has not credited the RR account, release Form FMS-3864 and establish a 90 day call-up. If no reply is received from the FMS-3864, refer the case to RRA PAS.

Note: If the status message on either the Payment Investigation Referral, the Status of Non-Receipt Claims/Cancellation Requests list or PI STATUS shows "DUPLICATE STOP," the payment services unit (PSU) should follow up by releasing form FMS-3864, Agency Recertification follow-up. Do not release an RL-78 in "DUPLICATE STOP" cases.

2. DD/EFT Payment - When the six-month call-up expires for cases in which reclamation of a DD/EFT payment has been requested and Form FMS-133 has not been received, the payment services group (PSU) will trace by releasing Form Letter RL-78a to the Treasury Chicago Financial Center. Show the processing date (PROC DT) from the status list, folder record or PI STATUS for the "date of referral." Establish a call-up for sixty days from the current date. If a reply is not received to the RL-78a within

the sixty days, send an RL-78a with the "second tracer" box checked. If no reply to the second RL-78a is received from Treasury, refer the case to the Supervisor, Payment Services Unit to trace with the Chicago Financial Center by phone.

Appendices

Appendix A - G-333

Form G-333 is obsolete. Use the FAST-Payment Investigation Entry (PIENTRY) system to initiate non-receipt claims and reclamation, photocopy, and status requests. Refer to RCM 9.7 for PIENTRY instructions.

Appendix B - Department of the Treasury Telephone Contacts - Check Claims Branch

The Department of the Treasury has furnished the Railroad Retirement Board with contact information for the Check Claims Branch:

Telephone: (855) 868-0151

E-mail: check.claims@fms.treas.gov

As a reminder, Treasury records are maintained based on the check symbol and check serial number. This information must be provided when making an inquiry. The check symbol/check serial number can be found on PISTATUS, PACER, the Credit/Charge Folder Notice, the FMS-3858 Claims Document Package, or on the check itself. Contact the Direct Deposit Specialist if you need assistance obtaining this information.

Appendix C - FMS-3864 Instructions

FMS-3864 - (Prepare an original and two copies)

Use

Form FMS-3864 is to be used for trace and follow-up actions with the Department of the Treasury (Treasury) on stop requests or inquiries on paper checks.

IMPORTANT: Treasury requires that agencies use the original, carbonized, multi-page form. Do not use photocopied forms. Treasury will return any follow-up requests that are made on photocopied forms. If additional forms are needed, notify the Planning and Budget Unit (PBU) in the Administrative Operations Section to order the forms from Treasury.

The FMS-3864 is divided into three parts; parts A, B, and C.

PART A: STOP REQUEST INFORMATION - Provides the identifying information of the check in question.

Item	Entry
Date	The date the form is being released to Treasury.
Agency Return Address	Provide the name and address of the Railroad Retirement Board. Also, show your unit designation; i.e., BRB-RPS.
Check Symbol Number	The 4-digit number preceding the check serial number. This number can be found on the FMS-3858 Claims Document.
Check Serial Number	Generally 8 digits. This number can be found on the FMS-3858 Claims Document.
Check Date	The date of the check.
Check Amount	The amount of the check.
Stop Reason Code	The reason a stop was placed on the check. This information can be found on PI STATUS or on the FMS-3858 Claims Document.
DAS Date	The date the Daily Advice of Status was created. This information can be found in the upper left hand corner on the FMS-3858 Claims Document.
Status Code	The numeric number identifying the status of the check followed by a written explanation of the code; i.e., 65 - PAYMENT OVER CANCELLATION-REVERSAL OF PREVIOUS AGENCY CREDIT TO RFC BY 215; PHOTOCOPY AND CLAIM ATTACHED. This information can be found on the FMS-3858 Claims Document.
Payee Name	Self-explanatory.
Agency/Payee ID No.	The railroad claim number.
Agency Location Code (ALC)	Always enter 60009301.
Agency Reference Number	Leave Blank.

PART B: AGENCY REASON FOR FOLLOW-UP - The reason you are tracing with Treasury. Mark the appropriate box. Use item 11 - Other, if the choices provided does not cover your particular follow-up situation.

PART C: RESPONSE TO AGENCY - Treasury will complete this section when responding to your followup request.

Disposition

The original and one copy is to be mailed to Treasury. The address is located in the bottom left hand corner of the form. The remaining copy is to be filed in the claim folder. Establish a 90 day call-up for Treasury's response.

Appendix D - Limited Payability Cancellation Reversals Program Instructions

Use

To notify the Bureau of Fiscal Operations (BFO) when checks issued 10/1/89 and later have been cancelled due to Limited Payability and, the checks have been reissued, used to offset an overpayment, or there is no entitlement to the checks.

- A. Establishing Report in User Follow-up--Before you can forward limited payability cancellation information to BFO, the report screen must be established in the user FOLLOWUP MENU.

Step 1. Enter the Railroad Automated Processing Integrated Database (RRAPID) using normal sign on and password procedures. From the RRAPID menu, select HSL (H) and press ENTER.

Step 2. The message "YOU HAVE NEW MAIL" will appear in the lower left hand corner of your screen. From the HSL menu, select MAIL. The Mail Menu will appear.

Step 3. From the mail menu, select 8, RECEIVE MAIL. The incoming Mail Menu will appear.

Step 4. The cursor will automatically position itself at the ENTER CODE field. From the list, type the numeric code associated with the topic "LIMITED PAY CANCELLATION REVERSALS". Press ENTER.

Step 5. From the options list at the bottom of the screen, type in M (MODIFY) and press ENTER.

Step 6. The cursor will reposition itself at the top of screen. Tab down to the options list and type in S (SEND) and press ENTER. The Send Letter screen will appear.

Step 7. Type in the number "1" on the line that reads "SELECT OPTION TO CHOOSE RECEIVERS" and press ENTER. This action will send the report to your followup menu. To exit the system, press the corresponding numeric code for LOGOFF and press ENTER.

- B. Entering and Sending Data to BFO--Once the report has been properly forwarded to the FOLLOWUP MENU, you can begin entering and sending data to BFO.

Step 1. From the FOLLOWUP MENU, select "LIMITED PAY CANCELLATION REVERSALS".

Step 2. From the options list at the bottom of the screen, type M (MODIFY). Press ENTER.

Step 3. Type in the beneficiary's name and railroad claim number. If the check involves a social security (SS) benefit amount, type in the SS claim number and BIC code.

Step 4. If the check was reissued to the same payee, list the amount of the check under "Entitled Payments" by its components; i.e., Tier 1, Tier 2, VDB, etc.

If: (1) the payee is not entitled to the check, (2) the check is being paid as an accrued annuity, or (3) the check was used to offset an overpayment, list the amount of the check under "Non-Entitled Payments" by its components; i.e., Tier 1, Tier 2, VDB, etc.

NOTE: If SMIB premiums were deducted from the annuity at the time the check was issued, the returned check will be net of SMIB. Unless SMIB was being deducted from the SS benefit, for the purpose of the transfer, the SMIB amount is to be deducted from the Tier 1 benefits. If the SMIB amount is greater than Tier 1, the balance of the SMIB amount is to be subtracted from the Tier 2 and if necessary, from the VDB.

Tax withholding amounts, if any, are to be deducted from the component from which it was withheld.

Step 5. If the check does not include an SS benefit amount, proceed to Step 8. If the check includes an SS benefit amount, press ENTER to page to the next screen.

Step 6. Enter the check number and check date of each check that includes an SS benefit amount.

Step 7. Place an "X" on the line by the SSA Program Service Center (PSC) having jurisdiction over the social security benefit. This information can be found in the claim folder or, refer to RCM 10.6 for a listing of the PSCs by social security numbers.

Step 8. After all entries have been made, TAB to the options list and type S (SEND). Press ENTER. The Send Letter screen will appear.

Step 9. Type in "A LPC REVERSALS" on the line that reads "OR ENTER NAME TO SEND TO ONE PERSON". Press ENTER. The message "LETTER HAS BEEN SENT" will appear in the bottom left hand corner of the screen.

Step 10. To exit, press the up arrow key once, type in the number 1, and press ENTER. The FOLLOWUP MENU will appear. The cursor will position itself at the ENTER CODE field. To exit the system, type the corresponding numeric code for LOGOFF and press ENTER.

Exhibit 19

09/29/95

R E A D L E T T E R

TOPIC: Limited Pay Cancellation Reversals

FROM: J G RICE

Beneficiary Name: _____

RRB Claim Number: _____ SS Claim Number _____

Post Effective Period

(Payments Dated 10/1/89 or Later)

Entitled

Non-Entitled

Type of Funds

Payments

Payments

Tier 1

Tier 2

VDB

Supplemental

OASI

DI

Total

_____	_____
_____	_____
-----	-----

(C)ONTINUE, (D)ELETE, (M)ODIFY, (P)RINT, (Q)UIT, (R)ECEIVERS, OR (S)END: C

NEXT PAGE: 2

Exhibit 20

09/29/95

R E A D L E T T E R

TOPIC: Limited Pay Cancellation Reversals

FROM: J G RICE

Enter the check numbers and check dates ONLY if any of the amounts shown above involve OASI and DI.

Check Number

Check Date

Transfer the SS benefit amount to the PSC indicated by the "X"

_____ Northeastern PSC ALC 28-04-5200

_____ Mid Atlantic PSC ALC 28-04-5300

_____ Southeastern PSC ALC 28-04-5400

_____ Great Lakes PSC ALC 28-04-5500

_____ Mid American PSC ALC 28-04-5600

_____ Western PSC ALC 28-04-5900

_____ BDI ALC 28-04-3000

(C)ONTINUE, (D)ELETE, (M)ODIFY, (P)RINT, (Q)UIT, (R)ECEIVERS, OR (S)END: C

NEXT PAGE: 2

9.7.5 FAST

A. FAST Is an Input Option

The FAST (Field-Address-Suspension-Termination) System accepts change of address (COA), suspension/termination (S/T), and payment investigations (PI) of non-receipt/reclamation/photocopy/status requests, by both headquarters and field personnel. The FAST system can be used in place of input forms G-607, G-96, and SF-1199a. The input forms must be used for transactions which FAST cannot process.

B. FAST Is a RRAPID Database System

FAST is a RRAPID database system that usually interacts with DATA-Q. FAST automatically extracts much of the data required for a transaction from the beneficiary's DATA-Q record. The required remaining data is input via input entry screens. However FAST-PI, under certain circumstances, does allow for direct entry outside of DATA-Q.

C. FAST Prevents Most Errors

Transactions entered through FAST are edited after data has been entered. Transactions are not taken into the database until the data entered by the user has cleared all edits. Errors are identified through error messages displayed on input entry screens. Most errors can be corrected immediately and, thus, most system rejects are prevented.

D. FAST Transactions Create Database Records

All accepted FAST transactions create records, which are stored on a database until they are batched and processed through:

- the DAISY system for change of address and suspension/termination; and,
- the Automated Stop Payment system for non-receipt claims, reclamations, or photocopy and status requests.

All FAST transactions are tracked for purposes of security.

E. Pending FAST Transactions Can Be Viewed and Corrected or Deleted

Pending FAST transactions can be viewed and corrected or deleted, if necessary. Once DAISY or the Automated Stop Payment system processes a FAST transaction, it can no longer be viewed on FAST.

F. Accessing FAST

FAST was developed with a link to DATA-Q. This means FAST can be accessed after you have successfully signed on to DATA-Q and selected the proper beneficiary record that requires action. It is important to make certain that the proper beneficiary has been selected before accessing the particular FAST activity.

- Sign on to DATA-Q in the usual manner;
- Select the proper beneficiary; and,
- Select the appropriate FAST input screen by pressing one of the following PF keys:
 - PF 7 - Suspension/Termination
 - PF 8 - Change of Address/REP Payee
 - PF 9 - Non-receipt Claim
 - PF10 - Direct Deposit/Change of Address

9.7.10 FAST Suspensions and Terminations

The FAST (Field-Address-Suspension-Termination) system is used to enter suspension or termination transactions through the CRT terminal instead of submitting Form G-96. The on-line suspension/termination system does not obsolete Form G-96. Form G-96 must be used only when entry on FAST-S/T is not possible, e.g., terminating constructive awards.

9.7.11 How FAST Processes Suspension/Termination Transactions

When a suspension/termination action is processed through FAST, the user:

- calls up the DATA-Q record of the annuitant or beneficiary whose payment is to be suspended or terminated;
- by pressing the PF-7 key, accesses the suspension/termination input entry screen;
- enters the required information (suspension/termination reason code, effective date, and letter code, if applicable); and
- responds to edit messages, if necessary, until the data is accepted by the system.

The FAST System:

- edits the information entered by the user for consistency;

- When acceptable data has been entered, creates a transaction consisting of the data entered by the user and data that it extracts from DATA-Q (prefix and claim number, payee code, date of birth, and payment rate);
- stores the transaction on the database; and
- selects the transaction at the appropriate time for processing through DAISY.

If the transaction processes successfully through DAISY, DATA-Q is updated for the suspension or termination. If the transaction rejects in DAISY, a reject referral is produced and the suspension/termination must be processed again.

9.7.12 Viewing the Fast Suspension/Termination Entry Screen

Any employee who has access to DATA-Q may view the FAST suspension/termination entry screen to determine if an on-line suspension or termination transaction is pending. To view the suspension/termination data entry screen, first locate the record of the annuitant on DATA-Q whose payment is to be stopped. Then press the PF-7 key. The suspension/termination entry screen will appear. If a suspension/termination transaction is pending on the FAST database, the screen will display the data entered to create that transaction.

9.7.13 Who Can Input FAST Suspension/Termination Transactions

Headquarters and field personnel who have responsibilities for taking suspension and termination actions have security clearance to input FAST Suspension/Termination activities. One must have security clearance access to DATA-Q in order to use FAST-Suspension/Termination. However, a separate security table is maintained which authorizes users to input data into FAST-S/T. If one does not have clearance to input FAST-Suspension/Termination activity, the screen will display the following message:

**** NO PENDING FAST-S/T TRANSACTION - INPUT NOT AUTHORIZED ****

A FAST-S/T security table is maintained within the FAST system to control access to suspension and termination codes. FAST-S/T users at headquarters are authorized to input all suspension and termination codes available for use on Form G-96, with certain restrictions. FAST-S/T users in the field are restricted to use of certain codes. The access levels are detailed in 9.7.14.

9.7.14 Types of Suspensions and Terminations that can be Processed on FAST

When FAST-Suspension/Termination was implemented in August 1987, only a limited number of suspension and termination codes could be entered on FAST. Effective March 1, 1990, FAST-S/T may be used to process any of the suspension and

termination codes used on Form G-96. FAST-S/T users in headquarters and the field have separate levels of access to the codes available on the system.

FAST-S/T users at headquarters are authorized to input all suspension and termination codes available for use on Form G-96, with certain restrictions. Field users have access only to certain codes.

A mechanical program, the FAST-MAP/SURVEA load, is run on a monthly basis to add suspension/termination records from the retirement (MAP) and survivor (SURVEA) monthly attainment programs to the FAST-S/T database. These transactions can be recognized by the USER SIGNON name 'MAP' or 'SURVEA' and the UNIT ID that is equal to the month and year of the MAP/SURVEA run (i.e., 0393).

Suspension and Termination Codes Available to Field Users

FAST-S/T users in the field have access to a limited group of the suspension and termination codes available on FAST-S/T. When the reason for termination is death, the FAST system will continue to automatically terminate the railroad annuity, supplemental annuity, and social security benefit, if any. For reasons other than death, field users may only use FAST-S/T to suspend or terminate the railroad annuity and supplemental annuity, if any. Social Security benefits may not be suspended or terminated, for a reason other than death, by a field user.

FAST-S/T users in the field may use only the following suspension and termination codes:

1. Termination codes

Employee

01 - Employee died

08 Employee disability annuitant recovered

20 RR disability annuitant returned to substantial gainful employment
(Medicare continues)

Spouse

51 - Spouse died

53 - Spouse no longer has child in care

57 - Spouse divorced

- Divorced Spouse remarries

Survivor

20 RR disability annuitant returned to substantial gainful employment (Medicare continues)

41 - Survivor died

44 - Child remarried or adopted

- Widow(er) or parent remarried

45 - Widow does not have entitled child in care or child in care attains age 18

47 - Student ceased full-time attendance

All Payees

61 - Application or award cancelled

2. Suspension codes

Employee

02 - Employee returned to employer service

09 Employee disabled annuitant earned **over** the monthly amount in the current year (example: if 2016 is the current year, the monthly amount is \$880 and if disabled employee annuitant earns over \$880 then suspend using code 09). Refer to the chart in FOM 1 1125.5.2 for the current year's monthly amount.

63 - Employee annuity suspended for representative payee development; also deletes direct deposit, if present.

Spouse

52 - Spouse in employer service

64 - Spouse annuity suspended for representative payee development; also deletes direct deposit, if present.

Survivor

11 - Survivor in employer service

12 - Survivor under age 70 excess earnings

65 - Survivor annuity suspended for representative payee development; also deletes direct deposit, if present.

All Payees

76 – Investigation Abandoned

Suspension and Termination Codes Available to Headquarters Users

Effective February 15, 1990, FAST-S/T users at headquarters have access to all suspension and termination codes available for use on Form G-96, with certain restrictions. Use of code 62 (Deletion of CHICO master record) and code 66 (Suspend annuity to recover overpayment) is restricted to headquarters personnel having responsibility for those functions.

If an annuitant is receiving an employee annuity and a supplemental annuity, a RR suspension or termination will suspend or terminate both annuities. However, if an annuitant is receiving any other combination of two regular monthly RR annuities (e.g., an employee annuity and a widow's annuity), access each DATA-Q record to enter suspension or termination transactions on each annuity.

If suspension or termination action is required on an SS benefit being paid by RRB, (in other than death cases and when requested by SSA), refer the case to the on-site representative.

FAST-S/T users at headquarters may use the following suspension and termination codes:

1. RR Termination codes

Employee

01 - Employee died

08 - Employee disability annuitant recovered

20 - RR disability annuitant returned to substantial gainful employment (Medicare continues)

Spouse

51 - Spouse died

53 - Spouse no longer has child in care

55 - Spouse entitled to greater benefit (remarried widow)

57 - Spouse divorced

- Divorced spouse remarried

59 - Spouse termination - EE's benefit terminated

Survivor

20 - RR disability annuitant returned to substantial gainful employment (Medicare continues)

41 - Survivor died

42 - Survivor child attained age 18

- Survivor disabled child recovered

- Survivor student attained age 19

- Survivor disabled widow recovered

44 - Child remarried or adopted

- Widow or parent remarried

45 - Widow does not have entitled child in care or child in care attains age 18

46 - Survivor entitled to equal or greater benefit

47 - Student ceased FTA

All payees

61 - Application or award cancelled

62 - Deletion of CHICO master record

2. SS Termination codes

SS only

03 - Attainment of age 18 or 22 and not disabled - LAF T4 - BIC C

- Mother term. last child 16 - LAF T4 - BIC other than C

08 - Beneficiary no longer disabled - LAF T8

10 - Entitled to different benefit - LAF T5, AD

13 - Withdrawn or cancelled claim - LAF TR, T+

14 - Student ceased FTA - LAF T6 - BIC C

- Mother term. No child in care - LAF T6 - BIC other than C

15 - Marriage, divorce, remarriage - LAF T3

17 - Primary benefit terminated - LAF T2

21 - RRB no longer has certification

25 - Other - LAF T9, TP, or T0

3. RR or SS Termination codes

Employee

01 - Employee died

Spouse

51 - Spouse died

Survivor

41 - Survivor died

All payees

18 - Garnishment case - terminate third-party payment

62 - Deletion of CHICO master record

4. RR Suspension codes

Employee

02 - Employee returned to employer service

06 - Employee-other

09 - Employee disabled annuitant earned over the current monthly disability earnings limit in a month

63 - Suspend employee annuity and delete direct deposit

Spouse

52 - Spouse in employer service

56 - Spouse-other

58 - Spouse employee benefit suspended

64 - Suspend spouse annuity and delete direct deposit

Survivor

- 11 - Survivor in employer service
- 12 - Survivor under age 70 excess earnings
- 16 - Survivor payee not determined
 - Survivor withdrawn for investigation
 - Survivor-other
- 65 - Suspend survivor annuity and delete direct deposit

All payees

- 54 - Annuity reduced to zero
 - Annuity waived
- 66 - Suspend annuity to recover overpayment
- 67 - Suspend to apply garnishment
- 76 – Investigation Abandoned

5. SS Suspension codesSS only

- 26 - Work and earnings - LAF S2
 - Foreign work and earnings - LAF S1
- 27 - SS primary benefit suspended - LAF S3, S5
- 28 - Rep payee not determined - LAF S8
- 30 - Suspend for investigation - LAF S4
- 31 - Better address required - LAF S6
- 50 - Young mother - no child in care - LAF S4
 - Other - LAF S7, S9, SD, SF, SH, SJ, SK, SL, SM, SP, SW

SS Suspensions - Deferred status

- 71 - Work and earnings - LAF D2

- Foreign work and earnings - LAF D1
- 72 - Aux. ben. withheld due to primary's wk. & earnings - LAF D3
 - Aux. ben. w/h - primary foreign work & earnings - LAF D5
- 73 - Recovery of erroneous payment - LAF D6
- 75 - Young mother - no child in care - LAF D4
 - Receipt of Public Assistance - LAF DP
 - Receipt of Workman's Compensation - LAF DW
 - Deferred-other - LAF D9
- 6. RR or SS Suspension codes
 - All payees
 - 66 - Suspend annuity to recover overpayment
 - 67 - Suspend to apply garnishment

9.7.15 The Function Of The FAST Suspension/Termination Effective Date

FAST suspension/termination transactions require entry of a suspension/termination effective date. The effective date is the first month for which an annuity is not due (not the date of the payment to be stopped). For example, if an employee died on September 2, 1987, 09-02-1987 is entered as the termination effective date, since no annuity is due for the month of September. The effective date is the first month in which entitlement is lost or a suspension event occurs. However, when suspending to develop for a representative payee, the effective date is the month, day, and year in which the RRB became aware of the need to start development action.

The system will accept an effective date that is up to three months after the current month (e.g., in August, it will accept an effective date as late as November). A future effective date may be entered in the following situations:

- employee returns to employer or last person service,
- spouse no longer has child in his/her care, or
- student ceases full-time attendance.

The FAST system determines when to remove the transaction from the database for processing through DAISY based on the effective date. If the effective date is later than

the current month the transaction remains on the database until the end of the month before the effective month. Then the transaction is processed through DAISY so that it stops the appropriate payment.

NOTE: When the FAST transaction is processed through DAISY/CHICO, the “day” field of the effective date is not displayed on DATAQ, only the month and the year is displayed.

9.7.16 Determining Which Payment Will Be Suspended Or Terminated

Which month's payment is suspended or terminated by the FAST transaction depends on the suspension/termination effective date entered and whether the transaction is entered before or after FAST suspension/termination cut-off. The FAST system selects transactions for processing through DAISY based on the suspension/termination effective date.

A. Suspension/Termination Effective Date Is In The Current Month Or Earlier

Transaction is entered before the FAST suspension/termination cut-off: the next monthly payment is stopped.

Example: A suspension transaction with a 09-87 or earlier effective date is entered on 09-02-1987. Payment for the month of September is stopped (10-1 check or EFT payment).

Transaction is entered after FAST cut-off through the end of the month; the payment after the next monthly payment is stopped.

Example: A suspension transaction with a 09-87 or earlier effective date is entered on 09-20-1987. Payment for the month of October is stopped (the 11-1 check or EFT payment).

B. Suspension/Termination Effective Date Is Later Than The Current Month

The payment that would have been due for the effective month of suspension/termination will be stopped.

Example: A suspension transaction with an 11-01-1987 effective date is entered in October. Payment for the month of November will be stopped (12-1 check or EFT payment).

9.7.17 FAST Letters

FAST-S/T can be instructed to release mechanical notices of suspension or termination to the annuitant/beneficiary. FAST letters should be released only when the RR annuity or SS benefit will be reinstated in the month of suspension, or when making a timely termination (i.e., payment for the effective month of termination is stopped). If

termination is not timely, a FAST letter should not be released and a special overpayment and/or adjustment letter must be prepared.

Following are tables listing RR and SS code letters as they correspond to the suspension and termination codes. Following the tables, the text of each code letter is shown, as well as, instructions as to when the letter should be released. Before releasing any letter, be sure to review the instructions and the text of the letter.

RR TERMINATION CODE LETTERS

RR TERM CD	REASON	LTR CODE
01/41/51	Death	---
42	Survivor child attained age 18	503
45	Widow - child attaining 18 <u>not</u> FTS	501
45	Widow - child attaining 18 <u>is</u> FTS	502
45	Wid. - child 18 not FTS-future elig.	515
47	Student ceased FTA	516
47	FTS attained age 19	513
47	FTS graduated	514
53	Sp.-child 18-sp. ent. red. 62 in future	505
53	Sp.-child 18-Sp. ent. full age 60 in future	506
53	Sp.-child 18-Sp. ent red. 60/30 in future	507

RR SUSPENSION CODE LETTERS

RR TERM CD	REASON	LTR CODE
06/16/56	EE/Spouse/Surv. - other	
"	SMIB deductions	151
"	Estimated excess earnings	169
"	Miscellaneous RR/SS	197

"	Miscellaneous RR only	199
66	Susp. to recover overpayment - RR/SS	197
66	Susp. to recover overpayment - RR only	199
67	Susp. to begin garnishment	172
67	Susp. to adjust garnishment	173

SS TERMINATION CODE LETTERS

SS TERM CD	REASON	LAF/BIC	LTR CODE
01/41/51	Death	T1	---
03	Attainment age 18	T4/C	353
03	Attainment age 22	T4/C	355
03	Mother term. last chld 18	T4/Not C	354
03	Mother term. last chld 16	T4/Not C	394
08	Ben. no longer disab.	T8/A	359
08	Ben. no longer disab.	T8/C	360
08	Ben. no longer disab.	T8/Not A or C	361
10	Ent. to different benefit	T5	356
10	Ent. to different benefit	AD	365
13	Withdrawn/Canc. claim	TR,T+	363
14	Student ceased FTA	T6/C	357
14	Mother term. no child in care	T6/Not C	358
15	Marriage/divorce/remarriage	T3	352
17	Primary benefit terminated	T2	351/390
17	Ben. term. - SS ben.	B/C to SSA	391

21	RRB no longer has certification	C	391
2	Other	T9/TP	362

SS SUSPENSION CODE LETTERS

SS SUSP CD	REASON	LAF/BIC	LTR CODE
26	Work and earnings	S2	374
26	Foreign work and earnings	S1	373
27	SS Primary suspended	S3	375
27	SS Prim. susp. (foreign wk.)	S5	377
28	Payee not determined	S8	379
30	Suspend for investigation	SO/A	370
30	Suspend for investigation	SO/C	371
30	Suspend for investigation	SO/Not A or C	372
31	Better address required	S6	---
50	Young mother no chld in care	S4	376
50	Other	S7, S9, SD, SF, SH, SJ, SK, SL, SM, SP, SW	380/198
67	Suspend to begin garnishment	-	172
67	Suspend to adjust garnishment	-	173
71	Work and earnings	D2	382
71	Foreign work and earnings	D1	381
72	SS Primary deferred	D3	383
72	SS Prim. def. foreign wk.	D5	385

73	Recovery of overpayment	D6	386
75	Young mother no chld in care	D4	384
75	Receipt of Public Assistance	DP	388
75	Receipt of Workman's Comp.	DW	389
75	Other	D9	387

- A. RR Suspension Code Letters - When payments will be reinstated in the month of suspension, an entry in the code letter field of the FAST-S/T entry screen will generate a computer-printed RL-176 which will be released to the annuitant. RR suspension letters are detailed below:

Code Letters 151 and 169

A copy of the letter will be sent to the appropriate field office. The standard text of the letters is as follows:

YOUR MONTHLY BENEFITS MUST BE ADJUSTED BECAUSE...

(INSERT)

THIS ADJUSTMENT MAY CAUSE A DELAY IN THE RECEIPT OF YOUR NEXT PAYMENT. HOWEVER, A PAYMENT WILL BE SENT TO YOU AT THE EARLIEST POSSIBLE DATE. SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS ADJUSTMENT, CALL OR WRITE THE BOARD OFFICE NEAREST YOU. THERE IS AN OFFICE LOCATED AT (Address of field office).

The first sentence of the letter will be completed as follows:

Code 151 - MEDICARE PREMIUMS WILL BE DEDUCTED FROM YOUR BENEFITS.

Code 169 - YOUR EXPECTED EARNINGS FOR THIS YEAR WILL EXCEED THE EXEMPT AMOUNT.

Code Letter 172

Use this code letter when suspending an annuity to begin or adjust garnishment withholding. A copy of the letter will be released to the appropriate field office.

YOUR ANNUITY HAS BEEN SUSPENDED TO BEGIN OR ADJUST WITHHOLDING IN ACCORDANCE WITH A GARNISHMENT, ASSIGNMENT, OR COURT-ORDERED PROPERTY DIVISION.

THIS MAY CAUSE A DELAY IN THE RECEIPT OF YOUR NEXT PAYMENT; HOWEVER, A PAYMENT WILL BE SENT TO YOU AT THE EARLIEST POSSIBLE DATE. SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS ADJUSTMENT, CONTACT THE NEAREST RAILROAD RETIREMENT BOARD OFFICE. MOST RAILROAD RETIREMENT BOARD OFFICES ARE OPEN TO THE PUBLIC FROM 9:00 A.M. TO 3:00 P.M. MONDAY THROUGH FRIDAY. IF YOU COME IN PERSON, TAKE THIS NOTICE WITH YOU.

THERE IS AN OFFICE LOCATED AT (Address of field office).

Code Letter 173

Use this code letter when suspending to adjust the amount of the annuity payment being sent to the third-party payee in a garnishment case. A copy of this letter will not be released to the field office.

DUE TO A REDUCTION IN THE AMOUNT OF THE PAYMENT, THERE WILL BE A DELAY IN THE NEXT PAYMENT TO BE MADE IN CONNECTION WITH ENFORCEMENT OF LEGAL PROCESS FOR SUPPORT.

Code Letter 197

Use this code letter whenever suspending the RR portion only of a combined RR/SS payment, and that portion will be reinstated in the month of suspension. Be sure to include the reason for adjustment in the reinstatement award letter. The text of the letter is as follows:

YOUR MONTHLY RAILROAD RETIREMENT ANNUITY MUST BE ADJUSTED. THIS MAY CAUSE A DELAY IN THE RECEIPT OF THE RAILROAD RETIREMENT PORTION OF YOUR NEXT PAYMENT. THE SOCIAL SECURITY PORTION OF YOUR PAYMENT WILL BE RELEASED AS USUAL, WITHOUT DELAY. YOUR RAILROAD RETIREMENT PAYMENT AND AN EXPLANATION WILL BE FORWARDED TO YOU AT THE EARLIEST POSSIBLE DATE.

A copy is not sent to the servicing field office.

Code Letter 199

Use this code letter whenever suspending an RR only annuity, and the annuity will be reinstated in the month of suspension. Be sure to include the reason for adjustment in the reinstatement award letter. The text of the letter is as follows:

YOUR MONTHLY BENEFITS MUST BE ADJUSTED. THIS MAY CAUSE A DELAY IN THE RECEIPT OF YOUR NEXT PAYMENT. A PAYMENT AND AN EXPLANATION OF THE ADJUSTMENT WILL BE SENT AT THE EARLIEST POSSIBLE DATE.

A copy is not sent to the servicing field office.

B. SS Suspension Code Letters

Code Letter 198

Use this code letter when suspending the SS portion only of a combined RR-SS payment and that portion will be reinstated in the month of suspension. Be sure to include the reason for adjustment in the reinstatement award letter. The text of the letter is as follows:

YOUR MONTHLY SOCIAL SECURITY BENEFIT MUST BE ADJUSTED. THIS MAY CAUSE A DELAY IN THE RECEIPT OF THE SOCIAL SECURITY PORTION OF YOUR NEXT PAYMENT. THE RAILROAD RETIREMENT PORTION OF YOUR PAYMENT WILL BE SENT AS USUAL, WITHOUT DELAY. YOUR SOCIAL SECURITY PAYMENT AND AN EXPLANATION WILL BE SENT TO YOU AT THE EARLIEST POSSIBLE DATE.

A copy is not sent to the servicing field office.

SS Suspension Code Letters - (Continued) - Use the following code letters when suspending an RR certified SS benefit. A copy of the letter will be sent to the appropriate RRB field office. The code letter states:

THE SOCIAL SECURITY ADMINISTRATION HAS REQUESTED THE RAILROAD RETIREMENT BOARD TO SUSPEND YOUR BENEFITS

(SEE REASONS LISTED BELOW)

IF YOU BELIEVE THAT THIS DETERMINATION IS NOT CORRECT, YOU MAY REQUEST THAT YOUR CLAIM BE RE-EXAMINED. IF YOU WANT THIS RECONSIDERATION, YOU MUST REQUEST IT NOT LATER THAN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. YOU MAY MAKE YOUR REQUEST THROUGH ANY SOCIAL SECURITY OFFICE. IF ADDITIONAL EVIDENCE IS AVAILABLE, YOU SHOULD SUBMIT IT WITH YOUR REQUEST.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, CONTACT THE NEAREST DISTRICT OFFICE OF THE SOCIAL SECURITY ADMINISTRATION. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE BRING THIS NOTICE AND ALL OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

The first sentence of the letter will be completed as follows:

LETTER	SUSP	SSA LAF	REASON FOR ADJUSTMENT
CODE	CODE	CODE	

370	30	S0 IF BIC=A)	PENDING ADDITIONAL INFORMATION WHICH IS NEEDED TO DETERMINE WHETHER YOU ARE STILL DISABLED.
371	30	S0 (IF BIC=C)	PENDING ADDITIONAL INFORMATION WHICH IS NEEDED TO DETERMINE WHETHER YOU, OR THE PERSON ON WHOSE RECORD YOU RECEIVE BENEFITS, IS STILL DISABLED.
372	30	S0(IF BIC= A OR C)	PENDING ADDITIONAL INFORMATION WHICH IS NEEDED TO DETERMINE WHETHER THE PERSON ON WHOSE RECORD YOU RECEIVE BENEFITS IS STILL DISABLED.
373	26	S1	BECAUSE YOU ARE WORKING OUTSIDE THE UNITED STATES ON 7 OR MORE DAYS DURING A MONTH. IF YOUR WORK PLANS CHANGE, PLEASE NOTIFY ANY SOCIAL SECURITY OFFICE PROMPTLY.
374	26	S2	BASED ON YOUR ESTIMATED EARNINGS FOR THIS YEAR. IF YOUR ESTIMATE OF EARNINGS FOR THE YEAR CHANGES, PLEASE NOTIFY ANY SOCIAL SECURITY OFFICE PROMPTLY.
375	27	S3	BASED ON THE ESTIMATED EARNINGS FOR THE PERSON ON WHOSE SOCIAL SECURITY RECORD YOU RECEIVE BENEFITS.
376	50	S4	BECAUSE YOU NO LONGER HAVE A CHILD IN YOUR CARE ENTITLED TO RECEIVE SOCIAL SECURITY BENEFITS.
377	27	S5	BECAUSE THE PERSON ON WHOSE SOCIAL SECURITY RECORD YOU RECEIVE BENEFITS IS WORKING OUTSIDE THE UNITED STATES ON 7 OR MORE DAYS DURING A MONTH.
379	28	S8	BECAUSE THE SSA IS REVIEWING THE QUESTION OF WHO SHOULD RECEIVE THE SOCIAL SECURITY BENEFITS

PAYABLE ON THIS RECORD. A SOCIAL SECURITY REPRESENTATIVE MAYBE GETTING IN TOUCH WITH YOU ABOUT THIS IF THEY HAVE NOT ALREADY DONE SO. WHEN A DECISION HAS BEEN REACHED, THEY WILL CONTACT YOU.

Code Letter 380

If the reason for adjustment of an SS only case is other than the ones covered by code letters 370 - 379, use letter code 380. This is a miscellaneous code letter which is suitable for SS benefits suspended under LAF codes S7, S9, SD, SF, SH, SJ, SK, SL, SM, SP, or SW. (See RCM 7.4 Appendix B)

The letter states:

THE SOCIAL SECURITY ADMINISTRATION HAS REQUESTED THE RAILROAD RETIREMENT BOARD TO SUSPEND YOUR BENEFITS. YOU WILL BE NOTIFIED AT A LATER DATE AS TO WHEN YOUR BENEFITS CAN BE RESUMED.

IF YOU BELIEVE THAT THIS DETERMINATION IS NOT CORRECT, YOU MAY REQUEST THAT YOUR CLAIM BE REEXAMINED. IF YOU WANT THIS RECONSIDERATION, YOU MUST REQUEST IT NOT LATER THAN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. YOU MAY MAKE YOUR REQUEST THROUGH ANY SOCIAL SECURITY OFFICE. IF ADDITIONAL EVIDENCE IS AVAILABLE, YOU SHOULD SUBMIT IT WITH YOUR REQUEST.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, CONTACT THE NEAREST DISTRICT OFFICE OF THE SOCIAL SECURITY ADMINISTRATION. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE BRING THIS NOTICE AND ALL OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

Code Letters 381 - 389

Use these code letters when suspending an RR certified SS benefit that has been placed in a deferred status (LAF Code D). A copy is sent to the appropriate RRB field office.

The letter states:

THE SOCIAL SECURITY ADMINISTRATION HAS REQUESTED THE RAILROAD RETIREMENT BOARD TO TEMPORARILY WITHHOLD YOUR SOCIAL SECURITY BENEFITS.

(SEE REASONS BELOW)

YOUR NEXT PAYMENT WILL BE MADE AS SOON AS THE REQUIRED AMOUNT OF BENEFITS HAS BEEN WITHHELD.

IF YOU BELIEVE THAT THIS DETERMINATION IS NOT CORRECT, YOU MAY REQUEST THAT YOUR CLAIM BE REEXAMINED. IF YOU WANT THIS RECONSIDERATION, YOU MUST REQUEST IT NOT LATER THAN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. YOU MAY MAKE YOUR REQUEST THROUGH ANY SOCIAL SECURITY OFFICE. IF ADDITIONAL EVIDENCE IS AVAILABLE, YOU SHOULD SUBMIT IT WITH YOUR REQUEST.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, CONTACT THE NEAREST DISTRICT OFFICE OF THE SOCIAL SECURITY ADMINISTRATION. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE BRING THIS NOTICE AND ALL OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

Code Letter 386

Code letter 386 will close with the following paragraph instead of the one shown above:

YOU SHOULD HAVE RECEIVED A LETTER FROM THE SOCIAL SECURITY ADMINISTRATION REGARDING THE OVERPAYMENT WHICH CAUSED THIS ACTION. IF YOU HAVE NOT RECEIVED SUCH A LETTER OR NEED MORE INFORMATION ABOUT THE OVERPAYMENT, CONTACT THE NEAREST SOCIAL SECURITY DISTRICT OFFICE. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU CALL IN PERSON, PLEASE BRING THIS NOTICE AND ANY OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

LETTER CODE	SUSP CODE	SSA LAF CODE	REASON FOR ADJUSTMENT
381	71	D1	BECAUSE OF YOUR WORK AND EARNINGS OUTSIDE OF THE UNITED STATES.
382	71	D2	BECAUSE OF YOUR WORK AND EARNINGS.
383	72	D3	BECAUSE OF THE WORK AND EARNINGS OF THE PERSON ON WHOSE RECORD YOU ARE RECEIVING BENEFITS.
384	75	D4	SINCE YOU NO LONGER HAVE A CHILD WHO IS UNDER AGE 18, OR DISABLED, IN YOUR CARE.

385	72	D5	BECAUSE OF THE WORK AND EARNINGS OUTSIDE THE UNITED STATES OF THE PERSON ON WHOSE RECORD YOU ARE RECEIVING BENEFITS.
386	73	D6	TO RECOVER THE OVERPAYMENT DESCRIBED IN THEIR LETTER TO YOU.
387	75	D9	(NO REASON PRINTED.)
388	75	DP	BECAUSE OF YOUR RECEIPT OF PUBLIC ASSISTANCE.
389	75	DW	BECAUSE OF YOUR RECEIPT OF WORKMAN'S COMPENSATION.

- C. RR Termination Code Letters - Use the following code letters when terminating an RR annuity. Code paragraph 199 regarding reconsideration and appeals is included on all termination code letters. A copy of the letter will be sent to the appropriate field office.

Code Letter	Situation
501	Use in manual termination of WCIA-last child attaining age 18 IS NOT an FTS; widow will be eligible in future.
	YOUR MOTHER'S/FATHER'S ANNUITY HAS ENDED BECAUSE YOUR CHILD IS ATTAINING AGE 18 THIS MONTH. THE CHILD SHOULD CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD IF HE (SHE) BECOMES:
	<ul style="list-style-type: none"> A FULL TIME STUDENT AT A HIGH SCHOOL OR ELEMENTARY SCHOOL BEFORE ATTAINING AGE 19 AND HAS NOT MARRIED, <u>OR</u>
	<ul style="list-style-type: none"> DISABLED BEFORE ATTAINING AGE 22 AND HAS NOT MARRIED.
	YOU MAY BE ELIGIBLE AGAIN FOR A MOTHER'S/FATHER'S ANNUITY IF THE CHILD BECOMES DISABLED BEFORE AGE 22, HAS NOT MARRIED AND IS IN YOUR CARE.
	YOU MAY BE ELIGIBLE FOR A WIDOW(ER)'S ANNUITY AT AGE 60 (AGE 50 IF DISABLED). AT THAT TIME YOU WILL HAVE TO

Code Letter	Situation
	FILE A NEW APPLICATION WITH THE RAILROAD RETIREMENT BOARD.
	IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.
	THERE IS AN OFFICE LOCATED AT (ADDRESS OF NEAREST FIELD OFFICE).
502	Use in manual termination of WCIA-last child attaining age 18 is an FTS; widow will be eligible in future.
	YOUR WIDOW'S CURRENT INSURANCE ANNUITY HAS ENDED BECAUSE YOUR CHILD IS ATTAINING AGE 18 THIS MONTH. ALTHOUGH THE CHILD IS ENTITLED TO AN ANNUITY AS A FULL-TIME STUDENT, A WIDOW UNDER AGE 60 CANNOT QUALIFY FOR AN ANNUITY ON THIS BASIS.
	YOU MAY BE ELIGIBLE AGAIN FOR A MOTHER'S/FATHER'S ANNUITY IF THE CHILD BECOMES DISABLED BEFORE AGE 22, HAS NOT MARRIED AND IS IN YOUR CARE.
	IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u> .
503	Use in manual termination of a CIA when child attains age 18 this month.
	YOUR CHILD'S INSURANCE ANNUITY HAS ENDED BECAUSE THE CHILD HAS ATTAINED AGE 18 THIS MONTH.
	FURTHER BENEFITS MAY BECOME PAYABLE IF THE CHILD BECOMES:
	<ul style="list-style-type: none"> A FULL-TIME STUDENT AT A HIGH SCHOOL OR ELEMENTARY SCHOOL BEFORE ATTAINING AGE 19 AND HAS NOT MARRIED, <u>OR</u>,
	<ul style="list-style-type: none"> DISABLED BEFORE ATTAINING AGE 22 AND HAS NOT MARRIED.
	IF HE (SHE) BECOMES ELIGIBLE FOR FURTHER BENEFITS, OR

Code Letter	Situation
	IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER CONTACT THE NEAREST OFFICE OF THE BOARD.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u> .
505	Use when terminating a spouse annuity based on minor children in her care - last child attaining age 18; spouse will qualify for reduced annuity at age 62.
	YOUR ANNUITY ENDED THIS MONTH. YOU WERE PREVIOUSLY NOTIFIED THAT YOUR ANNUITY WOULD END WHEN YOUR CHILD ATTAINED AGE 18 UNLESS THE CHILD WAS TOTALLY AND PERMANENTLY DISABLED AND IN YOUR CARE.
	WHEN YOU REACH AGE 62, YOU MAY QUALIFY FOR A SPOUSE ANNUITY AT A REDUCED RATE. IF YOU DECIDE TO WAIT UNTIL AGE 65, YOU MAY QUALIFY FOR AN UNREDUCED ANNUITY AT THAT TIME.
	YOU MUST FILE AN APPLICATION BEFORE A SPOUSE ANNUITY CAN BE PAID AGAIN. YOU MAY DO SO AT ANY BOARD OFFICE WHEN YOU ARE QUALIFIED FOR AN ANNUITY. THE ENCLOSED FORM GIVES THE CONDITIONS UNDER WHICH YOU MAY QUALIFY FOR AN ANNUITY. IF YOU NEED FURTHER INFORMATION, CALL OR WRITE THE NEAREST DISTRICT OFFICE OF THE BOARD. PLEASE TAKE THIS LETTER WITH YOU IF YOU CALL IN PERSON.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u> .
	ENCLOSURE
	G-177a
506	Use when terminating a spouse annuity based on minor children in her care--last child attaining age 18, spouse will qualify for unreduced annuity at age 60.
	YOUR ANNUITY ENDED THIS MONTH. YOU WERE PREVIOUSLY NOTIFIED THAT YOUR ANNUITY WOULD END WHEN YOUR CHILD ATTAINED AGE 18 UNLESS THE CHILD WAS TOTALLY AND PERMANENTLY DISABLED AND IN YOUR CARE.

Code Letter	Situation
	WHEN YOU REACH AGE 60, YOU MAY AGAIN QUALIFY FOR AN UNREDUCED SPOUSE ANNUITY.
	YOU MUST FILE AN APPLICATION BEFORE A SPOUSE ANNUITY CAN BE PAID AGAIN. YOU MAY DO SO AT ANY BOARD OFFICE WHEN YOU ARE QUALIFIED FOR AN ANNUITY. THE ENCLOSED FORM GIVES THE CONDITIONS UNDER WHICH YOU MAY QUALIFY FOR AN ANNUITY. IF YOU NEED FURTHER INFORMATION, CALL OR WRITE THE NEAREST DISTRICT OFFICE OF THE BOARD. PLEASE TAKE THIS LETTER WITH YOU IF YOU CALL IN PERSON.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u> .
	ENCLOSURE
	G-177a
507	Use when terminating a spouse annuity based on minor children in her care--last child attaining age 18; spouse may qualify for reduced annuity at age 60.
	YOUR ANNUITY HAS ENDED THIS MONTH. YOU WERE PREVIOUSLY NOTIFIED THAT YOUR ANNUITY WOULD END WHEN YOUR CHILD ATTAINED AGE 18 UNLESS THE CHILD WAS TOTALLY AND PERMANENTLY DISABLED AND IN YOUR CARE.
	WHEN YOU REACH AGE 60, YOU MAY QUALIFY FOR A SPOUSE ANNUITY AT A REDUCED RATE. IF YOU DECIDE TO WAIT UNTIL AGE 65, YOU MAY QUALIFY FOR AN UNREDUCED ANNUITY AT THAT TIME.
	YOU MUST FILE AN APPLICATION BEFORE A SPOUSE ANNUITY CAN BE PAID AGAIN. YOU MAY DO SO AT ANY BOARD OFFICE WHEN YOU ARE QUALIFIED FOR AN ANNUITY. THE ENCLOSED FORM GIVES THE CONDITIONS UNDER WHICH YOU MAY QUALIFY FOR AN ANNUITY. IF YOU NEED FURTHER INFORMATION, CALL OR WRITE THE NEAREST DISTRICT OFFICE OF THE BOARD. PLEASE TAKE THIS LETTER WITH YOU IF YOU CALL IN PERSON.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST</u>

Code Letter	Situation
	<u>FIELD OFFICE).</u>
	ENCLOSURE
	G-177a
509	Use when terminating a WCIA/surviving divorced mother's annuity/remarried young mother's annuity - last child attaining age 16; mother/father may be eligible at age 60.
	YOUR ANNUITY HAS ENDED BECAUSE YOUR CHILD HAS ATTAINED AGE 16. THE CHILD'S ENTITLEMENT TO AN ANNUITY WILL CONTINUE UNTIL (S)HE ATTAINS AGE 18 OR MARRIES.
	YOU MAY BE ELIGIBLE AGAIN FOR AN ANNUITY IF THE CHILD BECOMES DISABLED BEFORE AGE 22, HAS NOT MARRIED, AND IS IN YOUR CARE; OR YOU MAY BE ELIGIBLE FOR AN ANNUITY AT AGE 60 (AGE 50, IF DISABLED). AT THAT TIME YOU WILL HAVE TO FILE A NEW APPLICATION WITH THE RAILROAD RETIREMENT BOARD.
	IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE).</u>
510	Use when terminating a surviving divorced mother--last child attained age 16; surviving divorced mother will not be eligible in the future as surviving divorced wife. (10-year marriage requirement not met)
	YOUR ANNUITY HAS ENDED BECAUSE YOUR CHILD HAS ATTAINED AGE 16. THE CHILD'S ENTITLEMENT TO AN ANNUITY WILL CONTINUE UNTIL (S)HE ATTAINS AGE 18 OR MARRIES.
	YOU MAY BE ELIGIBLE AGAIN FOR AN ANNUITY IF THE CHILD BECOMES DISABLED BEFORE AGE 22, HAS NOT MARRIED, AND IS IN YOUR CARE.
	IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE).</u>

Code Letter	Situation
513	Use when terminating a student in the month the student attains age 19 or later; no overpayment involved.
	BENEFITS FOR A STUDENT END WITH THE MONTH THE STUDENT ATTAINS AGE 19, UNLESS A HIGH SCHOOL STUDENT REACHES AGE 19 DURING A SCHOOL TERM. IN SUCH CASES, BENEFITS MAY CONTINUE FOR TWO MONTHS AFTER THE MONTH IN WHICH AGE 19 WAS ATTAINED, OR, IF EARLIER, UNTIL THE END OF THE COURSE. SINCE THESE CONDITIONS HAVE BEEN MET, NO FURTHER BENEFITS ARE PAYABLE.
	IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u> .
514	Use when terminating a student in the month the student graduates from a post-secondary school - No overpayment involved.
	BENEFITS FOR A STUDENT END WITH THE MONTH THE STUDENT COMPLETES THE REQUIREMENTS FOR A DIPLOMA. SINCE YOU HAVE COMPLETED REQUIREMENTS FOR A DIPLOMA, NO FURTHER BENEFITS ARE PAYABLE.
	IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u> .
515	Use in 1981 Act case for manual termination of WCIA - last child attaining age 18 IS NOT an FTS; widow will be eligible in future.
	YOUR WIDOW'S CURRENT INSURANCE ANNUITY HAS ENDED BECAUSE YOUR CHILD IS ATTAINING AGE 18 THIS MONTH. IF THE CHILD BECOMES A FULL-TIME STUDENT, OR BECOMES DISABLED BEFORE ATTAINING AGE 22 AND HAS NOT MARRIED, HE (SHE) SHOULD CONTACT THE NEAREST OFFICE OF THE BOARD.
	YOU MAY BE ELIGIBLE FOR A WIDOW'S INSURANCE ANNUITY AT AGE 60 (AGE 50, IF DISABLED). AT THAT TIME, YOU WILL

Code Letter	Situation
	HAVE TO FILE A NEW APPLICATION WITH THE RAILROAD RETIREMENT BOARD.
	IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u> .
516	Use when terminating a student who is no longer in full-time attendance; no overpayment involved.
	YOUR ANNUITY HAS BEEN TERMINATED BECAUSE YOU CEASED FULL-TIME SCHOOL ATTENDANCE THIS MONTH.
	IF YOU HAVE ANY QUESTIONS ABOUT THIS LETTER, CONTACT THE NEAREST DISTRICT OFFICE OF THE BOARD.
	THERE IS AN OFFICE LOCATED AT <u>(ADDRESS OF NEAREST FIELD OFFICE)</u> .

- D. SS Termination Code Letters - Use the following code letters when terminating an RR certified SS benefit. A copy of the letter will be sent to the appropriate RRB field office.

The basic text of the letter is as follows:

THE SOCIAL SECURITY ADMINISTRATION HAS REQUESTED THE RAILROAD RETIREMENT BOARD TO TERMINATE YOUR BENEFITS

(SEE REASONS LISTED BELOW)

IF YOU BELIEVE THAT THIS DETERMINATION IS NOT CORRECT, YOU MAY REQUEST THAT YOUR CLAIM BE RE-EXAMINED. IF YOU WANT THIS RECONSIDERATION, YOU MUST REQUEST IT NOT LATER THAN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. YOU MAY MAKE YOUR REQUEST THROUGH ANY SOCIAL SECURITY OFFICE. IF ADDITIONAL EVIDENCE IS AVAILABLE, YOU SHOULD SUBMIT IT WITH YOUR REQUEST.

(USED ON ALL BUT LETTER #363)

WHEN BENEFITS ARE TERMINATED DURING A YEAR AND A BENEFICIARY IS UNDER AGE 70, AN ANNUAL REPORT OF EARNINGS MUST BE FILED IF THE BENEFICIARY HAS INCOME FROM WORK EXCEEDING THE YEARLY LIMIT. THIS REPORT SHOULD INCLUDE THE BENEFICIARY'S EARNINGS

FOR THE ENTIRE YEAR BOTH BEFORE AND AFTER THE BENEFITS WERE TERMINATED.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, CONTACT THE NEAREST DISTRICT OFFICE OF THE SOCIAL SECURITY ADMINISTRATION. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE, OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE BRING THIS NOTICE AND ALL OTHER MATERIAL YOU HAVE ABOUT YOUR CLAIM WITH YOU.

LETTER CODE	TERM CODE	SSA LAF CODE	BIC	REASON FOR ADJUSTMENT
351	17	T2		DUE TO THE DEATH OF THE PERSON ON WHOSE ACCOUNT YOU ARE RECEIVING BENEFITS.
352	15	T3		DUE TO YOUR CHANGE IN MARITAL STATUS.
353	03	T4	C(AGE 18)	SINCE YOU HAVE REACHED AGE 18. IF YOU ARE DISABLED OR ATTENDING SCHOOL FULL-TIME, PLEASE CONTACT ANY SOCIAL SECURITY OFFICE AS BENEFITS MAY AGAIN BE PAYABLE.
354	03	T4	C (CHILD AGE 18)	SINCE YOU NO LONGER HAVE A CHILD WHO IS UNDER AGE 18, OR DISABLED, IN YOUR CARE.
355	03	T4	C(AGE 19)	SINCE YOU HAVE REACHED AGE 19, OR ARE NO LONGER ATTENDING SCHOOL FULL-TIME.
356	10	T5		ON THIS SOCIAL SECURITY ACCOUNT NUMBER. IT HAS BEEN DETERMINED THAT YOU ARE ENTITLED TO AN EQUAL OR GREATER AMOUNT OF BENEFITS ON ANOTHER NUMBER. YOU SHOULD BE RECEIVING BENEFITS BASED UPON THAT NUMBER.
357	14	T6	C	BECAUSE YOU ARE NO LONGER ATTENDING SCHOOL FULL-TIME, OR ARE NO LONGER DISABLED.
358	14	T6	C	SINCE YOU NO LONGER HAVE A CHILD IN YOUR CARE ENTITLED TO RECEIVE SOCIAL SECURITY BENEFITS.
359	08	T8	A	SINCE YOU HAVE RECOVERED FROM YOUR DISABILITY.

360	08	T8	C	SINCE YOU, OR THE PERSON ON WHOSE ACCOUNT YOU ARE RECEIVING BENEFITS, HAS RECOVERED FROM DISABILITY.
361	08	T8	= C OR A	SINCE THE PERSON ON WHOSE ACCOUNT YOU ARE RECEIVING BENEFITS HAS RECOVERED FROM DISABILITY.
362	25	T9,	TP	(NO REASON PRINTED).
363	13	TR, T+		SINCE YOU HAVE WITHDRAWN YOUR APPLICATION FOR SOCIAL SECURITY BENEFITS.
365	10	AD		BECAUSE ALL BENEFITS NOW PAYABLE HAVE BEEN COMBINED WITH YOUR OWN BENEFITS SO THAT ONE PAYMENT CAN BE MADE UNDER YOUR OWN NUMBER. DUE TO THE DEATH OF THE PERSON ON WHOSE ACCOUNT YOU ARE RECEIVING BENEFITS.
<u>ADDITIONAL PARAGRAPHS:</u>				
SURVIVOR BENEFITS ARE PAYABLE BY EITHER THE RAILROAD RETIREMENT BOARD OR THE SOCIAL SECURITY ADMINISTRATION, BUT NOT BY BOTH, EVEN THOUGH THE EMPLOYEE MAY HAVE RECEIVED BENEFITS FROM BOTH AGENCIES WHILE HE WAS ALIVE. THE RAILROAD RETIREMENT BOARD HAS JURISDICTION OF YOUR SURVIVOR BENEFITS.				
NOTICE OF THE EMPLOYEE'S DEATH WAS RECEIVED TOO LATE TO PREVENT THE RELEASE OF SOCIAL SECURITY BENEFITS ISSUED AFTER THE MONTH OF DEATH. THESE OUTSTANDING AND NOT DUE BENEFITS WILL BE RECOVERED FROM YOUR SURVIVOR AWARD.				
390	17	T2	B/C	

Code Letter 391

Use code letter 391 when terminating RR certified SS benefits in "No C/C" cases when payment of benefits will be transferred to SSA. The code letter will consist of three paragraphs as shown in the "REASON" column for code letter 391 below.

LETTER CODE	TERM CODE	SSA LAF CODE	BIC	REASON FOR ADJUSTMENT
391	17,21	C,T2	B/C	SURVIVOR INSURANCE BENEFITS ARE NOT PAYABLE TO YOU UNDER THE RAILROAD RETIREMENT ACT BECAUSE THE EMPLOYEE

				<p>WAS NOT INSURED UNDER THAT ACT FOR DEATH BENEFITS.</p> <p>BECAUSE YOU ARE NOT ENTITLED TO A RAILROAD RETIREMENT ANNUITY, RESPONSIBILITY FOR PAYMENT OF YOUR SOCIAL SECURITY BENEFIT MUST BE RETURNED TO THE SOCIAL SECURITY ADMINISTRATION.</p> <p>THE SOCIAL SECURITY ADMINISTRATION WILL BEGIN PAYING YOUR SOCIAL SECURITY BENEFITS IN THE NEAR FUTURE. IF YOU DO NOT RECEIVE PAYMENT WITHIN A REASONABLE TIME OR IF YOU HAVE ANY QUESTIONS ABOUT YOUR BENEFIT, CONTACT THE NEAREST DISTRICT OFFICE OF THE SOCIAL SECURITY ADMINISTRATION. IF YOU CALL IN PERSON BEFORE YOU RECEIVE PAYMENT, PLEASE BRING THIS LETTER WITH YOU.</p>
394	03	T4	= C (CHILD AGE 16)	<p>SINCE YOU NO LONGER HAVE A CHILD WHO IS UNDER AGE 16, OR DISABLED, IN YOUR CARE. WHEN YOU ARE AGE 62, YOU MAY BE ENTITLED TO RETIREMENT BENEFITS. IF YOU ARE A WIDOW OR WIDOWER, YOU MAY BE ENTITLED AT AGE 60 OR AT AGE 50 IF YOU ARE DISABLED. NOTIFY ANY SOCIAL SECURITY OFFICE IF YOU THINK YOU MIGHT BE ELIGIBLE.</p>

9.7.19 Death Notification Entry

Death Notification Entry (DNE) is an electronic process which transmits notification of the death of an annuitant to the financial institution (FI). DNE transactions are limited to annuities paid via Direct Deposit/Electronic Funds Transfer (DD/EFT).

DNEs are issued daily, without regard to monthly cut-offs. DNE transactions are created from APPLE First Notice of Death (FNOD) information and from FAST-Suspension/Termination (FAST-S/T) transactions. Returned payments, death terminations from the PAM system, and annuities in suspense prior to the death termination will not create a DNE transaction.

NOTE: If a FNOD or FAST-S/T transaction is erroneous or contains a wrong date of death and, the transaction is not deleted or modified before close of business on the day the transaction is entered, a DNE with the incorrect information will be released to the FI. When this occurs, immediately notify the FI. Provide the FI with the correct date of death or, inform the FI that the report of death was in error and is to be disregarded. Additionally, wrong date of death reports and erroneous reports of death are to be handled according to the instructions in RCM sections 6.6.141 and 6.4.46, respectively.

A DNE transaction furnishes the FI with the following information:

- claim number
- name of the annuitant
- account number
- date of death
- annuitant's social security number
- the next recurring payment amount

Upon receipt of the DNE, FIs are encouraged to "flag" the deceased customer's account to prevent further acceptance of post-death payments. Federal payments received after the FI has been notified of a customer's death by DNE, must be returned within 3 business days of the payment date. Prompt return of the payment by the FI reduces and in some cases, eliminates the need to recover outstanding payments via the reclamation process.

9.7.20 Suspension/Termination Display and Input

After determining that the beneficiary's payments should be suspended or terminated and that the correct beneficiary's record is displayed on the DATA-Q screen, press the PF-7 key. The FAST SUSPENSION/TERMINATION ENTRY SCREEN will appear. If no suspension/termination transaction has been entered for that record, the lower half of the screen will be titled "ENTER S/T INFORMATION" and no S/T data will appear. If a suspension/termination transaction has been entered, the lower half of the screen will be titled "CURRENT S/T INFORMATION" and S/T data will appear. (See RCM 9.7.23 for more information regarding pending transactions.)

A. Top Half of Screen

The FAST Suspension/Termination system prefills certain information directly from the beneficiary's record. Because of the DATA-Q link, the actual number of input items that the user must complete to process a transaction is reduced. Input errors are held to a minimum and can be corrected on-line. Prefilled fields cannot be changed by the user.

The following items are prefilled from DATA-Q:

- claim number (CLAIM NO)
- payee code (P/C)
- name (first line of the address block as it appears on DATA-Q (NAME))

- date of birth (DOB)
- payment rate information (CURRENT RATE INFO: CHECK, RR,SUPP, SS)

The date and time that the screen is displayed is shown in the upper right-hand corner of the screen.

NOTE: Double check to make sure that the proper beneficiary is displayed.

While edits can prevent data input errors, they cannot prevent the suspension/termination of the wrong beneficiary.

B. Lower Half of Screen

The lower half of the split screen contains all the data input items, which must be filled by the user. There are seven data input fields (UNIT ID, RR & SS SUSP/TERM CODE, EFF DATE, and LETTER CODE). The user sign-on will be carried through from the DATA-Q sign-on function.

A message line is also located on the bottom of the FAST S/T entry screen. If an S/T transaction is being entered in a "dual" annuity case, the message "DUAL ANNUITANT CASE/ACTION NEEDED ON ANOTHER CLAIM NUMBER?" will be displayed.

9.7.21 Entering Data On FAST Suspension/Termination Screen

A. How To Enter Data

The FAST-S/T screen has been expanded to include entry fields for suspension/termination of SS benefits. In order to suspend or terminate both the RR annuity and SS benefit, the appropriate data must be entered in both the RR and SS entry fields. (Exception: If a death code is entered in either the RR or SS line, FAST will automatically carry the same codes into the other line after the PF-2 edit key is pressed.)

The first data entry field is UNIT ID. After that field is completed, the cursor will position itself under the data entry fields according to the composition of the monthly rate. That is, if the monthly rate is RR only, the cursor will not move to the SS line; if the monthly rate is SS only, the cursor will not move to the RR line; if the monthly rate is RR & SS, the cursor will move to the RR line first, and then to the SS line.

Enter suspension/termination data according to the following instructions:

1. UNIT ID

- Enter your 4-digit organization code in the UNIT ID field. If you are not sure of your correct organization code, refer to RCM 9.7 Appendix A.

RR Entry Fields

2. SUSP/TERM CODE

- Enter the appropriate 2-digit RR suspension/termination code. Refer to RCM 9.7.14B for suspension/termination codes. Note: A termination code entered will terminate an annuity that is in suspended status.

3. EFF DATE

- If known, enter the effective date of the RR suspension/termination. The entry must include two digits for the month; followed by a hyphen, two digits for the day; followed by a hyphen, and four digits for the year.

Example: The annuitant died on January 15, 1990. The entry in the EFF DATE field would be 01-15-1990.

Refer to RCM 9.7.15 when entering future effective dates. If the effective date is unknown, enter 00-00-0000.

NOTE: Whenever a 00-00-0000 effective date is used, you must develop for the actual suspension/termination effective date. When the actual month and year of the suspension/termination event is learned, process a new FAST-S/T transaction.

4. LETTER CODE

- Enter the appropriate three-digit letter code.

This input field does not always require an entry. If a notice should not be released, leave this field blank. Refer to RCM 9.7.17 for tables of susp/term codes and corresponding letter codes.

SS Entry Fields

5. SUSP/TERM CODE

- Enter the appropriate 2-digit SS suspension/termination code. Refer to RCM 9.7.14B for suspension/termination codes.

6. EFF DATE

- If known, enter the effective date of the SS suspension/termination. This entry must include two digits for the month; followed by a hyphen, two digits for the day; followed by a hyphen, and four digits for the year.

Example: The annuitant died on January 15, 1990. The entry in the EFF DATE field would be 01-15-1990.

Refer to RCM 9.7.15 when entering future effective dates. If the effective date is unknown, enter 00-00-0000.

NOTE: Whenever a 00-00-0000 effective date is used, you must develop for the actual suspension/termination effective date. When the actual month and year of the suspension/termination event is learned, process a new FAST-S/T transaction.

7. LETTER CODE

- Enter the appropriate three-digit letter code. If a notice should not be released, leave this field blank.

This input field does not always require an entry. Refer to RCM 9.7.17 for tables of susp/term codes and corresponding letter codes.

B. How to Start The Edit Process

After all of the entries have been made, press the PF-2 key to activate the edit process.

9.7.22 Editing Data

A. Input Passes Edits

If the data passes the edits, this message will appear in white on the screen:

"NO ERRORS DETECTED, HIT PF 2 TO
SUBMIT RECORD TO THE DATABASE"

Press the PF-2 key a second time. In response to the PF-2 key a confirmation message will appear in white on the screen:

"RECORD HAS BEEN ADDED TO THE DATABASE.
HIT PF KEY TO CONTINUE"

NOTE: Before storing the data, if it is necessary to change the data entered, move the cursor to the field to be changed, correct the data and then press the PF-2 key. The data will be edited again. If the transaction passes the edits, it will be stored on the database. If the transaction does not pass all edits, an edit message will appear.

B. Input Does Not Pass Edits

If an invalid entry is made, the cursor will be positioned under the invalid item and an error message will be displayed on the screen. FAST can only indicate one invalid entry at a time. Therefore, after correcting the invalid item and hitting the PF-2 key, the system may identify a second item needing correction. The fields are edited in the same sequence that they are entered by the user. When all the data is valid, this message will appear on the screen:

"NO ERRORS DETECTED,

HIT PF 2 TO SUBMIT RECORD TO THE DATABASE."

Refer to RCM 9.7.26 for a list of the edit messages and corrections.

Press the PF-2 key. This confirmation message will appear in white on the screen:

"RECORD HAS BEEN ADDED TO THE DATABASE.

HIT PF KEY TO CONTINUE."

C. Print-outs

To make a screen print, use your system's print function.

D. Return to DATA-Q

To enter another suspension/termination transaction, or return to DATA-Q, press the PF-6 key.

E. Return to RRAPID Menu

When finished with FAST/DATA-Q press the CLEAR key to return to the RRAPID Menu.

9.7.23 Pending Transactions

A suspension or termination transaction pends on the database until it is transferred to a file for processing through DAISY. When a suspension/termination transaction for a particular claim is pending on the database, the data that was input to create that transaction appears on the data entry screen under the heading "CURRENT S/T INFORMATION." A pending transaction may be changed or deleted, if necessary, before it is removed from the FAST database for processing through DAISY.

FAST-Suspension/Termination can be modified an unlimited number of times while they are pending on the database. The latest transaction or G-96 on record will be processed through DAISY. Suspension/termination transactions created by G-96 input forms cannot be viewed on FAST.

How long a transaction pends on the database depends on when in the month it is entered and the suspension/termination effective date.

A. Pends Until the Close of the Work Day

Transactions entered from the second to the last work day of the month through the cut-off for FAST suspensions/terminations in the following month are removed from the database at the end of each work day and processed through DAISY overnight, provided the suspension/termination effective date is the same as the cut-off month or earlier. Transactions entered on the day before cut-off are an exception. Since there is no DAISY run that evening, they do not process through DAISY until the following night.

Example: FAST Suspension/Termination cut-off is September 17. Suspensions or terminations with a 09-01-1987 or earlier effective date entered through FAST from August 28 (the second to the last work day of August since the weekend falls on the 29th and 30th) through September 15 and on September 17 will process through DAISY overnight and appear on DATA-Q the morning of the next work day after they are entered. Transactions entered on September 16, the day before cut-off, will not appear on DATA-Q until September 18.

B. Pends Until the Second Work Day of the Following Month

Transactions entered after the monthly FAST suspension/termination cut-off pend through the second work day of the following month when they are removed for processing through DAISY.

Example: Transactions with a 07-01-1989 or earlier effective date entered after the June 19 cut-off pend on the database through July 5. They would appear on DATA-Q on July 6.

C. Pends Until Future Month

Transactions with an effective date later than the current month pend on the database until the end of the second work day of the effective date month.

Example: A suspension transaction with an 08-89 effective date is entered through FAST in June. The transaction pends on the database through August 2 (the second work day of the effective date month). The transaction will appear on DATA-Q on August 3.

NOTE: There is sometimes a delay in DATA-Q's being updated, for example, after the cost-of-living adjustment. A pending suspension/termination transaction may still have been processed through DAISY even though it will not appear on DATA-Q until it is updated. Be aware of the DATA-Q update date.

9.7.24 Modifying A Pending Transaction

If a pending transaction exists, the input items will be filled under the "CURRENT S/T INFORMATION" legend on the bottom half of the split screen. The following message will appear at the bottom of the screen:

"S/T EXISTS. FOR DATAQ - HIT PF 6. TO MODIFY - ENTER ALL DATA THEN PF 3. TO DELETE - ENTER UNIT ID THEN PF 4. TO ENTER TRACK-HIT PF8."

After reviewing the screen and determining that a modification is necessary, input all data for the modified transaction even if some of the data will not change.

- SUSP/TERM CODE
- EFF DATE
- UNIT ID
- LETTER CODE (when appropriate).

The cursor will automatically move to the next input field once the required positions are filled. Press the PF-3 key. If the data is valid, this message will appear on the screen:

"NO ERRORS DETECTED,

HIT PF-3 TO MODIFY CURRENT RECORD ON THE DATABASE"

To cancel the transaction at this time before it has been accepted, Press PF-6. You will return to DATA-Q. To enter the transaction, press the PF-3 key again. This message will appear on the screen:

"RECORD ON DATABASE HAS NOW BEEN MODIFIED.

HIT PF KEY TO CONTINUE."

To make a screen print, use the print function on your system.

If the data is invalid, an error message will be displayed and the cursor will position itself under the erroneous entry. Refer to RCM 9.7.26 for edit messages and corrective actions. Make corrections and press the PF-3 key again until all input data is valid and the modification can be made.

Example: The beneficiary advises the field office that he plans to return to work at the railroad on September 1, 1988. A FAST transaction is processed after the August FAST S/T cutoff date showing 09-01-1988 as the EFFECTIVE DATE. He calls in a few days later and says he will NOT begin employment until October 1, 1988. A second FAST transaction modifies the EFF DATE to 10-01-1988.

9.7.25 Deleting A Pending Transaction

After you have determined that a pending action should be deleted, move the cursor to the UNIT ID data entry field and enter your four-digit UNIT ID and press the PF-4 (Delete) key. If the data is valid, the following message will appear on the screen:

"NO ERRORS DETECTED, HIT PF-4 TO SUBMIT

DELETE ACTION TO THE DATABASE."

To cancel the transaction before it is accepted, press PF-6. You will return to DATA-Q. Otherwise, press PF-4 again to enter the transaction. The following message will appear on the screen:

"RECORD ON DATABASE IS NOW A DELETION RECORD.

HIT PF KEY TO CONTINUE."

NOTE: If a death termination is being deleted, check the remarks section of the APPLE FNOD screen before completing the deletion action. If the message "SSA/CMS DEATH MATCH TERM, NOTIFY DMS IF ERRONEOUS REPORT OF DEATH IS RECEIVED" is present, Notify the Death Match Section. The discrepant report of death information must be reconciled.

If the data is invalid, an error message will be displayed and the cursor will position itself under the erroneous entry. Refer to RCM 9.7.26 for error messages and corrective actions. After correcting the data, press PF-4.

9.7.26 Edit Messages And Corrective Actions

Activity entered through FAST is edited on line. Activity is not passed to the database until all the input information has cleared all edits. Errors are identified through error messages displayed at the bottom of the input entry screen. Errors can be corrected by typing over the erroneous entry with the correct information. Since most errors can be identified and corrected on-line, very few FAST suspension/termination transactions reject in DAISY. Listed below are the error messages that are displayed in the FAST edit process, and the corrective action that should be taken. These messages are listed in the order that the data is entered by the user.

A. Suspension/Termination Code

1. Message: "NO S/T CODE ENTERED - ENTER S/T CODE." This edit occurs if the RR or SS SUSP/TERM CODE has been omitted, or is incomplete.

Correction: Type in an appropriate RR and/or SS SUSP/TERM CODE. See RCM 9.7.14B for available codes.

2. Message: "INVALID S/T CODE - ENTER VALID S/T CODE." This edit occurs if the RR or SS SUSP/TERM CODE entered is not a valid code as detailed in RCM 9.7.14.

Correction: Type in one of the codes detailed in RCM 9.7.14 as appropriate for the action being taken.

3. Message: "INVALID ENTRY - CASE IS TERMINATED." This edit occurs if the RR annuity and/or SS benefit is terminated and a Suspension code is entered in the RR and/or SS SUSP/TERM CODE field.

Correction: No action can be taken since a suspension transaction cannot be processed against a terminated record.

B. Effective Date

1. Message: "NO EFFECTIVE DATE ENTERED - ENTER EFFECTIVE DATE." This edit occurs if the RR or SS SUSP/TERM CODE field has been completed and the corresponding EFF DATE field has been left blank, or is incomplete.

Correction: Type in a valid effective date, in the proper month-day-year format with a hyphen separating the two-digit month, the two-digit day, and the four-digit year. If the effective date is unknown, type in 00-00-0000. Remember to develop for the exact effective date. When the month and year of the suspension/termination event is learned, process a new FAST S/T transaction.

2. Message: "INCORRECT MONTH - ENTER CORRECT MONTH." This edit occurs if the "MM" positions of the EFF DATE entry are other than a number 01 through 12.

Correction: Type in a valid month entry in the "MM" positions of the EFF DATE.

3. Message: "INCORRECT DAY - ENTER CORRECT DAY." This edit occurs if the "DD" positions of the EFF DATE entry are other than a number 01 through 31.

Correction: Type in a valid month entry in the "DD" positions of the EFF DATE.

4. Message: "INCORRECT YEAR - ENTER CORRECT YEAR." This edit occurs if the year is 1978 or earlier.

Correction: Type a valid year (after 1978) in the "CCYY" positions of the EFF DATE.

5. Message: "EFFECTIVE MONTH ZEROES, YEAR MUST BE ZEROES." This message occurs if the "MM" positions of the EFF DATE are 00 and the "CCYY" positions are not 0000.

Correction: Type in 0000 in the "CCYY" positions of the EFF DATE. Remember to develop for the exact effective date. When the month and year of the suspension/termination event is learned, process a new FAST S/T transaction.

6. Message: "EFFECTIVE YEAR OR DAY ZEROES, MONTH MUST BE ZEROES." This message occurs if the "CCYY" and "DD" positions of the EFF DATE are 0000 and 00 and the "MM" positions are not 00.

Correction: Type in 00 in the "MM" positions of the EFF DATE. Remember to develop for exact effective date. When the month and year of the suspension/termination event is learned, process a new FAST S/T transaction.

7. Message: "EFFECTIVE DATE MORE THAN 3 MONTHS IN FUTURE - ENTER VALID EFFECTIVE DATE." This edit occurs if an effective date more than three months after the current month is entered (for example, an effective date later than November is entered in August). A suspension/termination transaction with an effective date more than three months after the current month cannot be processed on FAST.

Correction: If the effective date is within three months, type in the correct date. If the effective date is more than three months after the current month, no action can be taken at this time on FAST. Hold the case until you are within 3 months of the action.

8. Message: "EFFECTIVE DATE GREATER THAN CURRENT DATE - ENTER VALID EFFECTIVE DATE." This edit occurs if the effective date is later than the current month, day and year and the SUSP/TERM code is 01, 41, 51, 57, 63, 64 or 65.

Correction: Type in an effective date of the current month or earlier. If payments are not to be suspended or terminated immediately this transaction cannot be processed on FAST.

9. Message: "EFFECTIVE DATES RR AND SS NOT BOTH IN FUTURE - ENTER VALID EFFECTIVE DATE." This edit occurs if effective dates have been entered in both the RR and SS lines and one date is a future date and the other date entered is either a different future date or the current date.

Correction: If the effective dates are correct, the system will not accept the transaction as entered. Correct the transaction to enter the

suspension or termination with the earliest effective date only, and control the case for entry of the transaction with the later effective date, after the first transaction has processed on CHICO. If the effective dates entered are not correct, enter a valid effective dates.

10. Message: "DATE ENTERED NOT NUMERIC - ENTER NUMERIC DATE" This edit occurs if THE "MM", "DD", or "CCYY" positions of the EFF DATE are not numeric.

Correction: Type in a valid numeric entry.

C. Unit ID

1. Message: "NO UNIT ID ENTERED - ENTER UNIT ID." This edit occurs if the unit ID has been omitted, or is incomplete.

Correction: Type in the correct UNIT ID.

2. Message: "UNIT ID NOT NUMERIC - ENTER NUMERIC UNIT ID." This edit occurs if the unit ID entered does not consist of four digits.

Correction: Type in the correct four-digit unit ID.

3. Message: "INVALID UNIT ID - ENTER VALID UNIT ID." This edit occurs if the first digit of the UNIT ID is not a "2" for headquarters personnel, or a "7" for field office personnel.

Correction: Type in a UNIT ID with a 2 or 7 in the first position.

D. Letter Code

1. Message: "LETTER CODE DOES NOT CORRESPOND WITH S/T CODE." This edit occurs if the LETTER CODE entry does not correspond to the SUSP/TERM CODE entry as shown in RCM 9.7.17.

Correction: Either delete or correct the letter code so that it is appropriate for the SUSP/TERM CODE, or correct the SUSP/TERM CODE as appropriate if the correct letter code was entered.

9.7.30 Field Office Handling Of FAST Suspension/Termination Transactions

Field offices use the FAST suspension/termination system to stop payments when they are informed by the annuitant of one of the suspending or terminating events that can be processed through FAST.

NOTE: While death terminations can be processed using FAST, all death terminations are to be processed using APPLE.

Field offices do not use FAST to suspend or terminate payments in the following situations:

- a third party provides information that could cause termination or suspension of an annuity and the field office is unable to verify the information through the annuitant;
- a representative payee is being developed, but the field office has determined that the annuitant is benefiting from the annuity payments. When the representative payee development is completed, the field office will process the representative payee selection on FAST-COA.
- the spouse payment is not terminated when notice of the employee's death is received.
- payments are not terminated based on the field office copy of a MAP or SURVEA letter.

In these situations, and any other situation requiring codes not available to the field (See RCM 9.7.14), headquarters is responsible for suspending or terminating payments.

9.7.31 Headquarters Handling Of FAST Suspension/Termination Transactions

While field offices will be stopping annuity payments in certain situations, headquarters will maintain responsibility for determining that all necessary action has been taken after the suspension or termination of benefits.

A. Suspension/Termination Initiated by Field Office

Headquarters must be notified whenever additional actions are required that cannot be handled by the field office.

B. Suspension/Termination Initiated by Headquarters

The examiner or development clerk should follow through with any additional action necessary in accordance with current suspension/termination procedures.

9.7.35 Processed Activity

Activity that has been input to the FAST system is not processed until it is batched, put on a file, and processed through the DAISY system.

Pending transactions will remain on the screens until processed. Therefore, if the transaction can be viewed on FAST it has not yet been updated to the checkwriting system. Once processed, the transaction will no longer appear on FAST.

Batched activity may be verified for processing on the following sources:

- DATA-Q - DATA-Q is updated soon after the activity is processed. The DATA-Q screen shows payment status, effective date of suspension or termination, actual date the suspension or termination was processed and the reason for suspension or termination. FAST transactions can be identified by a voucher number of 011.
- PREH – PREH (3277 on the full inquiry menu or RECUR on the general inquiry menu) is also updated soon after the activity is processed and is a good source for verification. The 3277 or RECUR screens show payment status, effective and actual dates of the suspension or termination, and the reason for the suspension or termination. FAST transactions can be identified by a voucher number of 011.
- SAMM - The SAMM tape is a record of all daily activity. In addition to suspension/termination information, this tape provides the identification of the unit and person that processed the suspension or termination. The activity is stored on tape according to the transaction run date. The voucher number will be shown as 011.
- MOMS - Suspension/termination activity may be checked on the MOMS tape produced on the first of the month following the month annuity payments were stopped.

9.7.70 FAST Payment Investigation Entry (PIENTRY)

The FAST Payment Investigation Entry (PIENTRY) is used to release mechanical SF-1184, Unavailable Check Cancellation, requests to Treasury. Non-receipt claims and, reclamation, photocopy, and status requests entered on PIENTRY are transferred to a computer file for processing by Treasury. Transactions are entered in the following instances:

Non-Receipt Claim

The payee or representative payee initiates a claim for the proceeds of a payment that has not been received, or has been lost, stolen, mutilated, or destroyed.

NOTE: Occasionally, a financial institution (FI) will notify RRB of checks that were lost or stolen after being cashed by the payee. The FI may submit a non-receipt claim. When this occurs, secure the exact check symbol and check number of the check and advise the FI to file a “Holder In Due Course” or “Lost-In-Transit” claim with its servicing Federal Reserve Bank. Do not process a non-receipt claim. If there is any doubt, refer the case to Policy & Systems-Payment Analysis & Systems.

Reclamation (Non-Entitlement)

The RRB determines that the payee is not entitled to the proceeds of a check that is not in the possession of either the RRB or Treasury (it is unknown if the check has been

negotiated) and recovery cannot be made by any other means. Or, the RRB determines that a payee enrolled in direct deposit is deceased or incompetent.

Status or Photocopy

The RRB determines that a photocopy of a check or payment status information is needed for administrative purposes.

A. Multiple Requests

Information for up to 24 payments in one case can be entered on PIENTRY at one time. Additional requests must be entered after the first 24 pending transactions have processed, generally the following business day.

B. Non-Recurring Payments

Requests for non-recurring payments (accruals or one payment only payments) require the check number assigned by Treasury. This information is found by accessing Treasury's PACER system.

C. Courtesy Disbursements

Requests for Courtesy Disbursements, released as a result of a B or C non-receipt claim, require the check number assigned by Treasury. This information is found by accessing Treasury's TIE File system.

D. Identical Payment Issue Date (Month and Year)

Requests for payments issued in the same month and year cannot be entered on PIENTRY on the same day. The additional request must be entered after the first request has processed, generally the following business day.

9.7.71 How Payment Investigation Transactions Are Processed

When a payment investigation transaction is processed through PIENTRY, the user:

- Calls up the DATA-Q record of the annuitant or beneficiary for whom the payment investigation is to be processed;
- By pressing the PF-9 key, accesses the payment investigation input entry screens or accesses PIENTRY via the RRAPID Main Menu;
- Enters the required information (unit ID, reason code, payment date, etc); and,
- Responds to edit messages, if necessary, until the data is accepted by the system.

PIENTRY:

- Edits the information entered by the user for consistency;
- When acceptable data has been entered, creates a transaction consisting of the data entered by the user and data that it extracts from DATA-Q (prefix and claim number, payee code, name, address, etc.); and,
- Stores the transaction on the database.

9.7.72 Viewing The FAST-Payment Investigation Entry Screens

Any employee who has access to DATA-Q may view the PIENTRY screens to determine if a non-receipt claim or reclamation, status, or photocopy request for a particular payment is pending transmission to Treasury. Pending transactions are batched and processed daily. Check PISTATUS for transactions that have been released to Treasury.

To view the payment investigation data entry screens, first locate the annuitant's record on DATA-Q, then press the PF-9 key. The payment investigation review menu screen will appear.

NOTE: If the annuitant is not on DATA-Q, access PIENTRY from the RRAPID Main Menu (see section 9.7.80).

When a payment investigation transaction has been entered on PIENTRY and has not been sent to Treasury for processing, the payment date will be shown on the review menu. To view the data entered for a particular payment date, enter the corresponding two-digit menu number in the SELECT OPTION field and then press the PF-5 key. The PAYEE IDENTIFICATION screen will appear. This is the first of three data entry screens. The second and third screens, BANK IDENTIFICATION INFORMATION and PAYMENT IDENTIFICATION INFORMATION, respectively, can be viewed by pressing the PF-5 key.

NOTE: The PF-5 key function was created as a view-only option. It is not necessary to enter the UNIT ID on the review menu screen when the PF-5 key is used.

9.7.73 Who Can Input Payment Investigation Transactions

Headquarters and field off personnel, who have responsibilities for taking payment investigation actions, have security clearance to input payment investigation transactions. One must have security clearance access to DATA-Q to view a pending transaction. However, a separate security clearance is required for PIENTRY to input data. If one does not have clearance, when an attempt is made to input a transaction, the screen will display the following message:

“SECURITY VIOLATION ON TASK CODE
ENTER NEXT TASK CODE”

9.7.74 Type Of Payment Investigation Transactions That Can Be Processed On PIENTRY

Listed below are acceptable payment investigation codes and their descriptions.

CODE	REASON
A	<p>RRB REISSUE BEFORE STATUS – Use when:</p> <ul style="list-style-type: none"> • The payee claim dire need or a due check is returned to RRB for reissuance. • Payment was not DD/EFT. • The payee is entitled to the check. • If lost or stolen, the check was <u>not</u> endorsed. • The check is less than a year old. <p>RRB is certifying a second payment <u>before</u> Treasury determines the status of the original payment (payment is recertified <u>outside</u> of the Courtesy Disbursement process).</p>
B	<p>MASS LOSS – Use when:</p> <ul style="list-style-type: none"> • Payment was not DD/EFT. • The check is part of a confirmed mass loss situation occurring in the current month. • The payee is entitled to the check. <p>Treasury will issue a Courtesy Disbursement before the status of the original check is known.</p> <p>NOTE: This reason code is reserved for authorized users in the Programs Support Division-Clerical Services Section, and is limited to mass loss claims.</p>
C	<p>NON-RECEIPT-RFC REISSUE – use when:</p> <ul style="list-style-type: none"> • The payee is entitled to the payment. • The payment was sent via DD/EFT and the FI has confirmed

	<p>non-receipt of the payment.</p> <ul style="list-style-type: none"> • The payment was issued as a paper check and the payee claims non-receipt, or loss, theft, or mutilation of the check. • If lost or stolen, the check was not endorsed. • The check is less than a year old. <p>In check cases, Treasury will issue a Courtesy Disbursement only after the status of the original payment is determined to be outstanding. IN DD/EFT cases, Treasury will release Form FMS-150.1 or FMS 150.2 to the financial institution (FI). A replacement payment is not issued until the original payment is returned to the RRB.</p>
D	<p>NON-RECEIPT-RRB REISSUE – Use when:</p> <ul style="list-style-type: none"> • The payment was not DD/EFT. • The payee is entitled to the check and additional adjudication actions are required by RRB. • The payee claims non-receipt, loss, theft, or mutilation of the check. • If lost or stolen, the check was not endorsed. • The check is less than a year old. <p>RRB will recertify a second payment outside of the Courtesy Disbursement process, after status of the original payment is determined to be outstanding.</p>
E	<p>RECLAMATION-DECEASED – Use when:</p> <ul style="list-style-type: none"> • The payee died prior to issuance of the payment. • The payee's estate is not entitled to the proceeds of the payment. • If payment was made by check, the check is less than a year old. <p>NOTE: In representative payee cases, when payments were made by check, use reason code "E" only if the representative payee is the one who died. When payments were made by DD/EFT, use reason code "E" when the annuitant or the representative payee is the one who died.</p>

F	<p>RECLAMATION-OTHER – Use when:</p> <ul style="list-style-type: none"> • Payment was <u>not</u> DD/EFT. • The payee is not entitled to all or part of the proceeds of the payment. • The check is less than a year old.
G	<p>LOST/STOLEN-ENDORSED – Use when:</p> <ul style="list-style-type: none"> • Payment was <u>not</u> DD/EFT. • The payee is entitled to the check. • The check was endorsed and then lost or stolen, • The check is less than a year old. <p>NOTE: Do not use code “G” to process a lost/stolen claim filed by a financial institution (see section 9.7.70).</p>
K	<p>PHOTOCOPY – Use when:</p> <ul style="list-style-type: none"> • Payment was <u>not</u> DD/EFT. • A photocopy of a check is required for agency use and non-receipt of checks more than a year old.
L	<p>CERTIFIED PHOTOCOPY – Use when:</p> <ul style="list-style-type: none"> • Payment was <u>not</u> DD/EFT. • The photocopy of the check must be certified to satisfy legal requirements.
M	<p>STATUS – Use when:</p> <ul style="list-style-type: none"> • The status of a check or DD/EFT payment is required for agency use. • The annuitant claims non-receipt of a check that is more than a year old, and there is no record that the check was previously cancelled.
S	<p>AGENCY MATCH-NON-ENTITLEMENT – Use when:</p>

	<ul style="list-style-type: none"> • Cross-reference with another agency's record indicates the payee is not entitled to all or part of the proceeds of the check. • RRB ha not confirmed the non-entitlement report. • Payment was not DD/EFT. • The check is less than a year old.
T	<p>AGENCY MATCH-DECEASED – use when:</p> <ul style="list-style-type: none"> • Cross-reference with another agency's record indicates payee is deceased. • RRB has not confirmed the death report. • Payment was made by DD/EFT. <p>NOTE: Use code “E” if the report of death has been confirmed.</p>
U	<p>RECLAMATION-LEGAL INCAPACITATION – Use when:</p> <ul style="list-style-type: none"> • The payee has been declared incompetent. • The payment was made by DD/EFT.

9.7.75 Determining When payment Investigation Transactions Will Be Processed

Transactions entered on PIENTRY are processed and transmitted at the close of each business to Treasury for processing. When a transaction is pending for a particular payment, the data that was input to create that transaction appears on the data screens. A pending transaction can be changed or deleted, of necessary, before it is processed. (See section 9.7.86 and 9.7.87)

9.7.80 Payment Investigation Display And Input

The FAST-Payment Investigation Entry (PIENTRY) system consists of four screens. Depending on the type of transaction being processed, entries may not be needed on each screen. In most cases, the system will pre-fill certain items; in some instances it may be necessary to alter or delete pre-filled information.

Before entering any transaction on PIENTRY, make sure the action was not previously taken. This can be determined by viewing the FAST-Payment Investigation Review Menu screen or FAST-Payment Investigation Status. The Review Menu lists pending cases that will be processed on the next run and PISTATUS lists transactions

previously submitted to Treasury. After determining that a payment investigation is in order, check to see if the annuitant's record is displayed on the DATA-Q screen.

NOTE: Check to make sure the proper annuitant record is displayed. While edits can prevent data input errors, they cannot prevent the entry of payment investigation information on the wrong record.

Annuitant on DATA-Q

Press the PF-9 key. The FAST-Payment Investigation Review Menu will appear.

REVIEW MENU

This screen displays any previous transactions entered that have not been processed. Up to twenty-four transactions can be stored. Any one of these transactions can be reviewed by entering the appropriate number in the 'SELECT OPTION' field. The 'UNIT ID' is also entered on this screen. The claim number and payee code are pre-filled from DATA-Q.

If no transactions are pending on the review menu, the FAST-Payment Investigation system pre-fills certain information from the annuitant's record on DATA-Q. Because of the DATA-Q link, the actual number of input items that the user must complete to process a transaction is reduced. Input errors are held to a minimum and can be corrected on-line.

The following items are pre-filled on the appropriate payment investigation screens from DATA-Q if there are no pending transactions on the Review Menu:

- Prefix
- Claim Number
- Payee Code
- Name
- Current address
- Direct deposit information
- Payment amount

In addition, the following items will be pre-filled from DATA-Q if there are no pending transactions on the Review Menu when the reason code entered is B or C:

Object code

RR amount

SUP amount

SS amount

SS fund code

However, when a transaction has been entered on FAST and is shown as pending on the Review Menu, all of the data from the earliest transaction date on the Menu (excluding the payment date) will appear on the entry screens.

Annuitant Not On DATA-Q

If the annuitant's record is not on DATA-Q, verify the claim number. If the claim number is correct, press the CLEAR key to return to the RRAPID Main Menu. Enter the number assigned to PIENTRY (for the Payment Investigation Entry screen) next to the word, SELECTION. Press ENTER and a screen resembling the Review Menu will appear.

Enter the following:

- Beneficiary symbol (e.g., W, WC, M, L)
- Prefix (e.g., A, D, H)
- Claim number, and
- Payee code.

Then press the ENTER key. The "UNIT ID" must also be entered on this screen.

The FAST-Payment Investigation entries are made on three screens. The screens are broken down into different subject areas, Payee Identification Information, Bank Identification Information, and Payment Identification Information.

PAYEE IDENTIFICATION INFORMATION

This screen contains information regarding the payee and the initial entries required for payment investigation. The claim number, payee code and current name and mailing address are pre-filled either from DATA-Q or the earliest pending transaction. If no DATA-Q record exists and no pending transactions are shown on the Review Menu, all necessary entries must be made.

A code representing the reason for the payment investigation must be entered. If the reason code is pre-filled from the earliest pending transaction, the code must be reviewed and modified, if necessary. If the payee or representative payee is deceased, additional entries are required.

This screen also carries over the claim number, payee code, unit ID, requester (signon) and the dates of the last five pending transactions and total number of pending transactions, if present.

BANK IDENTIFICATION INFORMATION

This screen displays information regarding direct deposit. If direct deposit information is currently shown on DATA-Q or the earliest pending transaction, the bank information will be pre-filled. The bank information on this screen may be added, deleted or modified to agree with the bank information as it was for the payment being investigated.

This screen also carries over the claim number, payee code, unit ID, requester (signon) and the dates of the last five pending transactions, and the total number of pending transactions, if present.

PAYMENT IDENTIFICATION INFORMATION

This final screen provides a breakdown of the current payment information as shown on DATA-Q or from the earliest pending transaction. The breakdown may be modified or deleted, depending on the type of transaction and the payment in question. If no DATA-Q record exists and no pending transactions are shown on the Review Menu, all necessary entries must be made.

The month and 4-digit year; e.g. 1999, of the payment must be entered. If partial reclamation is involved, that information is entered on this screen.

This screen also carries over the claim number, payee code, unit ID, requester (signon) and the dates of the last five pending transactions and total pending transactions, if present.

9.7.81 Entering A Non-Receipt Claim On Fast Payment Investigation

After determining that a non-receipt claim should be entered on FAST (see FOM1 115.30.2 and 115.30.3) and that the correct annuitant record is displayed in the DATA-Q screen, press the PF-9 key.

A. Payment investigation Review Menu

The cursor will position itself under the entry fields in the following order.

1. SELECT OPTION

- To enter a new transaction, do not make an entry in this field. Use the TAB key to move the cursor to the next field.
- If it is necessary to review, modify or delete a pending transaction, enter the two-digit menu number corresponding to the payment date.

(See sections 9.7.86 and 9.7.87 for instructions on modifying or deleting pending transactions.)

2. UNIT ID

- Enter your 4-digit organization code in the UNIT ID field.
- Press the ENTER key. The first data entry screen will appear.

B. Payee Identification Information Screen

The cursor will position itself under the entry fields in the following order.

1. REASON CODE

- Enter the appropriate reason code. Depending upon the particular circumstances, reason code A, B, C, D or G must be entered for a non-receipt claim. Refer to section 9.7.74 for the table of reason codes.

2. DECEASED NAME

- DO NOT make an entry. Use the TAB key to move the cursor to the next field.

3. DATE OF EVENT

- DO NOT make an entry. Use the TAB key to move the cursor to the next field.

4. NAME/ADDRESS

Treasury will sue the information entered in this field to issue the replacement check for requests coded B or C. This field will be pre-filled from DATA-Q or the pending transaction with the earliest chronological payment date. Verify that the name, street address or box number, city, state and ZIP code for the annuitant or representative payee is the most current.

- If the information in this field is not the most current, or the field is blank, type in the correct data.
- DO NOT precede the address with the cent sign or a group mark. The edit process will not pass those characters.
- If the information pre-filled or entered in this field is correct and reflects a non-foreign address, press the PF-2 key at this point to activate the edit process for this screen.

NOTE: Also process an address change using FAST-Change of Address if the address shown on DATA-Q is not correct.

5. REP PAYEE DEC'D

- DO NOT make an entry. Use the TAB key to move the cursor to the next field if necessary.

6. GEOGRAPHIC CODE

- If the annuitant resides in a foreign country, enter the three-digit geographic code (see RCM 10.2 Appendix B).

After all of the entries on this screen have been made or verified, press the PF-2 key to activate the edit process. If the input passes the edits, this message will appear on the screen:

“PAYEE ID INFORMATION IS CORRECT – PRESS PF2 TO CONTINUE”

Press the PF-2 key a second time. The second data entry screen will appear.

If an invalid entry has been made, the cursor will position itself under the invalid item and an error message will be displayed on the screen. Refer to RCM 9.7.84 and 9.7.88 for instructions on handling error messages.

C. Bank Identification Information Screen

If the payment involved is a Direct Deposit/Electronic Funds Transfer (DD/EFT) payment, all four of the fields on this screen must be completed. If the payment is not a DD/EFT payment, these items must be blank.

If this screen is being pre-filled from DATA-Q and the payee is currently receiving payment by DD/EFT, these items will be pre-filled. If the pending transaction with the earliest chronological payment date contains DD/EFT information, these items will be pre-filled from that transaction. Verify the information and type in any corrections. If these fields are pre-filled, but the payment involved was not released DD/EFT, sue the space bar to delete the data in all four fields.

The cursor will position itself under the data entry fields in the following order.

1. BANK ROUTING NUMBER

- Enter or verify the routing number of the Financial Institution (FI) corresponding to the payment in question.

2. CHECK DIGIT

- Enter or verify the check digit of the FI corresponding to the payment in question.

3. DEPOSITOR ACCOUNT NUMBER

- Enter or verify the depositor account number. The first digit of the account number must be entered on the first position to the left. Leave blank any positions after the account number.

4. TYPE BANK ACCOUNT

Enter or verify the type of account at the FI. Enter "C" if the account is a checking account, "S" if the account is a savings account.

After all of the entries on this screen have been made or verified, press the PF-2 key to activate the edit process. Handle any error messages according to sections 9.7.84 and 9.7.88. When the input passes the edits, press the PF-2 key a second time. The last data entry screen will appear.

D. Payment Identification Information Screen

The cursor will position itself under the entry fields in the following order.

1. PAYMENT DATE

- Enter the month and 4-digit year; e.g. 1999, that the payment was dated. If the month is only one digit, enter the digit in the second position and enter a zero in the first position (e.g., 08-1999 for August 1999).

2. PAYMENT AMOUNT

- Verify the amount of the payment pre-filled from DATA-Q or the pending transaction with the earliest chronological payment date. If the amount is not correct, type in the correct amount.

3. PAYMENT TYPE

- The system will pre-fill a "1" – recurring payment. Enter or verify the type of payment in question according to the following table.

1 – Recurring payment

2 – Accrual or One Payment Only

9 – Courtesy Disbursement (Replacement check)

4. FIRST CHECK NO

- If the payment involved is recurring, DO NO make an entry in this field.
- If the payment involved is an accrual or one payment only check, obtain the check number from Treasury's PACER system. If the check number is less than eight digits, zero-fill the number from the left so that the last digit of the number is in the last position on the right (e.g. 0 0 9 9 9 9 9 9).
- If the payment involved is a replacement check, obtain the exact check number from Treasury's TIE FILE system.

5. OBJECT CODE

- If the reason code entered is B or C, verify that the object code pre-filled from DATA-Q is correct. If the reason code is other than B or C this field should be blank.
- Verify or enter the appropriate object code according to the following table.

0 – RR ONLY

1 – SMI REFUND

2 – SS ONLY

4 – SUP ONLY

5 – RR/SS/SUP

6 – RR/SS

7 – RR/SUP

6. RR AMOUNT

- If the reason code is B or C and the object code is 0, 5, 6 or 7, verify or enter the RR amount of the payment.

7. SUP AMOUNT

- If the reason code is B or C and the object code is 4, 5, or 7, verify or enter the SUP amount of the payment.

8. SS AMOUNT

- If the reason code is B or C and the object code is 2, 5, or 6, verify or enter the SS amount of the payment.

9. SS FUND CODE

- If the reason code is B or C and the object code is 2, 5, or 6, verify or enter the SS Trust Fund Information. The code entered is "1" for OASI and "2" for DI.

10. RECLAIM PARTIAL

- DO NOT make an entry.

11. AMOUNT

- DO NOT make an entry.

After all of the entries on this screen have been made or verified, press the PF-2 key to activate the edit process. Handle any error messages according to sections 9.7.84 and 9.7.88.

9.7.82 Entering Reclamation On Fast Payment Investigation

After determining that a reclamation action should be entered on FAST and that the correct annuitant record is displayed on the DATA-Q screen, press the PF-9 key.

NOTE: Requests for non-recurring payments (i.e., accruals, One Pay Only, or Courtesy Disbursements) require additional information maintained in PSD-CSS.

A. Payment Investigation Review Menu

The cursor will position itself under the entry fields in the following order.

1. SELECT OPTION

- If it is necessary to review, modify or delete a pending transaction, enter the two-digit menu number corresponding to the payment date. (See sections 9.7.86 and 9.7.87 for instructions on modifying or deleting pending transactions.)
- To enter a new transaction, do not make an entry in this field. Use the TAB key to move the cursor to the next field.

2. UNIT ID

- Enter your 4-digit organization code in the UNIT ID field.
- Press the ENTER key. The first data entry screen will appear.

B. Payee Identification Information Screen

The cursor will position itself under the entry fields in the following order.

1. REASON CODE

- Enter the appropriate reason code. Depending upon the particular circumstances, reason code E, F, S, T or U must be entered for a reclamation action. Refer to section 9.7.74 for the table of reason codes.

2. DECEASED NAME

- If the reason code is E or T, enter the name of the deceased payee, or deceased representative payee. In check cases when the annuitant died but the representative payee is still alive, the reason code should be "F" and this field should be left unfilled.
- Enter the payee's last name followed by a blank, followed by first name, followed by a blank, followed by middle initial. If the surname, first name and middle initial do not fit in 22 positions, use the first initial rather than the first name.

Example: ROBERT L DOUGLAS should be entered as:

DOUGLAS ROBERT L

3. DATE OF EVENT

- If the reason code is E or T, enter the month, day, and 4-digit year; e.g. 1999, that the payee died. If the exact day is not known, enter the first day of the month. Entering "00" for the day will cause an error message.

4. NAME/ADDRESS

- In the majority of cases, this field will be pre-filled from DATA-Q. Verify that the name, street address or box number, city and state for the annuitant or representative payee is that to which the last payment was released.
- If the information in this field is not correct, or the field is blank, type in the correct data.
- DO NOT precede the address with the cent sign or a group mark. The edit process will not pass those characters.

5. REP PAYEE DEC'D

- Enter an “X” in this field if the action is being taken because of the death of the representative payee.

6. GEOGRAPHIC CODE

- If the address entered is a foreign address, enter the three-digit geographic code (see RCM 10.2 Appendix B).

After all of the entries on this screen have been made or verified, press the PF-2 key to activate the edit process. If the input passes the edits, this message will appear on the screen:

“PAYEE ID INFORMATION IS CORRECT – PRESS PF2 TO CONTINUE”

Press the PF-2 key a second time. The second data entry screen will appear.

If an invalid entry has been made, the cursor will position itself under the invalid item and an error message will be displayed on the screen. Refer to RCM 9.7.84 and 9.7.88 for instructions on handling error messages.

C. Bank Identification Information Screen

If the payment to be reclaimed is a Direct Deposit/Electronic Funds Transfer (DD/EFT) payment, all four of the fields on this screen must be completed. If the payment is not a DD/EFT payment, these items must be blank.

In the majority of cases, these items will be pre-filled from DATA-Q or the pending transaction with the earliest chronological payment date. Verify the information and type in any corrections. If these fields are pre-filled, but the payment to be reclaimed was not released DD/EFT, use the space bar to delete the data in all four fields.

The cursor will position itself under the data entry fields in the following order.

1. BANK ROUTING NUMBER

- Enter or verify the routing number of the Financial Institution (FI) corresponding to the payment in question.

2. CHECK DIGIT

- Enter or verify the check digit of the FI as corresponding to the payment in question.

3. DEPOSITOR ACCOUNT NUMBER

- Enter or verify the depositor account number. The first digit of the account number must be entered on the first position to the left. Leave blank any positions after the account number.

4. TYPE BANK ACCOUNT

- Enter or verify the type of account at the FI. Enter “C” if the account is a checking account, “S” if the account is a savings account.

After all of the entries on this screen have been made or verified, press the PF-2 key to activate the edit process. Handle any error messages according to sections 9.7.84 and 9.7.88. When the input passes the edits the third data entry screen will appear.

D. Payment Identification Information Screen

The cursor will position itself under the entry fields in the following order.

1. PAYMENT DATE

- Enter the month and 4-digit year; e.g. 1999, that the payment was dated. If the month is only one digit, enter the digit in the second position and enter a zero in the first position (e.g., 08-1999 for August 1999).

2. PAYMENT AMOUNT

- Verify the amount of the payment pre-filled from DATA-Q. If the amount is not correct, type in the correct amount.

3. PAYMENT TYPE

- The system will pre-fill a “1” – recurring payment. Enter or verify the type of payment in question according to the following table.

1 – Recurring payment

2 – Accrual or One Payment Only

9 – Courtesy Disbursement (Replacement check)

At this point, if a partial reclamation amount or an accrual, one payment only or replacement check is no involved, press the PF-2 key to activate the edit process. If partial reclamation is necessary, continue to fields 10 and 11.

4. FIRST CHECK NO

- If the payment involved is recurring, DO NOT make an entry in this field.
- If the payment to be reclaimed is an accrual or one payment only check, obtain the check number from Treasury's PACER system. If the check number is less than eight digits, zero-fill the number from the left so that the last digit of the number is in the last position on the right (e.g. 0 0 9 9 9 9 9 9).
- If the payment to be reclaimed is a replacement check, obtain the exact check number from Treasury's TIE FILE system.

5. OBJECT CODE

- DO NOT make an entry. Use the TAB key to move the cursor to the next field.

6. RR AMOUNT

- DO NOT make an entry. Use the TAB key to move the cursor to the next field.

7. SUP AMOUNT

- DO NOT make an entry. Use the TAB key to move the cursor to the next field.

8. SS AMOUNT

- DO NOT make an entry. Use the TAB key to move the cursor to the next field.

9. SS FUND CODE

- DO NOT make an entry. Use the TAB key to move the cursor to the next field.

10. RECLAIM PARTIAL

- If the amount to be reclaimed is less than the "PAYMENT AMOUNT," enter an "X" in this field.

11. AMOUNT

- If an "X" has been entered in the "RECLAIM PARTIAL" field, enter the amount to be reclaimed in this field.

After all of the entries on this screen have been made or verified, press the PF-2 key to activate the edit process. Handle any error messages according to sections 9.7.84 and 9.7.88.

9.7.83 Entering Photocopy or Status Request On Fast Payment Investigation

After determining that a photocopy request should be entered on FAST and that the correct annuitant's/beneficiary's record is displayed on the DATA-Q screen, press the PF-9 key.

NOTE: Requests for non-recurring payments (i.e., accruals, One Pay Only, or Courtesy Disbursements) require the check number.

A. Payment Investigation Review Menu

The cursor will position itself under the entry fields in the following order.

1. SELECT OPTION

- To enter a new transaction, do not make an entry in this field. Use the TAB key to move the cursor to the next field.
- If it is necessary to review, modify or delete a pending transaction, enter the two-digit menu number corresponding to the payment date. (See sections 9.7.86 and 9.7.87 for instructions on modifying or deleting pending transactions.)

2. UNIT ID

- Enter your 4-digit organization code in the UNIT ID field.
- Press the ENTER key. The first data entry screen will appear.

B. Payee Identification Information Screen

The cursor will position itself under the entry fields in the following order.

1. REASON CODE

- Enter the appropriate reason code. Depending upon the particular circumstances, reason code K, L, or M must be entered for a photocopy or status request. Refer to section 9.7.74 for the table of reason codes.

2. DECEASED NAME

- DO NOT make an entry. Use the TAB key to move the cursor to the next field.

3. DATE OF EVENT

- DO NOT make an entry. Use the TAB key to move the cursor to the next field.

4. NAME/ADDRESS

- Treasury will use the information entered in this field to forward photocopies of checks to the RRB. Show "RR RET BD" in the first line, the bureau, unit, and last name of the requestor, in the second line, and the address, city, state and zip code in the third and fourth lines.

EXAMPLE:

RR RET BD

RBD-RPS-SMITH

844 N RUSH ST

CHICAGO IL

60611

- If a payee, his family, or representative payee requests a photocopy of a check because there is a question about the payment having been received, process the request as a non-receipt claim.

After all of the entries on this screen have been made or verified, press the PF-2 key to activate the edit process. If the input passes the edits, the following message will appear:

"PAYEE ID INFORMATION IS CORRECT – PRESS PF-2 TO CONTINUE"

If an invalid entry has been made, the cursor will position itself under the invalid item and an error message will be displayed on the screen. Refer to sections 9.7.88 for instructions on handling error messages.

C. Bank identification Information Screen

A photocopy or status request should not be entered for a Direct Deposit/ Electronic Funds Transfer (DD/EFT) payment. When entering a photocopy or status request for a payment which was not released DD/EFT, but the fields on this screen have been pre-filled from DATA-Q or the pending transaction with the

earliest chronological payment date, delete the DD/EFT information from all four fields using the space bar. After all of the entries on this screen have been deleted, press the PF-2 key to activate the edit process.

D. Payment Identification Information Screen

The cursor will position itself under the entry fields in the following order.

1. PAYMENT DATE

- Enter the month and 4-digit year; e.g. 1999, that the payment was dated. If the month is only one digit, enter the digit in the second position and enter a zero in the first position (e.g., 08-1999 for August 1999).

2. PAYMENT AMOUNT

- Verify the amount of the payment pre-filled from DATA-Q or the pending transaction with the earliest chronological payment date. If the amount is not correct, type in the correct amount.

3. PAYMENT TYPE

- The system will pre-fill a “1” – recurring payment. Enter or verify the type of payment in question according to the following table.

1 – Recurring payment

2 – Accrual or One Payment Only

9 – Courtesy Disbursement (Replacement check)

4. FIRST CHECK NO

- If the payment involved is recurring, DO NOT make an entry in this field.
- If the request is for an accrual or one payment only check, obtain the check number from Treasury's PACER system. If the check number is less than eight digits, zero-fill the number from the left so that the last digit of the number is in the last position on the right (e.g. 00999999).
- If the request is for a replacement check, obtain the exact check number from Treasury's TIE FILE system.
- The remaining entries on the screen are not applicable for a photocopy or status request. Therefore, press the PF-2 key to

activate the edit process. Handle any error messages according to sections 9.7.84 and 9.7.88.

9.7.84 Editing Data

A. Input Passes Edits

To activate the edit process for the entire record, the PF2 key is pressed after the entries on the third data entry screen (Payment Identification Information) have been completed. If the data passes the edits, this message will appear in white on the screen:

“NO ERRORS DETECTED, HIT PF-2 TO
SUBMIT RECORD TO DATABASE.”

NOTE: If the data passes the edits after pressing the PF-2 key the first time, the data cannot be changed at this point. If it is necessary to make a change, use the modification or deletion functions according to sections 9.7.86 and 9.7.87.

Press the PF-2 key a second time. In response to the PF-2 key a confirmation message will appear in white on the screen.

“RECORD HAS BEEN ADDED TO THE DATABASE,
HIT PF-2 TO CONTINUE.”

B. Input Does Not Pass Edits

If invalid entry is made, the cursor will be positioned under the invalid item and an error message will be displayed on the screen. FAST can only indicate one invalid entry at a time. Therefore, after correcting the invalid item and hitting the PF-2 key, the system may identify a second item needing correction.

When the edit process is activated after the user has entered or verified the data on the final data entry screen, and any item on a prior screen has not passed the edits, the prior screen will appear, and an error message will be displayed on the screen. When all the data is valid, this message will appear on the screen:

“NO ERRORS DETECTED,
HIT PF-2 TO SUBMIT RECORD TO DATABASE.”

Refer to section 9.7.88 for a full discussion of edit messages and corrections.

Press the PF-2 key. This confirmation message will appear in white on the screen:

“RECORD HAS BEEN ADDED TO DATABASE,
HITPF-2 TO CONTINUE.”

C. Return to DATA-Q

To enter a payment investigation transaction on a different record, or return to DATA-Q, press the PF-6 key.

D. Finish with FAST/DATA-Q

When finished with FAST/DATA-Q press the clear key to return to the RRAPID Main Menu and enter an “X” next to the word “SELECTION”.

9.7.85 Pending Transactions

A payment investigation transaction pends on the database until it is batched and processed and transmitted to Treasury at the close of each business day. When a transaction for a particular payee is pending on the database, the data that was input to create the transaction may be viewed on the data entry screens. (Refer to RCM 9.7.72 for instructions on accessing payment investigation data entry screens.) A pending transaction may be modified or deleted, if necessary, before it is removed from the FAST database for processing.

FAST-Payment Investigation transactions can be modified an unlimited number of times while they are pending on the database. Payment Investigation transactions created by the Automated Receivables, Reclamations, and Credits (ARRC) system cannot be viewed on PIENTRY.

9.7.86 Modifying a Pending Transaction

If a pending transaction exists, the payment date of the transaction will appear on the Payment Investigation Review Menu. If you wish to modify a pending transaction, locate the payment date of the transaction to be modified and take the following action:

- Enter the two-digit menu number corresponding to the payment date in the SELECT OPTION field. If there is more than one payment date shown that needs to be changed, each payment date must be modified separately.
- Enter your unit ID and hit the ENTER key. The cursor will automatically move to the first field of the first data entry screen.
- Use the TAB key to move the cursor to the field(s) that need to be changed. Modify data by typing over the entries in a given field.

- Press the PF-2 key to re-enter information for the first two screens whether or not a change was made. This is necessary in order to build a complete record. The system will automatically advance to the next screen.
- After making the changes (if any) on the final screen, press the PF-3 key.

If the data is valid, this message will appear on the screen:

“NO ERRORS DETECTED,

HIT PF-3 TO MODIFY CURRENT RECORD ON THE DATABASE.”

NOTE: If the data passes the edits after pressing the PF-3 key the first time, the data cannot be changed at this point. If it is necessary to make a change, again use the modification function or use the deletion function according to sections 9.7.86 and 9.7.87.

- To enter the transaction, press the PF-3 key again. This message will appear on the screen.

“RECORD ON DATABASE HAS NOW BEEN MODIFIED,

HIT PF-2 TO CONTINUE.”

If the data is invalid, an error message will be displayed and the cursor will position itself under the erroneous entry. Refer to section 9.7.88 for edit messages and corrective actions. Make corrections and press the PF-3 key again until all input data is valid and the modification is made.

9.7.87 Deleting a Pending Transaction

After determining that a pending action should be deleted, e.g. the transaction was for the wrong payment or the payee is no longer claiming non-receipt, locate the payment date of the transaction to be deleted on the review menu and take the following action:

- Enter the two-digit menu number corresponding to the payment date in the SELECT OPTION field. If there is more than one payment date shown that needs to be deleted, each payment date must be deleted separately.
- Enter your four digit unit ID and hit the ENTER key. The cursor will automatically move to the first field of the next screen.
- Use the PF-8 key to page forward to the final entry screen.
- Press the PF-4 (Delete) key.

If the data is valid, this message will appear on the screen:

“NO ERRORS DETECTED, HIT PF-4 TO SUBMIT
DELETION ACTION TO THE DATABASE.”

NOTE: If the data passes the edit after pressing the PF-4 key the first time, the deletion cannot be changed at this point. If the data should not be deleted, it will be necessary to again enter it.

- To enter the deletion, press PF-4 again. This message will appear on the screen:

“RECORD ON DATABASE IS NOW A DELETION RECORD,
HIT PF-2 TO CONTINUE.”

If the data is invalid, an error message will be displayed and the cursor will position itself under the erroneous entry. Refer to section 9.7.88 for edit messages and corrective actions. After correcting the data, press PF-4.

9.7.88 Edit Messages and Corrective Actions

Activity entered through PIENTRY is edited on-line. The activity is not passed to the database until all the input information has cleared all edits. Errors are identified through error messages displayed at the bottom of the input entry screen. Errors can be corrected by typing over the erroneous entry with the correct information. Since most errors can be identified and corrected on-line, few FAST-Payment Investigation transactions reject. Listed below are the error messages that are displayed in the FAST edit process, and the corrective action that should be taken. The messages are listed according to the screen in which they will appear.

REVIEW MENU

A. SELECT OPTION

Message: “SELECT OPTION IS INCORRECT. PLEASE REENTER. PRESS ENTER.” This edit occurs if a menu number, which does not contain a payment date, is entered. This edit will also occur if a number greater than 25 is entered.

Correction: Type in a valid two-digit menu number or leave as 00.

B. UNIT ID

Message: “UNIT ID IS INCORRECT. PLEASE REENTER - PRESS ENTER.” This edit occurs if the UNIT ID has been omitted or is incomplete.

Correction: Type in the correct UNIT ID.

DATA ENTRY SCREEN ONE – PAYEE IDENTIFICATION INFORMATION

1. Message: “ENTER OR VERIFY BENEFICIARY SYMBOL.” This edit occurs if the beneficiary symbol has been omitted, or is incomplete.

 Correction: Type in the correct beneficiary symbol (e.g., M, W, WC) or leave blank.
2. Message: “ENTER OR VERIFY PREFIX.” This edit occurs if the prefix has been omitted, or is incomplete.

 Correction: Type in an A, D or H.
3. Message: “ENTER OR VERIFY CLAIM NUMBER.” This edit occurs if the claim number has been omitted, or is incomplete.

 Correction: Type in the correct claim number.
4. Message: “ENTER VALID REASON CODE – MUST BE – A B C D E F G K L M S T U.” This edit occurs if the reason code is anything other than A B C D E F G K L M S T or U.

 Correction: Type in an A B C D E F G K L M S T or U. (See section 9.7.74 for a listing of the reason codes and their uses.)
5. Message: “ENTER OR VERIFY ZIP OR GEOGRAPHICAL CODE.” This edit occurs if the last two positions of this field are blank and the first three positions are less than 561 or greater than 998 or the entry is non-numeric.

 Correction: Type in the correct ZIP or GEOGRAPHICAL code in accordance with Appendix B of RCM 10.2 or the ZIP master.
6. Message: “ENTER OR VERIFY PAYEE CODE.” This edit occurs if the payee code is a blank or an alpha character.

 Correction: Type in the correct payee code.
7. Message: “REASON CODE E OR T – ENTER DATE OF EVENT.” This edit occurs if the code is E or T and the date of the event is blank or incomplete.

 Correction: Verify that the reason code should be E or T and type in date of event in the MM-DD-YYYY format.
8. Message: “REASON CODE E OR T – ENTER PAYEE/DECEASED NAME.” This edit occurs if the reason code is E or T and the payee/deceased name is blank or incomplete.

Correction: Verify that the reason code should be E or T. Type in the payee/deceased name. The name should be entered – last name, followed by a space, first name, followed by a space, followed by the middle initial.

9. Message: “ENTER OR VERIFY NAME AND ADDRESS.” This edit will occur if the name and address are blank or incomplete.

Correction: Type in the beneficiary’s name and address. If the reason code is K, the address must end with:

844 N RUSH ST

CHICAGO IL 60611

10. Message: “REMOVE GROUP MARK FROM ADDRESS.” This edit will occur if the cent or group mark is entered in the NAME/ADDRESS field.

Correction: Delete the cent sign or group mark from the address.

DATA ENTRY SCREEN TWO – BANK IDENTIFICATION INFORMATION

1. Message: “ENTER OR VERIFY CHECK NUMBER.” This edit occurs if the type of payment is 2 or 9 and the check number is incomplete or blank.

Correction: Type in the correct check number. If the type of payment is 2 or 9, an entry must be made.

2. Message: “ENTER OR VERIFY BANK ID INFO.” This edit occurs when direct deposit information is left blank in any of the following fields: check digit, bank routing number, depositor account number and/or bank account fields. If all four fields are blank the edit will not be applied.

Correction: Type the correct bank information for any field(s) not entered.

3. Message: “ENTER OR VERIFY BANK ROUTING NUMBER.” This edit occurs if the bank routing number is blank or incomplete and the check digit, bank account and depositor account number are entered, or if the bank routing number entered is not a valid routing number.

Correction: Enter the correct bank routing number.

4. Message: “ENTER OR VERIFY DEPOSITOR ACCOUNT NUMBER.” This edit occurs if the depositor’s account number is blank or incomplete and the routing number, check digit, or bank account entries are entered.

Correction: Type the correct bank information for any field(s) not entered.

DATA ENTRY SCREEN THREE – PAYMENT IDENTIFICATION INFORMATION

1. Message: “ENTER OR VERIFY PAYMENT DATE.” This edit occurs when the payment date is:

- blank, or
- not numeric, or
- the first two positions are greater than 12.

Correction: Enter a payment date that is:

- numeric, or
- The first positions are 01 through 12.

2. Message: “PAYMENT DATE GREATER THAN CURRENT DATE - ENTER VALID PAYMENT DATE.” This edit occurs when the payment date is greater than the current month and year.

Correction: Enter the correct payment date.

3. Message: “ENTER OR VERIFY PAYMENT AMOUNT.” This edit occurs if the payment amount is:

- blank, or
- non-numeric.

Correction: Enter a numeric amount.

4. Message: “ENTER PAYMENT TYPE – MUST BE 1-RECUR, 2-OPO/ACCR, 9-REPLACEMENT.” This edit occurs when a number other than a 1, 2 or 9 has been entered or the payment type is blank.

Correction: Enter payment type 1, 2 or 9.

5. Message: “ENTER OR VERIFY RECLAIM PARTIAL CODE.” This edit occurs if any character other than “X” has been entered.

Correction: Enter “X” in this field, or delete the entry if partial reclamation is not involved.

6. Message: “ENTER OR VERIFY RECLAIM PARTIAL AMOUNT.” This edit occurs when:

- the partial amount is non-numeric, or
- the partial reclamation code is entered and
- the partial amount is blank or incomplete, or
- a partial amount which does not equal the payment amount is entered.

Correction: Type in a Reclaim Partial amount that is less than the payment amount, or delete the reclaim partial code if partial reclamation is not involved.

The following messages will only appear if the reason code is B or C.

7. Message: "VERIFY OBJECT CODE – 0=RR, 1=SMI REF, 2=SS, 4=SUP, 5=RR/SS/SUP, 6=RR/SS, 7=RR/SUP." This edit occurs if:

- the reason code is B or C, and
- the object code is blank, or
- the object code is other than, 0, 1, 2, 4, 5, 6 or 7

Correction: Enter a valid object code.

8. Message: "OBJECT CODE IS 0-SS FUND CODE MUST BE SPACE." This edit occurs when the object code is 0 and the SS fund code field is not blank.

Correction: Verify the object code and delete the entry in the SS FUND CODE field.

9. Message: "OBJECT CODE IS 0-SUPP AMOUNT MUST=0.00." This edit occurs when the object code is 0 and an amount is entered in the SUP AMOUNT field.

Correction: Verify the object code and delete the entry in the SUP AMOUNT field.

10. Message: "OBJECT CODE IS 0 SS AMOUNT MUST=0.00." This edit occurs when the object code is 0 and an amount is entered in the SS AMOUNT field.

Correction: Verify the object code and delete the entry in the SS AMOUNT field.

11. Message: "OBJECT CODE IS 1-SS FUND CODE MUST BE SPACE." This edit occurs when the object code is 1 and the SS FUND CODE field is not blank.
- Correction: Verify the object code and delete the entry in the SS FUND CODE field.
12. Message: "OBJECT CODE IS 1-SUP AMOUNT MUST = 0.00." This edit occurs when the object code is 1 and an amount is entered in the SUP AMOUNT field.
- Correction: Verify the object code and delete the entry in the SUP AMOUNT field.
13. Message: "OBJECT CODE IS 1-SS AMOUNT MUST = 0.00." This edit occurs when the object code is 1 and an amount is entered in the SS AMOUNT field.
- Correction: Verify the object code and delete the entry in the SS AMOUNT field.
14. Message: "OBJECT CODE IS 1-RR AMOUNT MUST = 0.00." This edit occurs when the object code is 1 and an amount is entered in the RR AMOUNT field.
- Correction: Verify the object code and delete the entry in the RR AMOUNT field.
15. Message: "OBJECT CODE IS 2-RR AMOUNT MUST = 0.00." This edit occurs when the object code is 2 and an amount is entered in the RR AMOUNT field.
- Correction: Verify the object code and delete the entry in the RR AMOUNT field.
16. Message: "OBJECT CODE IS 2-SUPP AMOUNT MUST = 0.00." This edit occurs when the object code is 2 and an amount is entered in the SUP AMOUNT field.
- Correction: Verify the object code and delete the entry in the SUP AMOUNT field.
17. Message: "OBJECT CODE IS 4-SS FUND CODE MUST BE SPACE." This edit occurs when the object code is 4 and the SS FUND CODE field is not blank.
- Correction: Verify the object code and delete the entry in the SS FUND CODE field.

18. Message: "OBJECT CODE IS 4-SS AMOUNT MUST = 0.00." This edit occurs when the object code is 4 and an amount is entered in the SS AMOUNT field.
- Correction: Verify the object code and delete the entry in the SS AMOUNT field.
19. Message: "OBJECT CODE IS 4-RR AMOUNT MUST = 0.00." This edit occurs when the object code is 4 and an amount is entered in the RR AMOUNT field.
- Correction: Verify the object code and delete the entry in the RR AMOUNT field.
20. Message: "OBJECT CODE IS 6-SUP AMOUNT MUST = 0.00." This edit occurs when the object code is 6 and an amount is entered in the SUP AMOUNT field.
- Correction: Verify the object code and delete the entry in the SUP AMOUNT field.
21. Message: "OBJECT CODE IS 7-SS FUND CODE MUST BE SPACE." This edit occurs when the object code is 7 and the SS FUND CODE field is not blank.
- Correction: Verify the object code and delete the entry in the SS FUND CODE field.
22. Message: "OBJECT CODE IS 7-SS AMOUNT MUST = 0.00." This edit occurs when the object code is 7 and an amount is entered in the SS AMOUNT field.
- Correction: Verify the object code and delete the entry in the SS AMOUNT field.
23. Message: "ENTER OR VERIFY SS FUND CODE – MUST BE 1-OASI OR 2-DI." This edit occurs if either of the following situations exist.
- The object code is 2, 5 or 6 and the SS fund code is blank or a code other than 1 or 2.
- Correction: Enter a code 1 for OASI or code 2 for DI.
- The object code is 0, 1 or 4 and the SS Fund code is not blank.
- Correction: Delete the entry in the SS Fund code field.

24. Message: “ENTER OR VERIFY RR AMOUNT.” This edit occurs if either of the following situations exist.

- The object code is 0, 5, 6 or 7 and the RR amount is blank.

Correction: Enter the correct RR amount.

- The object code is other than 0, 5, 6 or 7 and the RR amount is not blank.

Correction: Delete the RR amount, or correct the object code.

25. Message: “ENTER OR VERIFY SS AMOUNT.” This edit occurs if either of the following situations exist.

- The object code is 2, 5 or 6 and the SS amount is blank.

Correction: Enter the correct SS amount.

- The object code is other than 2, 5 or 6 and the SS amount is not blank.

Correction: Delete the SS amount, or correct the object code.

26. Message: “ENTER OR VERIFY SUP AMOUNT.” This edit occurs if either of the following situations exist.

- The object code is 4, 5 or 7 and the SUP amount is blank.

Correction: Enter the correct SUP amount.

- The object code is other than 4, 5 or 7 and the SUP amount is not blank.

Correction: Delete the SUP amount, or correct the object code.

9.7.100 Processed Activity

Activity that has been input to the FAST-Payment Investigation Entry (PIENTRY) system will remain on the PIENTRY screens until it has been processed and sent to Treasury at the close of each business day. Pending transactions can be modified or deleted, as necessary. Therefore, if the transaction can be viewed on PIENTRY, it has not yet been sent to Treasury.

9.7.101 System Output

PIENTRY processing prepares two files, a claim file containing the transactions for transmission to Treasury and an initial status disposition file that is updated to

PISTATUS. In addition to the files, the system produces a letter to the annuitant/beneficiary acknowledging the non-receipt claim and ARRC reject notices.

Acknowledgment Letters

The letters are delivered to the mailroom for release. Only an original letter is produced. A copy is not generated for the field office.

RL-37 – Released when the payment involved was sent via EFT and the reason code on the transaction is C.

RL-38 – Released when the payment involved was a paper check and the reason code on the transaction is B or C.

RL-39 – Released when the payment involved was a paper check and the reason code on the transaction is G.

9.7.105 Payment Investigation On-Line Status System(PISTATUS)

The Payment Investigation On-Line Status (PISTATUS) System allows individuals to view the status of non-receipt claims and reclamations, photocopy, and status requests made by the Railroad Retirement Board (RRB) to the Department of the Treasury (Treasury). The PISTATUS screens will display all transactions entered on FAST-Payment Investigation Entry (PIENTRY) and transactions received from the Automated Receivable, Reclamation, and Credit (ARRC) system, plus status messages and processing dates, the user signon, and unit ID. PISTATUS is updated on a daily basis. The information for a specific transaction will be maintained on the system for 18 months.

PISTATUS is available to both headquarters and field personnel. PISTATUS is a view-only system. Data to create a transaction must be entered on PIENTRY (see sections 9.7.71 to 101) or through ARRC.

If it is necessary to access DATA-Q initially to extract some needed date, the PISTATUS screen can be accessed through DATA-Q. Otherwise, if an inquiry only relates to payment investigation status, then PISTATUS can be directly accessed from the main menu of the Railroad Automated Processing Integrated Database (RRAPID).

PISTATUS will display one of two types of status messages depending on what action has been completed at the time the system is viewed. The two types of messages are as follows:

Transmitted to Treasury

If the transaction has been transmitted to Treasury's Regional Financial Center (RFC), but we have not yet received the disposition (response) file showing Treasury's action, the STATUS MESSAGE displayed will be "SENT TO TREASURY." The date the transaction was submitted to Treasury will be shown under RRB PROC DT.

RFC Response

After Treasury has processed the file containing our transactions, they will return a disposition file showing the action they took, PISTATUS will be updated to reflect this action; the check number or EFT trace number and check symbol (CK NUMBER-SYM) and RFC processing date (RFC PROC DT) will be added to the screen. In addition the RRB PROC DT will be updated to show the date the disposition file was processed at RRB.

9.7.110 Viewing STATUS

(PISTATUS) consists of two screens, a PISTATUS Menu and a PISTATUS Screen

PAYMENT INVESTIGATION

STATUS MENU

This screen displays the payment dates of transactions processed for the beneficiary in the last 18 months. Any one of these transactions can be reviewed by entering the corresponding menu number in the SELECT OPTION field and pressing ENTER.

SELECT OPTION is a three-digit field in order to accommodate menu items numbered over 99. While the menu will display only the payment dates for the 24 latest transactions, the total number of transactions on the status database, for that beneficiary, is displayed in the TOTAL field. Any number up to the TOTAL may be entered in the SELECT OPTION field.

- Beneficiary On DATA-Q

If the beneficiary's record is on DATA-Q, select the DATA-Q record and press the PF-13 key. The payment Investigation Status Menu will appear.

- Beneficiary Not ON DATA-Q

If the beneficiary's record is not on DATA-Q, verify the claim number. If the claim number is correct, press the CLEAR key to return to the RRAPID Main Menu. Select the number assigned to PISTATUS on the RRAPID Main Menu and enter it next to the word, SELECTION. Press ENTER and the payment investigation status menu appears.

Enter the following:

- Beneficiary symbol (e.g. W, WC, M, L)

- Prefix (A, D, H)
- Claim number, and
- Payee code.

Then press the ENTER key. The payment dates of transactions processed for that beneficiary, within the last 18 months will be displayed on the screen. Any of the transactions can be reviewed by entering the corresponding menu number in the SELECT OPTION field and pressing ENTER. The status screen for that particular payment date will appear.

PAYMENT INVESTIGATION STATUS

This screen contains information regarding the status of non-receipt claims and reclamation, photocopy, and status requests. It is not necessary to return to the menu screen in order to view transactions for other payment dates. Use PF-7 to page back and PF-8 to page forward to view the status screens of transactions for other payment dates.

The following is a description of the fields displayed on the Payment Investigation Status screens.

A. Identifying Data

1. CLAIM NUMBER P/C

- The beneficiary symbol, prefix, claim number and payee code shown on the payment in question.

2. NAME/ADDRESS

- In a non-receipt claim, this will be the most current name and address, or that which was shown on the statement of non-receipt.
- In a reclamation or status request, this will be the name and address shown in the last payment released.
- In a photocopy request this will be the name and location to which the photocopy will be forwarded.

3. GEO CODE

- If the address shown in NAME/ADDRESS is a foreign address, the three-digit geographical code will be displayed. (See RCM 10.2 Appendix B)

4. REQUESTOR UNIT ID

- The user ID, or signon, and the organization code of the person that entered the original transaction on FAST-Payment Investigation will be displayed.
- If the ARRC system was used to enter the original transaction, G-333 will be shown under REQUESTOR and the UNIT ID field will show zeroes.

B. Direct Deposit Data

If the payment involved is a Direct Deposit/Electronic Funds Transfer (DD/EFT) payment the following fields will contain data. In check cases these fields will be blank.

1. ROUTING NO

- The routing number and check digit of the financial institution (FI) to which the payment was released.

2. ACCT TYPE

- The type of account at the FI to which the payment was released; CHECKING or SAVINGS.

3. ACCOUNT NUMBER

- The depositor account number at the FI.

C. Payment Information

1. PAYMENT DT

- The month and year that the payment was issued.

2. PAYMENT AMT

- The amount of the payment involved.

3. PAYMENT TYPE

- The type of payment involved.
REC – Recurring or monthly payment
ACC – Accrual or One Payment Only
CSY – Courtesy Disbursement

4. CK NUMBER-SYM

- The check number or EFT trace number and check symbol of the payment involved. This data is provided by Treasury.

Exception: When the payment involved is an accrual or one payment only, or a replacement check, the check number will have been entered by RRB, and verified by Treasury.

D. Status Data

1. REASON

- The reason code and description of the action requested (i.e., non-receipt claim, reclamation request, photocopy request). A list of the possible reason codes and their description follow:

A: RRB REISSUE BEFORE STATUS

Used by Headquarters in dire need non-receipt situations or when due checks are returned to the RRB for reissuance. RRB recertifies a second payment before Treasury determines the status of the original payment. A stop code A is valid only for check payments.

B: MASS LOSS

Used at the discretion of Headquarters in mass loss situations. Treasury issues a replacement before the status of the original check is known. A stop code B is valid only for check payments and is to be used only in the month the payment was issued.

C: NON-RECEIPT-RFC REISSUE

Used by Headquarters and field offices in routine non-receipt situations. In check cases, Treasury issues a replacement check only after the original payment is determined to be outstanding (uncashed). In EFT cases, Treasury releases a trace request, Form FMS-150.1 or Form FMS-150.2, to the FI.

D: NON-RECEIPT-RRB REISSUE

Used by Headquarters in non-receipt situations requiring additional adjudication action. RRB recertifies a second payment after the status of the original payment is determined to be outstanding (uncashed) and the credit is received from Treasury.

E: RECLAMATION-DECEASED

Used by Headquarters when the payee died prior to issuance of the check or DD/EFT payment. In representative payee cases, when payments were made by check, reason code E is used only if the representative payee is the one who died. When payments were made by DD/EFT, reason code E is used when the annuitant or representative payee died.

F: RECLAMATION-OTHER

Used by Headquarters when the payee is not entitled to all or part of the proceeds of the payment. In representative payee cases, when payments were made by check, reason F is used when the annuitant died but the representative payee is alive. A stop code F is valid only for check payments.

G: LOST/STOLEN ENDORSED CK

Used by Headquarters when the payee endorsed the check and the check was then lost or stolen. A code G is valid only for check payments.

K: PHOTOCOPY

Used by Headquarters when a photocopy of a check is required for agency use. A code K is valid only for check payments.

L: CERTIFIED PHOTOCOPY

Used by Headquarters when the photocopy must be certified to satisfy legal requirements. A code L is valid only for check payments.

M: STATUS

Used by Headquarters when the payment status of a check is required for agency use, or the annuitant claim non-receipt of a check that is more than a year old and there is no record that the check was previously cancelled.

S: AGENCY MATCH-NON ENTITL

Used by Headquarters when cross-reference with another agency's record indicates that the payee is not entitled to all or part of the proceeds of the check, and RRB has not confirmed the non-entitlement report. A code S is valid only for check payments.

T: AGENCY MATCH-DECEASED

Used by Headquarters when cross reference with another agency's record indicates that the payee is deceased, and RRB has not confirmed the report of death. A code T is valid only for DD/EFT payments.

U: RECLAMATION-LEGAL INCAP

Used by Headquarters when the payee has been declared incompetent. A code U is valid only for DD/EFT payments.

2. RFC PROC DT

- The date Treasury's Regional Financial Center (RFC) processed the transaction.

3. RRB PROC DT

- The date the status record is created or updated by RRB. A record will remain on the system for 18 months from this date.

4. ORIG REQ DT

- The date the original transaction was created by RRB. This field will show zeroes until a response is received from Treasury.

5. PREV ACTION DT

- The date that a previous action was processed by RFC for this payment.

6. PI UPDATED

- The date that PI STATUS was most recently updated.

7. STATUS MESSAGE

- The status of the transaction. The status messages are listed and defined in section 9.7.115.

9.7.115 Status Messages

A. Confirmation and Reject Messages

After Treasury has processed the file containing our initial transactions from PIENTRY and ARRC, they will return a disposition file showing the action they took. This file will contain status messages in the form of confirmations and rejects. The initial response is usually received from Treasury in two business days, but 30 days is allowed before tracing. A confirmation indicates that all

necessary agency action has been completed and Treasury is processing the transaction. A reject indicates that Treasury was not able to process the claim based on the information that was provided. The rejected request is referred to the individual that originally submitted the claim for review and resubmission, if necessary.

1. Confirmation Messages

- SF-1184 PROCESSED

Initial processing by Treasury is completed. Transactions involving DD/EFT payments are forwarded to the FI. Transactions involving check payments require additional processing by Treasury.

- EFT PAYMENT TRACE PROCESSED

Treasury has released a DD/EFT payment tracer, FMS-150.1 or FMS-150.2, to the FI to investigate the claim of non-receipt.

- EFT PROOF OF PAYMENT PROCESSED

Treasury has confirmed that a DD/EFT was received by the FI. Treasury's handling is completed.

- EFT TRACE FOLLOW-UP PROCESSED

Treasury has released a follow-up DD/EFT payment tracer, FMS-150.1, to the FI to investigate a previous claim of non-receipt for the payment.

- PHOTOCOPY/STATUS REQUEST PROCESSED

Treasury is processing the photocopy or status request.

2. Reject Messages

- AMOUNT DIFFERENCE – TREASURY AMOUNT \$999999.99

The payment amount shown on our transaction does not match the amount shown on Treasury records. The requestor will submit a corrected transaction.

- CLAIM SUBMITTED TOO EARLY

The EFT follow-up trace request is less than 30 days from the date the initial non-receipt request was released. You must allow 30-45 days before tracing with Treasury.

- PREV SF-1184 ACTION

A non-receipt or reclamation stop request has already been processed against the payment.

This message will also be generated in a DD/EFT case when a subsequent reclamation request is received after a reclamation request has been processed against other payments involving the same payee based on the same date of death.

- CHECK PREV CANCELLED

The payment was previously cancelled by Treasury. The credit has been forwarded to RRB.

- REJECT – DATE OF EVENT AFTER DATE OF PYMT

The date of death is after the payment date.

- REJECT – INVALID PAYMENT DATA

The direct deposit information is invalid. Treasury's records indicate that the payment was issued as a paper check.

- NO RECORD OF ISSUE

Treasury has no record that the described payment was issued.

- REJECT – DECEDENT/PAYEE NAME DISAGREE

The name of the deceased and the payee name do not match in a transaction code E or T.

- INVALID STOP REASON CODE

An incorrect stop reason code was used.

3. Paid Status Messages

The following paid status messages apply to check payments and indicate that the check has been cashed. This second step in Treasury's processing (the first being the confirmation of receipt of the claim from RRB) usually occurs within three business days from the date the claim was initially sent to Treasury. However, 30-45 days is allowed before tracing with Treasury.

- PAID-CERTIFIED PHOTOCOPY TO FOLLOW

In response to a transaction entered with reason code L, Treasury will forward a certified photocopy of the check to the RRB for release to the requestor.

- PAID-CCG RECLAMATION; NO PHOTOCOPY TO AGENCY

In response to a reclamation coded E or T, Treasury will use the photocopy to seek recovery of the check amount from the FI and will credit RRB if the amount is recovered.

- PAID-COURTESY DISB. ISSUED BEFORE STATUS

Treasury will use this message only for request reason code B. This message confirms that a replacement check was issued as a result of mass loss processing and the original check has been cashed. Treasury will forward a photocopy of the original check and a claim form to RRB for handling. If an overpayment is involved, Headquarters will initiate recovery action.

- PAID-ENDORSEMENT MAY PROHIBIT CLAIMS ACTION: PHOTOCOPY AND CLAIM TO FOLLOW

Treasury will use this status message only for requests coded G. Treasury will send the photocopy and claim form to the RRB for release to the payee.

- PAID-PHOTOCOPY AND CLAIM TO FOLLOW

Treasury will use this status message for requests coded A, C, D, F, S, and U. If the request reason code is C or D, Treasury will forward the photocopy and claim form directly to the payee. In the remaining request codes, the photocopy and claim form will be forwarded to RRB for release to the payee.

- PAID-PHOTOCOPY TO FOLLOW

Treasury will use this status message only for request reason code K. Treasury will forward the photocopy to the RRB for release to the requestor.

- PAID STATUS

Treasury will use this status message only for request reason code M. Treasury is not taking any additional action based on this request.

- PAID-STATUE OF LIMITATIONS EXPIRED: NO PHOTOCOPY AVAILABLE

Treasury will use this status message for request coded K and L. The check has been cashed, but because of the age of the check, Treasury is unable to provide a photocopy.

- PAID-ISSUE AMOUNT \$25 OR LESS; NO FURTHER ACTION WILL BE TAKEN

Treasury will use this status message for request codes E and T. Treasury will not pursue any further action because of the amount of the check.

4. Outstanding Status Messages

The following outstanding status messages indicate that the check has not been cashed.

- OUTSTANDING-CHECK CANCELLED: AGENCY CREDIT TO FOLLOW

This message will be received for request codes A, D, E, F, G, S, T and U. Treasury will cancel the payment and forward the credit to RRB.

- OUTSTANDING-NO PHOTOCOPY

Treasury will use this status message for request codes K or L. No photocopy can be sent because the check has not been cashed.

- OUTSTANDING STATUS

Treasury will use this status message only for request code M. Treasury is not taking any additional action.

- OUTSTANDING-COURTESY DISB. ISSUED

Treasury will use this status message only for request code C. Treasury has issued a replacement check to the payee according to our request.

- OUTSTANDING-REPLACEMENT CHECK ISSUED BEFORE STATUS

Treasury will use this status message only for request code B. Treasury has issued a replacement check to the payee according to our request for mass loss processing.

5. Miscellaneous Status Messages

- PYMT EXCEPTION-CCG WILL INVESTIGATE

The transaction is being handled manually by Treasury's Check Claim Group in Hyattsville, MD. The case must be controlled for the results of the investigation.

- STATUS OF LIMITATION EXPIRED

Treasury is unable to take any claims action because of the age of the check. Treasury will sue this message when a non-receipt or reclamation request is received for a check payment that is over a year old.

- LIMIED PAYABILITY CANCELLATION

This message will be received when a stop code K, L, or M is processed against a payment that remained uncashed 12 months after its issue date. Treasury previously cancelled the check and forwarded the credit to the RRB.

9.7.150 FAST – Change of Address

The FAST system can be used to enter certain types of change of address transactions through the Mainframe instead of submitting PC Form G-607 or keypunching Form SF-1199A. Currently, FAST may be used to change the annuitant's/beneficiary's home address, to add or cancel combined mailing, to add, change, or delete Direct Deposit information, and to add or change representative payee information, including changing direct deposit with a representative payee change.

PC Form G-607 must continue to be used for change of name and change of selected benefit information (e.g., clear mass adjustment earmark, change DOB, change SS Trust Fund, etc.). Also, Form G-607 can still be used to make address changes; to add or delete combined mailing; to add, change or delete Direct Deposit information and to add or change representative payee information even though these same changes can be processed through FAST. Therefore, this on-line system does not obsolete PC Form G-607.

FAST-COA can also be used to mechanically reinstate an annuity that is in code 98 suspense status by processing a change code of '2, 4, 5 or B.' Refer to section 9.7.163 for more details.

9.7.151 How FAST Processes Change Of Address And Direct Deposit Transactions

- A. Overview - When a change of address action is processed through FAST, the user:

- calls up the DATA-Q screen of the annuitant or beneficiary whose change of address, Direct Deposit enrollment, or representative payee transaction is to be processed;
- presses the PF-8 key to access the CHANGE OF ADDRESS ENTRY SCREEN (field offices will get the COA/PAYEE ENTRY SCREEN); or PF-10 to access the DIRECT DEPOSIT ENTRY SCREEN;
- enters the required information (change code, unit ID, new address, Direct Deposit information, or representative payee information); and
- responds to edit messages, if necessary, until the data is accepted by the system.

B. The FAST system:

- edits the information entered by the user for consistency;
- creates a transaction consisting of the acceptable data entered by the user and data that it extracts from DATA-Q (prefix and claim number, payee code, combined mailing indicator, representative payee type code, and Direct Deposit information);
- stores the transaction on the database; and
- transfers the transaction to tape for processing through DAISY.

If the transaction processes successfully through DAISY, DATA-Q is updated with the new information. If applicable, the last COA date and Direct Deposit date are updated, the representative payee type code, and the combined mailing indicator are changed. If the transaction rejects in DAISY, a reject referral is produced and the change must be processed again. The reject referrals are loaded to the Universal Star (USTAR) system for review and re-entry, if necessary.

At times the new information is processed but a referral is produced which requires review to determine that the change is indeed correct. Most times the referral involves the ZIP code in a change of address. If correction is necessary, DCU processes the change.

9.7.152 Viewing The FAST Pending Change Screen

You must have security clearance to access DATA-Q through the RRAPID Main Menu in order to access the FAST system. However, the DATA-Q access only allows viewing of the FAST PENDING CHANGE SCREEN to determine if an on-line change of address transaction is pending. A separate security clearance for FAST itself is necessary to actually enter a change, modification or deletion. Headquarters and field personnel who

have responsibilities for taking change of address actions have security clearance to input FAST-Change of Address transactions.

Any employee who has access to DATA-Q may view the FAST PENDING CHANGE SCREEN to determine if an on-line change of address, Direct Deposit enrollment, or representative payee selection is pending. To view the FAST PENDING CHANGE SCREEN, locate the DATA-Q record of the annuitant/beneficiary upon whom you are inquiring. Press the PF-8 key.

A. DATA-Q Record is Terminated

If the record of the annuitant/beneficiary is terminated, the FAST PENDING CHANGE screen will be displayed with blank pending information fields. The following message will be displayed at the bottom of the screen:

"RECORD IS TERMINATED

HIT ENTER TO RETURN TO DATA-Q"

A FAST transaction cannot be entered on a terminated record.

B. DATA-Q Record is Suspended or in Current Pay Status

1. The employee is authorized to input FAST-Change of Address transactions - The FAST PENDING CHANGE SCREEN will be displayed. The screen will display the data entered to create the pending transaction. The pending data fields that are displayed in white can be modified through this screen. Modification to the data fields that are displayed in green is not allowed. If no FAST transaction is pending, a blank input screen will be displayed.
2. The employee is not authorized to input FAST-Change of Address transactions - The FAST PENDING CHANGE SCREEN will be displayed. The screen will display the data entered to create the pending transaction. The pending data fields will be displayed in green. Modification to the pending data is not allowed. The message "USER NOT AUTHORIZED TO MODIFY OR DELETE THIS TRANSACTION" will be displayed. If no FAST transaction is pending, the pending data fields will be blank and the message "NO PENDING FAST-COA TRANSACTION - INPUT NOT AUTHORIZED" will be displayed.

9.7.153 Who Can Input FAST-Change Of Address Transactions

Headquarters and field personnel who have responsibilities for taking change of address actions have security clearance to input FAST-Change of Address (COA) activities. In addition, one must have security clearance to access DATA-Q in order to use the FAST-COA system. A separate security table is maintained which authorizes

users to input data into FAST-COA. If one does not have clearance to input a FAST-COA transaction, only pending transactions can be viewed. When no transaction is pending and one does not have security clearance to input FAST-COA transactions, the screen will display the following message:

"NO PENDING FAST-COA TRANSACTION – INPUT NOT AUTHORIZED"

A FAST-COA security table is maintained within the FAST system to control access to certain data input fields on the FAST-COA screens. If a FAST-COA user is authorized to input data to a particular field, the beginning and the end of that field will show the symbols (). If data is already entered and the user is authorized to change the entries in the field, the data will be displayed in white. If a FAST-COA user is not authorized to input data to a particular field or a FAST-COA screen, the data in the field will be displayed in green and the cursor will not rest under that field. Field office personnel and some HQ employees are authorized to input data to the Direct Deposit fields on the FAST-COA screens; employees in the agency's field offices are authorized to input data to the representative payee fields on the FAST-COA screens. All employees with FAST-COA access can change an address, delete DD from the checkwriting record and delete a pending FAST transaction (except representative payee changes).

9.7.154 Types of Change Codes That Can Be Processed On FAST

The FAST-Change of Address system can be used to change address information for all addresses, including foreign addresses. FAST will be expanded, in the future, to process other types of changes, such as, change of selected benefit information. Until that time, PC Form G-607 must be used to enter those changes.

Following is a list of change codes, with their descriptions, that FAST will accept.

- Change Code 2 - Change of Home Address Only

Use change code 2 to:

- Change the home address in an employee only case;
- Change the home address in a survivor case;
- Change both an employee and spouse home address when the combined mailing indicator is "yes" on both records. Changing either record will change the address on both records.

NOTE: If one change is entered to change two records, the pending FAST change will only be displayed on FAST for the beneficiary record in which the change was entered. However, both addresses will be changed when the activity is updated to the checkwriting master.

- Change one address in an employee and spouse case in which the combined mailing indicator is "no".

NOTE: Do not change a home address in a representative payee case based on the annuitant's signature on the change of address request. The representative payee's signature is required in order to change an address in a representative payee case. If a change of address is received directly from an annuitant in a representative payee case, refer the request to the appropriate field office for an investigation.

- Change Code 4 - Cancel Combined Mailing Code and Change Home Address

Combined mailing was discontinued in 1986. All checks are now mailed separately; however, the combined mailing indicator remains on record for change of address purposes.

Use change code 4 to:

- Change one address in an employee and spouse case in which the combined mailing indicator for the beneficiary whose address is changing is "yes."

- Change Code 5 - Add Combined Mailing Code and Change Home Address

Combined mailing was discontinued in 1986. All checks are now mailed separately; however, the combined mailing indicator remains on record for change of address purposes.

Use change code 5 to:

- Change both an employee and spouse home address when the combined mailing indicator in the CURRENT INFORMATION section is "no" on both records or "yes" on one record and "no" on the other record. Processing a code 5 change on either record will change the address on both records.

NOTE: If one change is entered to change two records, the pending change will only be displayed on FAST for the beneficiary record in which the change was entered. However, both addresses will be changed when the activity is updated to the checkwriting master.

- Change Code A - Add Direct Deposit Information Only

Use change code A to:

- Enroll an annuitant in the Direct Deposit program when a home address change is not necessary at the time of enrollment;
- Change existing Direct Deposit information in an annuitant record when a home address change is not necessary at the time of the Direct Deposit change.

NOTE: SPECIAL SECURITY CLEARANCE IS REQUIRED FOR THIS CODE. Field office personnel and a limited number of ORSP employees who are assigned to Ford City are authorized to input change code A transactions. These employees are responsible for the processing of Direct Deposit enrollments through FAST.

- Change Code B - Add Direct Deposit and Change Home Address

Use change code B to:

- Enroll an annuitant in the Direct Deposit program when a home address change is necessary at the time of the Direct Deposit enrollment.
- Change existing Direct Deposit information in an annuitant record when a home address change is necessary at the time of the Direct Deposit change.

NOTE: SPECIAL SECURITY CLEARANCE IS REQUIRED FOR THIS CODE. Field office personnel and some HQ employees are authorized to input change code B transactions. These employees are responsible for the processing of Direct Deposit enrollments through FAST.

- Change Code C - Delete Direct Deposit Only

Use change code C to:

- Delete the Direct Deposit information from an annuitant record when a home address change is not required at the time the Direct Deposit information is being deleted.

- Change Code D - Delete Direct Deposit and Change Home Address

Use change code D to:

- Delete the Direct Deposit information from an annuitant record when a home address change is required at the time the Direct Deposit information is being deleted.

NOTE: Direct Deposit deletions are only processed upon receipt of a signed statement from the annuitant requesting that payments no longer be sent to the financial institution. Do not process a Direct Deposit deletion without such documentation.

- Change Code R - Change Representative Payee Information

Field offices alone use change code R to:

- Add a representative payee's name and address to an annuitant's record;

- Change a representative payee name and address to a new name and address; or
- Change from a representative payee name and address to an annuitant name and address;
- Change a representative payee code on DATAQ (see RCM 5.10.3 for the types of representative payee codes).
- Add and or change a representative payee's name with a simultaneous direct deposit enrollment or change.

NOTE: SPECIAL SECURITY CLEARANCE IS REQUIRED FOR THIS CODE.

Only field office employees are authorized to input change code R transactions. The field offices are responsible for the appointment of representative payees for annuitants in domestic cases.

When a change code R transaction is processed, the combined mailing and Direct Deposit are cancelled, and the representative payee type code is changed. An electronic notice (e-notice) will be produced for each representative payee selection (change code R) processed through FAST. The Program Evaluation Section will review the notice. Any e-notice showing a questionable representative payee name or address will be forwarded to the Program Services Section in the Bureau of Field Service for investigation.

- Change Code S - Add Direct Deposit and Change Home Address in Child Support Payment Cases

Select FAST COA system users in HQ use change code S to add Direct Deposit and change the home address in child support payment cases. Code S changes may be added either on the COA/PAYEE ENTRY SCREEN via PF8 or on the DIRECT DEPOSIT ENTRY SCREEN via PF10.

9.7.155 Determining When Record Will Reflect Changes Entered

A transaction pends on the database until it is transferred to tape for processing. When a transaction is pending for a particular claim number, the data that was input to create that transaction appears on the PENDING CHANGE SCREEN under the legend, "ENTER NEW INFORMATION." A pending transaction may be changed or deleted, if necessary, before it is removed from the FAST database for processing.

The length of time a transaction pends is dependent upon whether the new data is entered before or after the cut-off date for FAST-Change of Address. You can obtain the monthly cut-off dates from the Monthly Operations Calendar, which is available on the Share drive.

9.7.160 Processing Changes Of Address On FAST

Change of Address Display and Input - After determining that the annuitant's/beneficiary's address should be changed and that the correct annuitant's/beneficiary's record is displayed on the DATA-Q screen, press the PF-8 key. If the record is terminated, the FAST PENDING CHANGE SCREEN will be displayed with blank pending information fields. The message "RECORD IS TERMINATED HIT ENTER TO RETURN TO DATA-Q" will be displayed at the bottom of the screen. If the record is in current pay status suspended, one of two screens will be displayed.

NOTE: Do not change a home address in a representative payee case based on the annuitant's signature on the change of address request. The representative payee's signature is required in order to change an address in a representative payee case. If a change of address is received directly from an annuitant in a representative payee case, refer the request to the appropriate field office for an investigation.

- A. No FAST Transaction Pending - If no FAST transaction is pending, the COA ENTRY SCREEN will be displayed. The lower half of the screen will display a blank address field, change code field, unit ID field, and foreign address indicator field.

An example of the COA ENTRY SCREEN follows:

```

FAMED004          COA/PAYEE ENTRY SCREEN          031412
                                                14:04

J DOE             CURRENT INFORMATION
123 MAIN ST       PREFIX MA RRB # 123-45-6789      PAYEE CODE
ANYTOWN           C/M NO   LAST COA 01-01-01      REP PAYEE
ST 12345          DIRECT DEPOSIT INFORMATION
                  DATE     ROUTE NO   ACCOUNT TYPE/NO

                  GEO CODE

----- ENTER NEW INFORMATION -----
SDU STATE CD >  <          NCP SSN >          <
SDU ID CODE >          <   NCP NAME >          <

REP PAYEE:>          <>          < REP PAYEE TYPE:> <
ANNUITANT:>          <
ADDRESS: >ϕ          <
          >          <
          >          <
          >          <
                  <   FOREIGN ADDRESS? (Y): >   <
ENTER CHANGE CODE: X  ENTER UNIT ID: XXXX   USER SIGNON
  
```

-----RESPONSES-----

NEXT CLAIM NUMBER = PF1 ADD = PF2 DATAQ = PF6 EXIT = CLEAR

B. FAST Transaction Pending - If a FAST transaction is pending for the record, the PENDING CHANGE SCREEN will be displayed. This screen will display any pending information: address, Direct Deposit, representative payee information, change code, unit ID, and signon of the person who entered the pending transaction. The screen will also display an additional line for entry of a revised change code and unit ID. An example of the PENDING CHANGE SCREEN follows:

1. Upper Half of Screen - The FAST-Change of Address system prefills certain information directly from the annuitant's/beneficiary's DATA-Q record. Because of the DATA-Q link, the actual number of input items that the user must complete to process a transaction is reduced. Input errors are minimized and can be corrected on-line. Fields that are prefilled from DATA-Q are displayed in green and cannot be accessed by the user. The same prefilled fields are displayed on both the entry screen and pending transaction screen.

NOTE: It is important to verify that the proper annuitant/beneficiary record is displayed before entering data. While edits can prevent data input errors, a change for the wrong annuitant/beneficiary cannot be prevented by the system.

The following items are pre-filled from DATA-Q, and displayed in the CURRENT INFORMATION SECTION of the COA ENTRY SCREEN or PENDING CHANGE SCREEN:

- Name
- Address
- Beneficiary Symbol and Prefix
- Claim Number
- Payee Code
- Combined-Mail Indicator
- Last COA Date
- Rep Payee Code
- Direct Deposit Information

- Geographic Code

NOTE: The GEO Code value will only be displayed when the annuitant record includes a foreign address or the name of a U.S. Possession (Virgin Islands, Guam, Puerto Rico, etc.).

2. Lower Half of Screen - The lower half of the screen contains the data input items to be filled in by the user. The user sign-on will be carried through from the

DATA-Q sign-on function.

A message line is also located on the bottom of the FAST COA entry screen. If a COA transaction is being entered in a "dual" annuity case, the message "DUAL ANNUITANT CASE/ACTION NEEDED ON ANOTHER CLAIM NUMBER?" will be displayed.

9.7.161 Entering Data On The FAST-COA Screen

Access the FAST-COA ENTRY SCREEN or PENDING CHANGE SCREEN by pressing the PF-8 Key.

- A. How to Enter Data - The cursor will position itself under the data entry fields in the following order.

1. CHANGE CODE

- Enter the appropriate change code. If on the COA Entry screen a code 2, 4, 5, C, D or S must be entered in this field. Refer to RCM 9.7.240 for a complete description of the change codes available on FAST-COA.

It is not necessary to press the ENTER key after entering data in a field; the cursor will automatically move to the next input field once the required positions are filled.

2. UNIT ID

- Enter your 4-digit organization code in this field. If you are not sure of your correct organization code, refer to RCM 9.7 Appendix A.

3. SDU STATE CD – Enter the appropriate two-character state or US territory designation.

NOTE: This field is only used by select HQ users.

4. SDU ID CODE - Enter the appropriate SDU case ID code.

NOTE: This field is only used by select HQ users .

After the entry of the two character state or U.S. territory designation, press the PF-2 key. This will activate a sweep of the State Table, which contains the necessary address and Direct Deposit account information for the appropriate state disbursing agency. This action will automatically fill the name, address, and EFT information needed to complete the 'S' code transaction. The non-custodial parent (NCP) fields, i.e., NCP SSN and NCP NAME, will be pre-filled if that information is in PREH.

After checking that the automatic entries match the state entered in the SDU STATE CD field, press the PF-2 key again to submit the 'S' code transaction to the database.

5. ADDRESS BLOCK

Begin each line with the first space indicated by the cursor. Use the new line key or tab key to move the cursor from line to line.

The following basic rules apply:

- The first address line contains the system-supplied group mark and is limited to 19 characters.
- The second and third lines are restricted to 20 characters. The fourth line is restricted to 19 characters.
- You must use at least two lines to change an address. For an address that consists of only the name of the city and state, enter the name of the city on the first line and the state and ZIP code on the second line.

NOTE: If the name consists of two lines, (e.g., representative payee involved), do not use more than three lines for the address change.

- Use the standard abbreviations shown in RCM 8.1 Appendix B or RCM 10.2 Appendix B.
- Spell out the full city proper name whenever possible. However, it is expected that acceptable abbreviations such as ST (Saint), FT (Fort) etc., will be used with the proper name. If space limitations prevent city, state and ZIP code from occupying the same line, move the ZIP code to the next line rather than abbreviating. If it is still necessary to abbreviate, check the ZIP master for an acceptable city name abbreviation.

- Omit all punctuation; including hyphens (-), apostrophes ('), ampersands (&), forward slashes (/), backslashes (\), percentage signs used as the abbreviation for "care of" (%), etc.
- Allow only one space between each item of the address (house number, direction, city, state and ZIP code).
- Only the home address should be shown in the address block. The annuitant/beneficiary must complete Form SF-1199A at a financial institution to initiate enrollment in the Direct Deposit program.
- Do not show the annuitant's name in the address block.
- Enter the ZIP code on the same line as the state, unless it makes the line too long; in which case, enter the entire ZIP code on the next line. The 5 digit ZIP code must be the last entry when completing the address block.
- For a foreign address the name of the country must be the last entry on the final line of the address. The name of the country cannot be abbreviated in any way. (Refer to RCM 8.1 Appendix B or RCM 10.2 Appendix B).

6. FOREIGN ADDRESS INDICATOR

- If you are entering a foreign address, enter a 'Y' in this field.
- If you are not entering a foreign address, leave this field blank.

B. How to Activate the Edit Process - After you have completed entering the data on the COA ENTRY SCREEN, press the PF-2 key to activate the edit process.

9.7.162 Editing Data From The COA Entry Screen

A. Input Passes Edits - If the data passes the edits, this message will appear in white on the screen:

"NO ERRORS DETECTED, HIT PF-2 TO SUBMIT RECORD TO THE DATABASE."

- Press the PF-2 key a second time. In response to the PF-2 key a confirmation message will appear in white on the screen.

"RECORD HAS BEEN ADDED TO THE DATABASE,HIT PF-1 TO RETURN TO ENTER NEXT CLAIM NUMBER"

NOTE: Before storing the data, if it is necessary to change the data entered, move the cursor to the field to be changed, correct the data and then press the PF-2 key. The data will be edited again. If the transaction passes the edits, it will be stored on the data base. If the transaction does not pass all edits, an edit message will appear.

- B. Input Does Not Pass Edits - If an invalid entry is made, the cursor will be positioned under the invalid item and an error message will be displayed on the screen. FAST can only indicate one invalid entry at a time. Therefore, after correcting the invalid item and hitting the PF-2 key, the system may identify a second item needing correction. The fields are edited in the same sequence that they are entered by the user. When all the data is valid, this message will appear on the screen:

"NO ERRORS DETECTED, HIT PF-2 TO SUBMIT RECORD TO THE DATABASE."

Refer to RCM 9.7.171 for a full discussion of edit messages and corrections.

- Press the PF-2 key. This confirmation message will appear in white on the screen:

"RECORD HAS BEEN ADDED TO THE DATABASE, HIT PF-1 TO ENTER NEXT CLAIM NUMBER"

- C. Print-outs - To print out the screen press the PRINT key. A print-out of the input screen should be filed on the left side of the folder as documentation.
- D. Enter Next Claim Number/Finished With FAST - To enter another transaction, press the PF-1 key. If you are finished with FAST, press the PF-1 key and then press the CLEAR key to return to the RRAPID Main Menu. From this point select another application/system by entering the assigned number next to the word, SELECTION. Then, press ENTER. To sign-off of RRAPID, enter an X next to the word, SELECTION and press enter to return to the RRB train logo screen.

9.7.163 Reinstating Undeliverable Suspensions (Code 98) On FAST

If a check is returned as undeliverable, the annuity is suspended using a code 98 and the claim is referred to the Payment Service Unit (PSU).

In the past, field offices would call PSU to report an address change on code 98 cases to ensure that these cases would receive priority handling. With the FAST system, field office or headquarters personnel may now input the necessary information on-line.

If a claim of non-receipt is received and DATA-Q shows that the annuity is in code 98 suspense status, a change of address transaction with a change code of '2, 4, 5 or B'

can be processed to reinstate payments. The change of address transaction will reinstate current payments and reissue any past payments that are due.

The following action should be taken to generate a mechanical reinstatement:

- Determine if a new address is involved.
- If so, enter the new address information.
- If the address has not changed and the check was erroneously returned by the post office, it is still necessary to process a change of address activity to generate the mechanical reinstatement process. **Note:** Only a change code of '2, 4, 5 or B' may be processed to reinstate payments. Process a change of address activity showing the current address, and print-out a copy of the input screen for folder documentation.

Only code 98 suspensions may be reinstated by processing a change of address transaction.

9.7.164 Processing Direct Deposit Enrollments on FAST

- A. General - Enrollment in the Direct Deposit (DD) program will be processed based upon a written request, a verbal request (telephone or in-person), or submission of a SF-1199A. A separate request is necessary for each payee. A representative payee who chooses to enroll in DD is restricted to submitting a SF-1199A. Information on processing Direct Deposit (DD) forms is found in RCM 10.2.

Note: "Formless enrollment" is permitted in field offices only. Enrollment requests without the SF-1199A received at headquarters, will be referred to the appropriate field office for processing.

The entry of Direct Deposit information is restricted to a specific group of FAST-COA users who have security access to the Direct Deposit input fields.

- B. Direct Deposit Display and Input - After determining that the correct annuitant's/beneficiary's record is displayed on the DATA-Q screen, press the PF-10 key. If the record is terminated, the FAST PENDING CHANGE SCREEN will be displayed with blank pending information fields. The message "RECORD IS TERMINATED HIT ENTER TO RETURN TO DATA-Q" will be displayed. If the record is in current pay status or suspended, one of two screens will be displayed.
1. No FAST Transaction Pending - If no FAST transaction is pending for the record, the FAST DIRECT DEPOSIT ENTRY SCREEN will be displayed. The lower half of the screen will display blank route number, check digit, account number, account type, change code, and unit ID fields.

When a change code B is entered on the DIRECT DEPOSIT ENTRY SCREEN, the FAST COA/DD ENTRY SCREEN will be displayed after you press PF-2 to activate the screen edits. The screen will display the Direct Deposit information just entered, and a blank address block. The UNIT ID SIGNON and CHANGE CODE are carried forward from the DIRECT DEPOSIT ENTRY SCREEN. The message "NO ERRORS DETECTED IN DIRECT DEPOSIT FIELDS - ENTER ADDRESS INFORMATION" will be displayed at the bottom of the screen.

2. FAST Transaction Pending - If a FAST transaction is pending for the record, the FAST PENDING CHANGE SCREEN will be displayed. The lower half of the screen will display the pending address and/or Direct Deposit information, the pending change code, the unit ID and the signon of the person who entered the pending transaction.
- C. Upper Half of Screen - The FAST-Change of Address system prefills certain information from the annuitant's/beneficiary's DATA-Q record to the DIRECT DEPOSIT ENTRY SCREEN. Because of the DATA-Q link, the actual number of input items that the user must complete to enter a transaction is reduced. Input errors are minimized and can be corrected on-line. Fields that are prefilled from DATA-Q are displayed in green and cannot be accessed by the user. The same prefilled fields are displayed on both the entry screen and pending transaction screen.

NOTE: It is important to verify that the proper annuitant/beneficiary record is displayed before entering data. While edits can prevent data input errors, a Direct Deposit enrollment or change for the wrong annuitant/beneficiary cannot be prevented by the system.

The following items are prefilled from DATA-Q and displayed in the CURRENT INFORMATION SECTION of the screens:

- Name
- Address
- Beneficiary Symbol and Prefix
- Claim Number
- Payee Code
- Combined-Mail Indicator
- Last COA Date
- Representative Payee Type Code

- Direct Deposit Information
- Geographic Code

NOTE: The GEO Code value will only be displayed when the annuitant record includes a foreign address or the name of a U.S. Possession (Virgin Islands, Guam, Puerto Rico, etc.).

- D. Lower Half of Screen - The lower half of the screen contains all of the data input items to be completed by the user. The user sign-on will be carried through from the DATA-Q sign-on function.

9.7.165 Entering Direct Deposit Data On FAST.

- A. How to Enter Data - The cursor will position itself under the data entry fields in the following order:

1. CHANGE CODE

- Enter the appropriate change code. A code A or B must be entered in this field. Refer to RCM 9.7.320 for an explanation of these change codes.

2. UNIT ID

- Enter your 4-digit organization code in this field. If you are not sure of your correct organization code, refer to RCM 9.7 Appendix A.

3. ROUTE NUMBER

- Enter the 8-digit bank routing number as shown on the Form SF-1199A.

4. CHECK DIGIT

- Enter the 1-position check digit as shown on the Form SF-1199A.

5. ACCOUNT NUMBER

- Enter the depositor account number as shown on the Form SF-1199A.

6. ACCOUNT TYPE

- Enter a "C" or "S" as shown on the Form SF-1199A.

- B. How to Activate the Edit Process - After you have completed entering the data on the DIRECT DEPOSIT ENTRY SCREEN or COA/DD ENTRY SCREEN, press the PF-2 key to activate the edit process.

9.7.166 Editing Data From The Direct Deposit Entry Screen Or The COA/DD Entry Screen

A. Input Passes Edits

1. Change Code A Transactions - If the data passes the edits, a routing number verification message with the name of the financial institution (FI) will be displayed on the screen in white, for example:

"FIRST NATIONAL BANK VERIFY FI. IF CORRECT PRESS PF2 AGAIN"

- If the financial institution is correct, press the PF-2 key a second time. In response to the PF-2 key this confirmation message will be displayed on the screen in white:

"RECORD HAS BEEN ADDED TO THE DATABASE, HIT PF-1 TO ENTER NEXT CLAIM NUMBER."

2. Change Code B Transactions - If the Direct Deposit data passes the edits, the FAST COA/DD ENTRY SCREEN will be displayed with this message displayed in white:

"NO ERRORS DETECTED IN DIRECT DEPOSIT FIELDS ENTER ADDRESS INFORMATION."

- After entering the address information, press the PF-2 key. If the Direct Deposit and address data passes the edits, a routing number verification message with the name of the financial institution (FI) will be displayed on the screen in white, for example:

"FIRST NATIONAL BANK VERIFY FI. IF CORRECTPRESS PF2 AGAIN"

- Press the PF-2 key again. In response to the PF-2 key this confirmation message will be displayed on the screen in white:

RECORD HAS BEEN ADDED TO THE DATABASE, HIT PF-1 TO ENTER NEXT CLAIM NUMBER."

NOTE: Before storing the data, if it is necessary to change the data entered, move the cursor to the field to be changed, correct the data and then press the PF-2 key. The data will be edited again. If the transaction passes the edits, it will be stored on the data base. If the transaction does not pass all edits, an edit message will appear.

- B. Input Does Not Pass Edits - If an invalid entry is made, the cursor will be positioned under the invalid item and an error message will be displayed on the screen. FAST can only indicate one invalid entry at a time. Therefore, after correcting the invalid item and pressing the PF-2 key, the system may identify a second item needing correction. The fields are edited in the same sequence that they are entered by the user. When all the data is valid, a routing number verification message with the name of the financial institution (FI) will appear on the screen, for example:

"FIRST NATIONAL BANK VERIFY FI. IF CORRECT PRESS PF2 AGAIN"

Refer to RCM 9.7.171 for a full discussion of edit messages and corrections.

- Press the PF-2 key. This confirmation message will appear in white on the screen:

"RECORD HAS BEEN ADDED TO THE DATABASE, HIT PF-1 TO ENTER NEXT CLAIM NUMBER."

- C. Print-outs - To print out the screen, press the PRINT key.
- D. Enter Next Claim Number/Finished with FAST - To enter another transaction, press the PF-1 key. If you are finished with FAST, press the PF-1 key and then CLEAR key to return to the RAPID Main Menu. From this point select another application/system by entering the assigned number next to the word, SELECTION. Then press ENTER. To sign-off of RRAPID, enter an X next to the word, SELECTION and press ENTER to return to the RRB train logo screen.

9.7.167 Modifying A Pending Transaction

If a pending transaction exists, the input items will be filled under the "ENTER NEW INFORMATION" legend on the bottom half of the split screen.

The following message will appear at the bottom of the screen:

"COA EXISTS. TO KEEP - HIT PF-6. TO MODIFY - ENTER ALL DATA THEN PF-3. TO DELETE - ENTER UNIT ID THEN PF-4."

Data shown under the legend "CURRENT INFORMATION" cannot be modified. New data must be entered on the screen under the legend "ENTER NEW INFORMATION."

After reviewing the screen and determining that a modification is necessary, input modified data by typing over the entries in the address block and Direct Deposit fields that require modification. It is not necessary to input the entire address if only one entry in the address block is changed. However, before entering the modified address or Direct Deposit information, the cursor will be positioned in the "REVISED CHANGE CODE" field. You must always:

- Enter the correct change code. If the code has not changed enter the same code shown in the "CURRENT CHANGE CODE" field.
- Enter your UNIT ID in the "REVISED UNIT ID" field.
- Enter the modified Direct Deposit or address information in the appropriate fields.

The cursor will automatically move to the next input field once the required positions are filled.

Press the PF-3 key.

- A. Data is Valid - If the data is valid, this message will appear on the screen:

"NO ERRORS DETECTED, HIT PF-3 TO MODIFY CURRENT RECORD ON THE DATABASE."

- To cancel the transaction at this time before it has been accepted, press PF-6. You will return to DATA-Q and the original pending transaction will remain on the data base.
- To enter the transaction, press the PF-3 key again. This message will appear on the screen.

"RECORD ON DATABASE HAS NOW BEEN MODIFIED, HIT PF-1 TO ENTER NEXT CLAIM NUMBER."

To print out the screen, press the PRINT key.

- B. Data is Invalid - If the data is invalid, an error message will be displayed and the cursor will position itself under the erroneous entry. Refer to RCM 9.7.171 for edit messages and corrective actions. Make corrections and press the PF-3 key again until all input data is valid and the modification can be made.

To print out the screen, press the PRINT key.

9.7.168 Deleting A Pending Transaction

After determining that a pending action should be deleted:

- Move the cursor to the UNIT ID data entry field and enter your four digit UNIT ID and press the PF-4 (Delete) key.

- A. Data is Valid - If the data is valid, this message will appear on the screen:

"NO ERRORS DETECTED, HIT PF-4 TO SUBMIT DELETION ACTION TO THE DATABASE."

- To cancel the transaction at this time before it is accepted, press PF-6. You will return to DATA-Q and the original pending transaction will remain on the data base.
- To enter the deletion transaction, press PF-4 again. This message will appear on the screen:

"RECORD ON DATABASE IS NOW A DELETION RECORD, HIT PF-6 TO RETURN TO DATA-Q."

- B. Data is Invalid - If the data is invalid, an error message will be displayed and the cursor will position itself under the erroneous entry. Refer to RCM 9.7.171 for edit messages and corrective actions. After correcting the data, press PF-4.

NOTE: If you delete a pending transaction, payments will continue to be released according to the CURRENT INFORMATION displayed in the upper half of the PENDING CHANGE SCREEN. If Direct Deposit information is displayed, payments will be released to that financial institution. If Direct Deposit information is not displayed, payments will be released to the address that is displayed.

9.7.169 Special Modification Situations

Although a limited number of FAST-COA users are authorized to input Direct Deposit (change code A and B) transactions through the DIRECT DEPOSIT ENTRY SCREEN, any authorized FAST-COA user can modify or delete a pending change code A or B transaction. This section explains the situations in which these pending transactions can be modified or deleted, and the steps necessary to process the modification or deletion.

A. Change Code A Transaction Pending

1. The Current Home Address is Incorrect - If the address displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN is incorrect and:
 - a. The Pending Direct Deposit Enrollment is Correct - Modify the pending transaction as follows:
 - Enter a change code B in the REVISED CHANGE CODE field;
 - Enter the Unit ID in the REVISED UNIT ID field;
 - Enter the new address information in the address block; and
 - Press the PF-3 key to begin the edit process. After the input passes all of the edits, press the PF-3 key again to add the transaction to the data base.

- b. The Pending Direct Deposit Enrollment is Incorrect - If the Direct Deposit information displayed in the NEW INFORMATION section of the PENDING CHANGE SCREEN is incorrect and:
- (1) All Direct Deposit (both current and pending) Information is to be Deleted From the Record - To enter the new address information, modify the pending transaction as follows:
 - Enter a change code D in the REVISED CHANGE CODE field;
 - Enter the unit ID in the REVISED UNIT ID field;
 - Enter the new address information in the address block; and
 - Press the PF-3 key to begin the edit process. After the input passes all of the edits, press the PF-3 key again to add the transaction to the data base.
 - (2) The Current Direct Deposit Information is Correct - If the Direct Deposit information displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN is correct, delete the pending transaction as instructed in RCM 9.7.168. After the deletion transaction has been removed from the data base (usually the next day), process the new address information by entering a change code 2, 4, or 5 transaction, as appropriate.

Exception: Users who are authorized to input Direct Deposit transactions can access the PENDING CHANGE SCREEN by pressing the PF-10 key from DATA-Q. Then, enter a change code 2, 4, or 5 transaction as appropriate, and use the space bar to remove the pending Direct Deposit information from the pending transaction.
 - (3) The Annuitant is not Currently Enrolled in Direct Deposit - If no Direct Deposit information is displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN, modify the pending transaction as follows:
 - Enter a change code D in the REVISED CHANGE CODE field;
 - Enter the Unit ID in the REVISED UNIT ID field;

- Enter the new address information in the address block; and
 - Press the PF-3 key to begin the edit process. After the input passes all the edits, press the PF-3 key again to add the transaction to the data base.
2. The Current Home Address is Correct - If the address displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN is correct and:
- a. The Pending Direct Deposit Enrollment is Correct - Do not modify or delete the pending transaction.
 - b. The Pending Direct Deposit Enrollment is Incorrect
 - (1) All Direct Deposit (both current and pending) will be Deleted from the Record - Modify the pending transaction as follows:
 - Enter a change code C in the REVISED CHANGE CODE field;
 - Enter the Unit ID in the REVISED UNIT ID field; and
 - Press the PF-3 key to begin the edit process. After the input passes all of the edits, press the PF-3 key again to add the transaction to the data base.
 - (2) The Current Direct Deposit Information is Correct - If the Direct Deposit information displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN is correct delete the pending transaction as instructed in RCM 9.7.168.
 - (3) The Annuitant is not Currently Enrolled in Direct Deposit - If no Direct Deposit information is displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN, delete the pending transaction as instructed in RCM 9.7.168.

B. Change Code B Transaction Pending

- 1. The Current Home Address is Incorrect - If the address displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN is incorrect and:
 - a. The Pending Direct Deposit Enrollment and Address Information are Correct - Do not modify or delete the pending transaction.

b. The Pending Direct Deposit Enrollment is Correct and the Pending Address Information is Incorrect - Modify the pending transaction as follows:

- Enter a change code B in the REVISED CHANGE CODE field;
- Enter the unit ID in the REVISED UNIT ID field;
- Enter the necessary corrections to the address block and the Foreign Address Indicator field (if necessary); and
- Press the PF-3 key to begin the edit process. After the input passes all of the edits, press the PF-3 key again to add the transaction to the data base.

c. The Pending Direct Deposit Enrollment is Incorrect - If the Direct Deposit information displayed in the NEW INFORMATION section of the PENDING CHANGE SCREEN is incorrect and:

(1) ALL Direct Deposit (both current and pending) is to be Deleted from the Record

- Enter a change code D in the REVISED CHANGE CODE field;
- Enter the Unit ID in the REVISED UNIT ID field;
- Enter the necessary corrections to the address block and the Foreign Address Indicator (if necessary); and
- Press the PF-3 key to begin the edit process. After the input passes all of the edits, press the PF-3 key again to add the transaction to the data base.

(2) The Current Direct Deposit Information is Correct - If the Direct Deposit information displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN is correct, delete the pending transaction as instructed in RCM 9.7.168. After the deletion transaction has been removed from the data base (usually the next day), process the new address information by entering a change code 2, 4, or 5 transaction, as appropriate.

Exception: Users who are authorized to input Direct Deposit transactions through FAST can access the PENDING CHANGE SCREEN by pressing the PF-10 key from DATA-Q. Then, enter a change code 2, 4, or 5 transaction, as

appropriate, and use the space bar to remove the pending Direct Deposit information from the pending transaction.

(3) The Annuitant is not Currently Enrolled in Direct Deposit - Modify the pending transaction as follows:

- Enter a change code D in the REVISED CHANGE CODE field;
- Enter the Unit ID in the REVISED UNIT ID field;
- Enter the necessary corrections to the address block and foreign address indicator, (if necessary); and
- Press the PF-3 key to begin the edit process. After the input passes all of the edits, press the PF-3 key again to add the transaction to the data base.

2. The Current Home Address is Correct - If the address displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN is correct and:

a. The Pending Direct Deposit Information is Correct - Modify the pending transaction as follows:

- Enter a change code A in the REVISED CHANGE CODE field;
- Enter the Unit ID in the REVISED UNIT ID field;
- Remove the pending address information from the address block and the foreign address indicator (if necessary) by using the space bar; and
- Press the PF-3 key to begin the edit process. After the input passes all of the edits, press the PF-3 key again to add the transaction to the data base.

b. The Pending Direct Deposit Enrollment is Incorrect - If the Direct Deposit information displayed in the NEW INFORMATION section of the PENDING CHANGE SCREEN is incorrect and:

(1) ALL Direct Deposit (both current and pending) is to be Deleted from the Record - Modify the pending transaction as follows:

- Enter a change code C in the REVISED CHANGE CODE field;

- Enter the Unit ID in the REVISED UNIT ID field;
- Remove the pending address information from address block and foreign address indicator field (if necessary) by using the space bar; and
- Press the PF-3 key to begin the edit process. After the input passes all of the edits, press the PF-3 key again to add the transaction to the data base.

- (2) The Current Direct Deposit Information is Correct - If the Direct Deposit information displayed in the CURRENT INFORMATION section of the PENDING CHANGE SCREEN is correct, delete the pending transaction as instructed in RCM 9.7.168.
- (3) The Annuitant is not Currently Enrolled in Direct Deposit - Delete the pending transaction as instructed in RCM 9.7.168.

C. Acknowledgement Message Display - When modifying a pending change code A or B transaction by entering a change code C or D transaction, the message "ALL DIRECT DEPOSIT WILL BE DELETED, HIT PF-3 TO MODIFY CURRENT RECORD ON THE DATABASE" will be displayed after the PF-3 key is pressed the first time and the transaction has passed all of the edits. Press the PF-3 key again to add the modification transaction to the data base.

9.7.170 When Pending Transactions Are Processed

A FAST-COA transaction pends on the data base until it is transferred to tape for processing through DAISY. When a transaction for a particular claim is pending on the data base, the data that was input to create that transaction appears on the pending change screen under the heading "ENTER NEW INFORMATION." A pending transaction may be changed or deleted, if necessary, before it is removed from the FAST data base for processing through DAISY.

FAST-COA transactions can be modified an unlimited number of times while they are pending on the data base. The latest transaction on record will be processed through DAISY. Change of address transactions created by G-607 input forms cannot be viewed on FAST.

How long a transaction pends on the data base depends on when in the month it is entered.

A. Transaction Entered on or Before Cutoff - Transactions entered from the second to the last work day of the month through the cut-off for FAST-COA in the

following month are removed from the data base at the end of each work day and processed through DAISY overnight.

Exception: Transactions entered on the day before cut-off will pend an extra day. No change of address-type activity is processed on the day before cut-off.

For example, if the FAST-COA cut-off is September 17, a change of address entered on or before that date will process through DAISY overnight and should appear on DATA-Q the next work day. Therefore, if the annuitant/beneficiary is not on Direct Deposit, the 10-1 payment will be released to the new address. (Transactions entered on September 16, the day before cut-off, would not appear on DATA-Q until September 18, because no change of address type activity is processed on the day before cut-off).

- B. Transactions Entered After Cutoff - Transactions entered after FAST-COA cut-off pend through the second to the last work day of the month when they are removed for processing through DAISY with the next month's activity.

For example, if an annuitant is not on Direct Deposit and the change of address is processed on September 18, after cut-off, the 10-1 payment will be released to the old address.

NOTE: There is sometimes a delay in DATA-Q's being updated, for example, after the cost-of-living adjustment. A pending change of address transaction may still have been processed through DAISY even though it will not appear on DATA-Q until it is updated. Be aware of the DATA-Q update date.

9.7.171 Edit Messages And Their Corrective Actions

- A. Overview - Activity entered through FAST is edited on-line. Activity is not passed to the data base until all the input information has cleared all edits. Errors are identified through error messages displayed at the bottom of the input entry screen. Errors can be corrected by typing over the erroneous entry with the correct information. Since most errors can be identified and corrected on-line, few FAST change of address transactions reject in DAISY. The listing of edit messages contained in this section has been divided into four categories: access edits, common edits, COA entry/modification edits, and Direct Deposit entry/modification edits. The edits for the representative payee fields are explained in FOM-I-1570. Representative payee (code R) transactions cannot be modified or deleted by headquarters employees.
- B. Access Edits - Listed below are the error messages that can occur when attempting to access a FAST-COA screen. These messages will be displayed at the bottom of the FAST PENDING CHANGE SCREEN.
1. Message: "RECORD IS TERMINATED, HIT ENTER TO RETURN TO DATA-Q." This message is displayed when the payment record of the

annuitant is terminated. No FAST-COA input is allowed when an annuitant record is terminated.

Correction: Verify that the proper annuitant/beneficiary record is displayed on the screen. If the incorrect record is displayed, press either the ENTER or the PF-6 key to return to DATA-Q.

2. Message: "INVALID PF KEY - USER NOT AUTHORIZED FOR DD ENTRY - ACCESS FAST-COA WITH PF-8. HIT ENTER TO RETURN TO DATA-Q." This message will be displayed when a user who is not authorized to enter Direct Deposit data attempts to enter FAST using the PF-10 key.

Correction: Press either the ENTER or the PF-6 key to return to DATA-Q. From the DATA-Q screen, press the PF-8 key to access the FAST-COA system.

3. Message: "USER NOT AUTHORIZED TO MODIFY OR DELETE THIS TRANSACTION." This message is displayed when a pending change code R transaction is accessed by a headquarters employee.

Correction: Change code R transactions can only be modified or deleted by field office employees.

- C. Common Edits - Listed below are the error messages that can occur on any of the FAST-COA system screens.

1. CHANGE CODE

- a. Message: "INVALID CHANGE CODE, ENTER VALID CHANGE CODE." This edit occurs if a code other than 2, 4, 5, A, B, C, D or R is entered.

Correction: Determine the type of change being processed and enter the appropriate code. On the COA ENTRY SCREEN, codes 2, 4, 5, C or D can be used. On the DIRECT DEPOSIT ENTRY SCREEN, codes A or B can be used. On the COA/DD ENTRY SCREEN, code B can be used. On the PENDING CHANGE SCREEN, codes 2, 4, 5, A, B, C or D can be used. Code R can only be used by field office employees. If the change code is other than 2, 4, 5, A, B, C or D submit the change on Form G-607.

- b. Message: "USER NOT AUTHORIZED FOR THIS CHANGE CODE."

This edit occurs if a change code R is entered by a headquarters FAST-COA user or if a change code A or B is shown on the COA

ENTRY SCREEN by a user not authorized to add Direct Deposit enrollments through FAST.

Correction: Change code R transactions cannot be entered by headquarters FAST users. Enter the correct change code 2, 4, 5, C, or D, as appropriate, or process the representative payee change manually.

- c. Message: "CHANGE CODE CANNOT ACCEPT DIRECT DEPOSIT DATA." This edit occurs when a change code 2, 4, or 5 is entered and there are entries in the Direct Deposit fields.

Correction: Correct the change code to A or B. These change codes are the only codes that will allow the entry of Direct Deposit information.

- d. Message: "DIRECT DEPOSIT INFORMATION NOT ENTERED - CHANGE CODE INVALID." This edit occurs when change code A or B is entered and the Direct Deposit fields are blank.

Correction: Enter the Direct Deposit information in the fields provided or enter the correct change code 2, 4, 5, C or D.

- e. Message: "CHANGE CODE CANNOT ACCEPT ADDRESS DATA." This edit occurs when a change code A or C is entered and the address block is filled.

Correction: Correct the change code to 2, 4, 5, B or D, as appropriate. If a change code of A or C is correct, space out the address information.

- f. Message: "NO CURRENT DIRECT DEPOSIT - CHANGE CODE INVALID." This edit occurs when a change code C is entered and there is no Direct Deposit information shown in the CURRENT INFORMATION section of the FAST screen.

Correction: Enter the correct change code. If you are attempting to delete a pending Direct Deposit enrollment, refer to the special modifications situations in RCM 9.7.169.

2. UNIT ID

- a. Message: "NO UNIT ID ENTERED - ENTER UNIT ID." This edit occurs if the UNIT ID has been omitted.

Correction: Type in the correct UNIT ID.

- b. Message: "UNIT ID NOT NUMERIC - ENTER NUMERIC UNIT ID." This edit occurs if the UNIT ID entered does not consist of four digits, or is incomplete.

Correction: Type in a valid UNIT ID.

- c. Message: "INVALID UNIT ID - ENTER VALID UNIT ID." This edit occurs if the UNIT ID entered is not valid as listed in RCM 9.7 Appendix A.

Correction: Type in a valid UNIT ID.

3. PF-KEY

- a. Message: "INCORRECT REPONSE KEY - TRY AGAIN." This edit occurs if the incorrect PF key is hit for the type of action being taken or if the enter key is pressed when a PF key should be pressed.

Correction: Press the proper PF key according to the action being taken. Press PF-2 to add a transaction, PF-3 to modify a pending transaction, PF-4 to delete a pending transaction and PF-6 to leave as is and return to DATA-Q. PF key instructions are displayed at the bottom of the screen.

- D. Change of Address Edits - Listed below are the error messages that occur when you are processing address changes through FAST.

1. ADDRESS BLOCK

- a. Message: "ENTER NEW ADDRESS INFORMATION." This edit occurs if the address block is blank.

Correction: The change code entered requires completion of the address block. Enter the new address information.

- b. Message: "BEGIN ADDRESS ON FIRST LINE." This edit occurs if the first line of the address block is blank.

Correction: Enter the address beginning with the first position of the first line.

- c. Message: "DO NOT ENTER GROUP MARK." This edit occurs if the group mark (¢) is entered in any line of the address block.

Correction: Remove the group mark from the address block.

- d. Message: "CLOSE SPACE AFTER GROUP MARK." This edit occurs if a space is entered between the group mark and the beginning of the address.

Correction: Use the TAB key to locate the beginning position of the address. It will appear on the screen that there is a space after the group mark, but there really is not in the record that will be created for the data base.

- e. Message: "ADDRESS MUST HAVE AT LEAST 2 LINES." This edit occurs if the address is entered on only one line. An address must have two lines.

Correction: Alter the entry of a new address so that the address consists of two lines.

- f. Message: "REMOVE PUNCTUATION FROM ADDRESS LINES." This edit occurs if punctuation marks (periods, commas, etc.) have been entered in the address block.

Correction: Remove all punctuation from the address block.

- g. Message: "ZIP CODE MISSING - ENTER ZIP CODE OR ANSWER FOREIGN ADDRESS QUESTION." This edit occurs if the address does not contain a ZIP Code; the ZIP code entered does not contain five numbers; or there is no space between the two-letter state abbreviation and the ZIP code.

Correction: Enter the proper five-digit ZIP Code when processing a domestic or U.S. possession address change. If you are processing a foreign address change, answer the foreign address question "Y" (Yes), and be sure to enter the country name, completely spelled out, in the last line of the address. (Refer to RCM 8.1 Appendix B or RCM 10.2 Appendix B).

- h. Message: "LAST POSITION OF LAST ADDRESS LINE MUST BE BLANK." This edit occurs if the last line of the address entered contains 20 characters, including spaces. The last line of the address is limited to 19 characters, including spaces.

Correction: Alter the last line of the address so that it does not exceed 19 characters, including spaces.

- i. Message: "BEGIN ADDRESS LINE IN FIRST POSITION." This edit occurs if any address line begins with a space.

Correction: Use the TAB key or the NEW LINE key to locate the beginning position of each address line. Begin entering address information in the first position of the address line.

- j. Message: "INVALID STATE CODE" This edit occurs if the two-digit state designation is invalid (for a COA transaction not designated as a foreign address).

Correction: Enter the correct two-digit state designation for the U.S. state, U.S. possession, or Armed Forces address for a domestic address OR enter "Y" in the foreign address indicator field for a foreign address.

2. FOREIGN ADDRESS INDICATOR

- a. Message: "INVALID ANSWER TO FOREIGN ADDRESS QUESTION." This edit occurs if the foreign address indicator field does not contain a "Y" or a blank space.

Correction: If you are processing a foreign address change, answer the foreign address question "Y" (yes) and be sure to enter the country name, completely spelled out, in the last line of the address. If you are not processing a foreign address change, this item should be blank. Delete any entry in this field if you are not processing a foreign address change.

- E. Direct Deposit Edits - Listed below are the error messages that occur when you are processing Direct Deposit transactions through FAST. These messages are listed in the order that variable data is entered. Address block edits are explained in RCM 9.7.171D.

1. ROUTE NUMBER

- a. Message: "ROUTE NUMBER MISSING." This edit occurs if the route number field is blank.

Correction: Enter the route number shown on the Form SF-1199A.

- b. Message: "ROUTE NUMBER CONTAINS A SPACE OR NON-NUMERIC - ENTER CORRECT ROUTE NUMBER." This edit occurs if spaces or non-numeric characters are present in the route number field.

Correction: Enter the correct eight digit route number shown on the Form SF-1199A, removing any spaces or non-numeric characters.

- c. Message: "ERROR - VERIFY RTN. THE RTN ENTERED IS NOT VALID." This edit occurs if the route number entered is not listed on the Financial Organization Master File (FOMF).

Correction: Verify that the financial institution (FI) shown on the Form SF-1199A is correct and re-enter the correct eight digit route number 2.

CHECK DIGIT

- a. Message: "CHECK DIGIT MISSING." This edit occurs if the check digit field is blank.

Correction: Enter the check digit shown on the Form SF-1199A.

- b. Message: "CHECK DIGIT INVALID - ENTER THE CORRECT CHECK DIGIT." This edit occurs if the check digit entered is not correct.

Correction: Enter the check digit shown on the Form SF-1199A. If this edit still occurs, verify the route number and re-enter the route number and check digit.

- c. Message: "CHECK DIGIT MUST BE NUMERIC - ENTER CORRECT CHECK DIGIT." This edit occurs if the check digit entered is not a number.

Correction: Enter the numeric check digit shown on the Form SF-1199A.

3. ACCOUNT NUMBER

- a. Message: "ACCOUNT NUMBER MISSING." This edit occurs if the account number field is blank.

Correction: Enter the account number shown on the Form SF-1199A.

- b. Message: "INVALID CHARACTER IN ACCOUNT NUMBER - ENTER CORRECT ACCOUNT NUMBER." This edit occurs if something other than a letter, number, or hyphen is entered in the account number field.

Correction: Enter the account number exactly as shown on the Form SF-1199A.

4. ACCOUNT TYPE

- a. Message: "ACCOUNT TYPE MISSING." This edit occurs if the account type field is blank.

Correction: Enter the account type as shown on the Form SF-1199A.

- b. Message: "ACCOUNT TYPE MUST BE "C" OR "S" - ENTER CORRECT ACCOUNT TYPE." This edit occurs if the entered account type is not a C or S.

Correction: Enter the account type as shown on the Form SF-1199A.

9.7.190 Field Office Handling Of FAST Change Of Address Transactions

After the field office has completed a FAST-Change of Address transaction they will:

- Document ContactLog with the notification of change of address information, i.e. telephone call, letter;
- Image any paper copies of the change of address documentation;

Note: If a change of address is processed by a district office in a spouse to widow(er) conversion case before the widow(er)'s annuity has been paid, the field office should inform the Survivor Benefits Division of the address change via an email to the SBD Group Mailbox. Also, If the spouse/widow is enrolled in International Direct Deposit, the Direct Deposit Specialist in the Unemployment and Programs Support Division (UPSD) should be notified of the address change. See FOM 115.22.1. When the field office processes a FAST-COA transaction to change the payee in a representative payee case (change code R), they will release RL-107 and RL-107B notices about the payee change to the annuitant and an RL-107A notice to the new payee. The field office will also, if appropriate, release an RL-107D notice about the payee change to the old representative payee and RL-107E notices to anyone who may have applied but was not selected as representative payee. If the annuitant is living with a third party who is not the representative payee, the field office will release an RL-107F notice to the third party custodian. The field office will image all of the original representative payee documentation.

9.7.191 Headquarters Handling Of Field FAST Change Of Address Transactions

If a change of address is processed for an annuitant who has a claim pending on RASI, make a Keymaster entry to change the address on RASI. Failure to take this action will cause the address to revert to the old address when the final RASI award is processed.

If a change of address is processed in a spouse to widow(er) conversion case before the widow(er) annuity has been paid (i.e., widow(er) is still in pay status as a spouse on DATA-Q) the field office will inform the Survivor Benefits Division of the address change

via an email to the SBD Group Mailbox. Also, If the spouse/widow is enrolled in International Direct Deposit, the Direct Deposit Specialist in the Unemployment and Programs Support Division (UPSD) must be notified of the address change. See FOM 115.22.1. The new address should then be entered on the widow(er) annuity award form.

9.7.192 Documentation Of FAST Direct Deposit Enrollments

The SF-1199As processed by HQs are field offices are to be imaged.

9.7.195 Processed Activity

Activity that has been input to the FAST system is not processed until it is batched and processed through the DAISY system.

Pending transactions will remain on the screens until processed. Therefore, if the transaction can be viewed on FAST it has not yet been updated to the checkwriting system. Once processed, the transaction will no longer appear on FAST.

Processing of batched activity may be verified on the following sources:

- DATA-Q - DATA-Q is updated soon after the activity is processed and is a source for verification. The DATA-Q screen shows the current address, the combined mailing indicator, the representative payee type code, and the date the change of address was processed. It also shows the Direct Deposit data and the date processed.
- SAMM - The SAMM tape is a record of all daily activity. In addition to change of address and Direct Deposit information, this tape provides the identification of the unit and person that processed the change of address. The activity is stored on microfilm according to the transaction run date. A FAST-Change of Address will be indicated by voucher number 11 (VOUCH NO 011).
- MOMS. - Change of address activity may be checked on the MOMS tape produced on the first of the month following the month the address change representative payee change or Direct Deposit enrollment was processed.

9.7.196 DAISY Rejects

Online edits and pre-filling of data fields ensure that most address changes and other FAST-COA transactions are processed without problems. Edits in DAISY batch processing, however, may detect problems that cause COA transactions to reject. COA transactions that reject must be corrected and reentered.

COA transactions that reject in DAISY processing are now loaded to the Universal Star (USTAR) system for handling. USTAR assigns the rejected COA transaction to the FAST user who input the COA transaction based on the FAST user signon ID. Field office and Operations users are responsible for handling their USTAR COA reject

assignments and reentering corrected FAST transactions, if necessary. The instructions for handling FAST-COA rejects on USTAR are located in FOM-1-1570.75. If you cannot determine the cause of the reject, contact the Payment Analysis and Systems section in Policy & Systems for assistance. 9.7.200 ORVL - The On-Line Rate Verification Letter

(ORVL) system allows authorized field office or headquarters employees to mechanically generate rate verification letters in one of three selected formats. It is accessed through DATA-Q located in the Railroad Automated Processing Integrated Database (RRAPID). ORVL is not located on the RRAPID Main Menu and must be accessed through auxiliary processing tasks of DATA-Q by pressing the PF-6 key. The ORVL system captures current pay data from the checkwriting database file and formats it into a letter. Individuals requesting letters through ORVL may customize letters by inserting variable information into several positions, including a four line free form paragraph area. In addition, some information secured from the database can be overlaid, if necessary.

Field office requests are generated immediately through a printer in the office. Headquarters requests are batched and prepared nightly.

The system does not relieve the record keeping requirements of the Privacy Act on the release of information. The system will retain no record of individual ORVL requests. Headquarters requests must be documented by final input screen retention as a file record.

9.7.201 What ORVL Can And Cannot Do

- A. What ORVL Can Do - The ORVL system can produce rate verification letters in three versions. The user enters any required letter inserts and generates the letter of choice by pressing one of three PF keys, each of which formats a separate letter. The RL-136 is prepared for release to the beneficiary with the inquirer identified, the RL-136a for third party release with a copy to the beneficiary and the RL-136b for direct beneficiary requests with no inquirer identified. Copies of the three letter formats are shown in Exhibits 1, 2, 3.

ORVL can produce letters at any time of the month. There is no dark period for ORVL processing. ORVL works with the information on the DATA-Q file.

ORVL secures information from DATA-Q, formats it as required and produces a letter. The system does nothing else.

- B. What ORVL Cannot Do - The system does not interact with the FAST system. The only similarity is that both systems are accessed through the DATA-Q program. If an annuitant's address change is placed in the body of the rate verification letter, it is still necessary to go into FAST-COA to process the COA.

ORVL cannot associate rate information with the payment beginning date. If an adjustment is processed before the time it is actually paid, i.e., the annual cost-of-living adjustment, ORVL will pickup the COL information as the current rate paid and place it in a letter being released before the new rate is received.

ORVL cannot provide information on activity in mechanical processing channels. For instance, if an adjustment is being processed which requires a floating SMIB premium to be invoked, the system will be unable to pickup Medicare information until the float is completed.

ORVL cannot automatically produce letters for multiple payees on a single claim number. Separate letters need to be requested for employee and spouse annuitants and for all children in a family group.

ORVL cannot place multiple rates into a mechanical letter. Any request requiring multiple rates must be handled by composing a special letter or by placing previous rate information in the free form area on the mechanically prepared ORVL letter.

ORVL does not maintain records of individual letters released. Folder documentation requirements can be fulfilled by maintaining copies of ORVL data input screens.

9.7.202 Who Can Access ORVL

ORVL entry is available to anyone with DATA-Q access. Since requests for rate verification are received both in the field and headquarters, the system was designed to perform in both areas.

The only difference between usage in field offices and headquarters is that letters can be generated immediately in the field, but must be batched and printed nightly when requested in headquarters. This difference is due to the limited placement of printers and the size and color of paper used in headquarters printers. Headquarters letters are produced with the standard Railroad Retirement Board letterhead; field generated letters have the requesting office's return address.

9.7.203 Accessing the ORVL System

Entry to ORVL is made through the DATA-Q system. No special security measures are needed to access ORVL. Once the claim number and payee code are selected, the user can request the rate verification letter option by selecting the menu of all options available from DATA-Q by pressing PF-3 or going directly to ORVL by pressing PF-6.

Once the ORVL request is entered, the terminal will present a data input screen pre-filled with data secured from DATA-Q.

9.7.210 Protected Data Pre-Filled On ORVL

When the user strikes the PF6 key directly from DATA-Q or from the menu screen, the ORVL system immediately displays an input screen seen below, pre-filled with information. Most of the information is placed in protected fields, i.e., it cannot be written over. All protected data is identified in green on the CRT input screen. Protected fields include the claim number and payee code, Medicare information, and railroad and social security benefit rate data.

Information in other areas of the input screen can be entered or overlayed as appropriate. This is explained in the next section.

All claim information present on the input screen is carried over into the ORVL letter text. Some of the rate information goes through calculation routines before it is placed in the ORVL text.

SEE EXHIBIT 28

9.7.211 Inputting Data To ORVL

The ORVL system draws DATA-Q information for entry into designated fields. The three letter versions available take the same data and place it into a format selected by the user. Certain fields can be inserted or overlayed as required by moving the cursor to the appropriate position using the tab or return keys. Most inserts are optional and the failure to provide entries will usually not prevent the production of a reasonable letter. If an insert is absolutely essential, i.e., name and address in a third party release letter (RL-136a), an edit message will appear.

When the input screen appears, the cursor is automatically positioned at the first entry requiring possible preparer input, the rate effective date. Once all spaces are filled in a field needing preparer input, the cursor will move to the succeeding field. If all available spaces are not needed, cursor movement can continue through the fields that can be inserted or overlayed by depressing the forward tab key. The backward tab key will allow movement in that direction. Cursor navigation through the input screen can also be done with the arrow keys. Pressing the return key will position the cursor at the beginning of the next line.

- A. Inserting Data to ORVL - Information can be inserted into several positions where either the inquirer is the source of the required entry or DATA-Q does not hold the necessary data.

Fields in which data may be inserted are the payment effective month and year, the inquirer reference number, and the inquirer name and address. Entering this information is generally optional except for the inquirer name and address in an RL-136 and RL-136a request.

1. The payment effective date entry is required because the DATA-Q accounting date will differ from the effective date. A letter can be generated with or without this information. Enter this data with two digit conversions of month and year, i.e., January 1989 is 01/89, December 1988 is 12/88, etc. If there is no entry in this area, the letter text indicates the rate information is current. This date can be furnished without extensive review for most adjustments and can usually be determined from the accounting date, i.e., the annual cost-of-living adjustment effective date is always December 1 and the accounting date is always in mid-December.
2. The reference number entry allows 12 characters when the inquirer has a specific file identifier other than the railroad claim number.
3. The inquirer name and address refers to a third party inquirer. Name and address information can be placed in a five line format with 20 spaces available per line. The positioning of this information on the ORVL letter depends on the version requested. Letter version selection depends on whether the beneficiary has authorized the release of rate information or if the requester is a routine user.

NOTE: If the inquirer's name and address and/or reference number is entered on the ORVL screen, but an RL-136b is requested, the inquirer's entry will be ignored.

4. A free form text area consisting of four lines with 80 characters each can be used as necessary. The information placed in that area will appear on the ORVL created letter exactly as shown. The system has no word processing capability. Words extending between lines should contain hyphenation. You may use this area to answer questions, provide additional rate information, etc.

B. Overlaying Existing Data - Information in two areas can be overlayed to update or modify data pulled from DATA-Q.

1. The annuitant's name and address can be modified if the DATA-Q information needs updating. Possible conditions requiring modification in this field are a change of address or the appointment of a representative payee. Since these changes are not processed into the individual's record through ORVL, a separate action must be taken on the FAST system.

If the beneficiary authorizes the release of rate information, but objects to the release of his address, use the space bar to delete the address from the third party RL-136a.

2. The annuitant's name is entered exactly as shown on the DATA-Q screen. In some instances, a name which is abbreviated for checkwriting purposes

can be expanded on the ORVL letter. Twenty spaces are available in this field.

NOTE: When overlaying existing data, do not use the delete or EOF keys on the terminal to remove existing information. You can type over information or use the space bar to eliminate existing data. Although the screen display indicates the delete and EOF keys are working, the actual printing does not recognize the deletion of the previous data.

9.7.212 Requesting The ORVL Letter

Once the preparer has completed any input screen data entry, the letter print request can be initiated. Letter preparation requires striking the PF key linked to the letter version twice consecutively. Prompts for the PF keys associated to each letter version are indicated at the bottom of the input screen. When the PF key is depressed, the message "RL-136X HAS BEEN PREPARED FOR PRINTING (IN THE FIELD) or (AT HEADQUARTERS). HIT PFX TO RELEASE." will appear. The letter preparation is triggered when the user depresses the PF key a second time. After depressing the PF key, a screen message appears stating "RL-136X WILL BE PRINTED (IN THE FIELD) or (AT HEADQUARTERS). HIT VALID RESPONSE KEY TO CONTINUE."

The three RL-136 letter versions available and their PF keys are:

- | | |
|-----------------|---|
| PF 21 - RL-136 | Rate Verification to Beneficiary for Release to Inquirer - This letter is typically used when a request for information is received from a third party to whom we cannot directly release information. This letter is sent to the beneficiary. It indicates who has requested the information and that the annuitant is responsible for releasing the information, if so desired. |
| PF 22 - RL-136a | Rate Verification to Inquirer with Copy to Beneficiary - This letter is designed for release to the third party requester directly. As a courtesy, a copy is prepared and released to the annuitant so that he is aware of the information provided. |
| PF 23 - RL-136b | Rate Verification to Beneficiary, Inquirer Not Identified - This letter is prepared for release to the annuitant at his request. It is designed so that the individual can utilize it at his discretion |
- A. Reviewing Input Before Printing Letter - Requiring the PF key to be depressed twice provides an opportunity to review input before printing the letter. The user should take the time before engaging the printer to assure that the proper letter version is being created, that any information inserted or overlayed is correct and that the F.O. code is correct for the field office or blank for headquarters requests. Once the information is verified by the user, the second depression of the PF key can be performed.

If the user reviewing the input screen determines that information should be changed or an incorrect letter version is being requested, the user can take the following action:

1. Incorrect information - Using the tab or arrow keys, reset the cursor at the information which needs to be changed. Re-enter the information and begin the print process.
2. Incorrect letter requested - If the first striking of the PF print key identifies the wrong letter, merely strike the correct PF key. This restarts the print process which again requires two consecutive strikes of the letter linked PF key.

9.7.213 ORVL System Edit Messages

Once the user requests preparation of the designated ORVL letter, the letter generating program goes through a series of edits to determine the acceptability of the desired output. Any edit message will appear on the CRT screen. Possible ORVL edits and messages are:

FIELD OFFICE NUMBER is not a required field. If it is not spaces, it is edited.

Edit:	Message:
Non-Numeric	Field office number is not numeric. Try again.
Not found on RRFO Table	Field office number invalid. Try again.

ANNUITANT ADDRESS is a required field for RL-136 and RL-136b requests.

Edit	Message:
Spaces in line 1 or line 2 or line 3	Annuitant's address must contain at least 3 lines. Try again.

ANNUITANT NAME is a required field for all letter requests.

Edit:	Message:
Spaces	Annuitant's name not entered. Try again.

RATE EFFECTIVE DATE is not a required field. It is edited if it is not spaces.

Edit:	Message:
Month Not Numeric	Rate effective month must be numeric. Try again.

Month Invalid (not 1-12)	Rate effective month invalid. Try again.
Monthly Spaces	Rate effective month not entered. Try again.
Year Spaces	Rate effective year not entered. Try again.
Year Not Numeric	Rate effective year must be numeric. Try again.
The INQUIRER'S ADDRESS is a required field for RL-136 and RL-136a requests.	
Edit:	Message:
Spaces on line 1	Inquirer's name/address not entered. Try again.
Spaces on line 2 or line 3	Inquirer's name/address must be at least three lines. Try again.

9.7.214 Information On The ORVL Letter

Information is taken from the input screen and placed in designated positions in the letter format. Information, other than rate data, is carried directly as shown. Some rate data is calculated before being placed in the letter.

- A. Protected Rate Data in the ORVL Letter - ORVL letters can contain a maximum of eight lines of rate information. Individual lines are included as required. Information placed on those lines is as follows:

REGULAR RAILROAD RETIREMENT ANNUITY includes the actual railroad annuity payable. Any taxes withheld are added back in. Any partial withholding or actuarial adjustment is not added back in. Rate shown is before any Medicare premium deduction. Any RR amount in suspense is considered payable and is included in the total. Any terminated amount is not included.

SUPPLEMENTAL ANNUITY includes the supplemental annuity actually payable. Any taxes withheld are added back in.

LESS FEDERAL INCOME TAX WITHHELD is a combined total of any taxes withheld from the regular railroad and the supplemental annuity, if any. This deducted amount is positioned slightly to the left of payable amounts on the letter.

NET MONTHLY RAILROAD ANNUITY is the total of the regular railroad and supplemental annuity amount after any tax withholding.

SOCIAL SECURITY PAID BY RRB includes any social security benefit payable or in suspense. Any Medicare premium deducted from the SS component is added back in.

TOTAL MONTHLY RATE PAYABLE is the total of RR, Supp and SS benefit components previously listed before any Medicare premium deduction.

LESS DEDUCTION FOR MEDICARE PREMIUM includes any Medicare premium deducted from either the RR or SS benefit component. Regular, variable or penalty SMIB rates are shown. Deduction includes any catastrophic premium taken from the individual's annuity benefits. Premiums paid through a state buy-in are not deducted. This deducted amount is located slightly to the left of payable amounts on the letter.

CHECK/PAYMENT AMOUNT is the amount of RR, Supp and SS benefits paid by the RRB after deductions for any Medicare premium and/or tax withholding. This line may contain the effective date if the user has provided an insert on the ORVL input screen.

If an individual's benefit has been terminated, and nothing is payable, a warning message 'NO RATES PAYABLE FOR THIS ANNUITANT' is displayed. This message is informational. A rate verification letter can be generated to confirm that the individual is not receiving any benefits.

B. Protected Information Provided Other Than Rate Data -

MEDICARE EFFECTIVE DATES are taken directly from the DATA-Q record. If an individual is only entitled to Part A coverage, that date is shown.

RR CLAIM NUMBER is taken directly from the DATA-Q record. The payee code is not carried into the ORVL letter. It is placed on the input screen primarily for file documentation on headquarters released letters.

C. Information Inserted or Overlaid on the Input Screen - Any information placed on the input screen through the insert or overlay utility is presented exactly as entered.

9.7.220 After Requesting The ORVL Letter

Once the user has requested the ORVL letter, several options exist for further processing. The individual can request another copy of the requested letter, request a letter on another payee code on the same claim number, request an ORVL letter on another claim number, or exit the system completely. Individual keys on the computer terminal can be used to accomplish these functions.

REQUESTING ANOTHER LETTER ON THE SAME CLAIM NUMBER AND PAYEE CODE

This action can be accomplished by striking the PF key for the letter version requested two consecutive times. If two copies of the same letter are needed, four strokes of the PF key will produce two letters.

REQUESTING A LETTER ON ANOTHER PERSON ON THE SAME CLAIM NUMBER

Striking the PF 6 key after the letter is produced will return the user to the DATA-Q screen for the claim number and payee code. Other payee codes can be accessed by using the PA 1 and PA 2 keys after returning to DATA-Q. Requesting ORVL on other payee codes requires re-entry of variable information.

REQUESTING A LETTER ON ANOTHER CLAIM NUMBER

If the user wishes to request an ORVL letter on another claim number, pressing the PF 1 key will return the screen to the DATA-Q entry display:

ENTER PREFIX X RRB# (9 DIGITS) XXXXXXXXXX and PAY CODE X

Pressing the 'Clear' key from ORVL will exit the application/system completely and return to the RRAPID Main Menu.

9.7.221 Releasing ORVL Letters

Addresses have been positioned on ORVL letters to allow insertion into window envelopes when properly folded. Headquarters requested letters are batched nightly and sent directly to the mailroom for release. No file copy is produced.

9.7.222 Documentation For Released ORVL Letters

Since the ORVL system maintains no record of letters released, any documentation of information released is the responsibility of the user.

Since no file copy is produced, a screen print of the letter release screen should be substituted for the actual letter. The final screen includes all necessary information including the users identification. Actual copies of letters will not be released for filing.

9.7.223 Special Situations

The three RL-136 version letters can be used to respond to almost any rate verification request with appropriate modification. However, if a situation arises which cannot be handled appropriately on ORVL, a manual letter should be prepared.

9.7.225 Working Information Letter on Beneficiary Rates (WILBR) System

The **Working Information Letter on Beneficiary Rates (WILBR)** system is a companion to the ORVL (On-line Rate Verification Letter) system. WILBR allows users to input a request for a post cost-of-living adjustment (COLA) rate verification letter at any time throughout the year. WILBR pends the letter up to the next COLA run in December, then processes the request after the COLA run, and produces an RL-136,

RL-136A, or RL-136B letter with the updated cost-of-living rate in early January of the following year.

NOTE: At this time, WILBR will be used only by the field offices. We anticipate that WILBR will be available to headquarters units sometime in 1997. Until WILBR is available for headquarters use, any rate verification requests which are received in headquarters and which would be entered on WILBR, i.e., requests received **prior** to the December COLA but which ask for the new COLA rate, should be sent to the appropriate field office for processing.

Headquarters personnel should not forward "current rate" verification requests or COLA rate verification requests received after the COL adjustment to the field offices. These types of requests should continue to be processed on ORVL.

At the time the WILBR request is entered, the user has the option of producing a WILBR "confirmation" letter, to serve as an interim reply to the rate verification requestor. The "confirmation" letter informs the requesting party that a rate verification letter, which includes the latest COLA rate, will be released in January of the following year. These "confirmation" letters are printed in the same way that ORVL letters are currently printed, i.e., requests originating from a field office will be printed at the field office's remote printer. However, in order to realize bulk mailing savings, all post COLA RL-136 series letters requested through WILBR will be printed and released from headquarters.

A rate verification letter request pending on WILBR can be modified, in the event of address changes, and/or deleted. After the WILBR requests have been batched, interchanged with DATAQ to obtain the COLA rates, and the RL-136 series letter is produced and released, a record of the release will remain on the WILBR system for five years.

WILBR does not replace ORVL, it is an alternative method for field offices to request a rate verification letter with future, i.e. post-COLA, rates. ORVL should continue to be used by both field office and headquarters personnel for cases in which a current rate verification letter is required.

Appendices

Appendix A - Unit ID Numbers to be used with FAST

UNIT ID	REFERRAL ABBREVIATION	UNIT NAME
0200	MMO	Management Member's Office
1400	H&A	Hearings and Appeals

2110	DIR	Office of Director of Retirement and Survivor Programs
2120	CIS	Congressional Inquiry Section
2134	DAS	Division of Adjudicative Services
2331	BRB	Office of Director of Retirement Benefits
2335	ICS	Initial Claims Section
2336	RPS	Retirement Post Section
2337	CBS	Combined Benefits Section
2341	BSB	Office of Director of Survivor Benefits
2343	SIS	Survivor Initial Section
2344	SPS	Survivor Post Section
2362	OPR	Overpayment Recovery Section
2365	PCS	Public Correspondence Section
2372	REC	Reconsideration Section
2381	BSU	Supervisor - Beneficiary Services Unit
2384	PSG	Payment Services Group
2393	BCS	Beneficiary Compliance Section
2840	TAX	Tax Inquiry and Annual Statements Section
4000	LAW	Bureau of Law

9.8.1 ALTA

A. ALTA Allows Examiners to Produce Manual Award Letters On-Line

Beginning in November 1988, examiners can create letters for most manual awards using ALTA (Automated Award Letters to Annuitants). ALTA is an on-line system that can be accessed using existing CRT terminals. ALTA will allow examiners to create, modify and delete award letters. ALTA also produces letters for mechanical systems, such as APPLE, ASTRO, SURPASS, MAP, RASI, and PAM.

In a browse mode, ALTA will allow examiners and field personnel to view data entry screens for released award letters and to view the text of code paragraphs in the ALTA library. Screens for released letters will remain on the ALTA database for at least 120 days after the voucher date.

From a selection of screens, the examiner will be able to build letters by selecting the letter type, entering code paragraphs needed and providing a payment summary if necessary. Any code paragraph that requires variable data to be inserted in a sentence will cause the system to automatically pull up a screen that will prompt the examiner to enter the required information. The examiner will also be able to include up to two individually composed paragraphs and to request additional letter copies and enclosures.

B. ALTA Is a Database System

Like FAST, ALTA is a database system that interacts with other data processing systems. ALTA will combine data selected and entered by the examiner on-line with data from a corresponding manual voucher obtained through the CHICO and Rate History (RH) files. ALTA will also process award letters that will combine data from a RR and an SS voucher. Information coming from CHICO and RH will help determine the composition of the letter, provide the annuitant's name and mailing address, provide limited payment summary information, and provide certain code paragraph inserts.

C. ALTA Prevents Errors Through On-line Edits

ALTA performs numerous up-front edits to prevent incorrect or incomplete award letters from being produced. ALTA's on-line edits:

- check for internal consistency of data,
- verify that the data is within its prescribed content and range, and
- apply relational edit checks between individual fields.

The ENTER key must be pressed at the completion of each screen to activate the edit process.

When all the required screens have been completed, the examiner must validate the letter. This tells the database that the letter is ready to be released.

The examiner must secure a printout of the main data entry screens used in developing the letter. The authorizer will review these screens for completeness and accuracy.

D. ALTA Releases Letter Only After the Voucher Clears

A letter input on ALTA will pend at least 120 days on the database for its corresponding voucher to clear. Pending letters will be purged on a monthly basis at the end (around the 26th) of the 2nd month following the month of entry on ALTA. For example, a letter entered on 11-25-02 will pend until 3-31-03 at which time it will be purged while a letter entered on 11-27-02 will be purged on 4-30-03. A listing will be produced at the end of each month detailing these purged letters.

When the voucher clears, information from CHICO and RH will be passed to the ALTA match program. ALTA uses the claim number and payee code to create a match between the letter pending on the ALTA database and the information coming from the voucher. Because of this, only one railroad and one social security letter can pend on ALTA on the same claim number and payee code at a time. When the match is complete, the letter is supplemented with the CHICO and RH information.

When a combined SS/RR award letter (RL-130tc, 130uc and 130xc) is being created, ALTA will pend the data from the first voucher to clear until the second voucher clears and is matched.

If an award rejects in vouchering, re-vouchering that award or vouchering a new award will trigger the release of a pending ALTA letter provided the new voucher date is within 120 days from when the letter was first entered.

Before a letter is purged from the database, the examiner can modify or delete the letter at any time until the voucher clears and releases the matched letter.

E. ALTA'S End-of-Line Edits

ALTA has an end-of-line edit system to determine whether the CHICO and RH data required was available, correct and consistent. These edits also indicate whether there was no match between a voucher and a letter on ALTA, or whether there was a match but that the letter was not validated (see Section 9.8.1.F). Incomplete and/or unvalidated letters will be printed as far as possible

and sent to their originating units. Completed, validated letters will be printed and released to the mailroom.

F. ALTA Produces Listings and Referrals to Aid Processing

The match program produces a daily listing (like DAISY) reflecting manual award activity and how it impacts on ALTA. This listing contains a balance sheet that summarizes the activity on ALTA. Reject referrals for award letter errors will also be produced daily for each run. These reject messages will inform the examiner of the nature of the particular error. Rejected letters will have to be corrected manually. ALTA listings and referrals are sorted by unit according to their voucher number assignments.

The daily ALTA listing will provide an effective means of pulling cleared vouchers from dormant.

ALTA will also provide a weekly count of letters produced by type, and a monthly listing of purged letter screens.

G. When Letters Cannot be done on ALTA

- A RR letter (with the exception of ASTRO RL-119A's and RESCUE RL-119R and RL-45R's) cannot be added to the ALTA database if a RR letter is already pending on ALTA on the same claim number and payee code. Similarly, an SS letter cannot be added to the ALTA database if an SS letter is already pending on ALTA on the same claim number and payee code.
- Letters for simultaneous RR Vouchers to one payee (e.g., simultaneous G-357's; an OPO and a zero accrual recurring voucher for taxation purposes). Do not use ALTA for simultaneous vouchers.
- SS letters requiring more than 12 date-breaks, retirement RR letters requiring more than 13 date-breaks and survivor RR letters requiring more than 15 date-breaks on the payment summary.
- Award letters with more than two individually composed paragraphs of 5 lines each.
- Award letters that require more than 10 examiner entered code paragraphs.
- SF-1166 award letters.
- Award letters returning payments to financial organizations (RCM 6.6.137).
- Award letters mailed to an address other than the address on CHICO.

- SS OPO letters (RL-130X or RL-130XC) if there is no SS accrual being paid out to the annuitant. In this situation, if a RR letter is required, the SS accrual being withheld should be explained in the RR letter.

9.8.2 Introduction And Main Menu

After you have signed on and set your terminal for upper and lower case letters (see NOTE 2, below), access ALTA by typing 9 on the RRAPID menu and pressing the ENTER key. The ALTA MAIN MENU SCREEN will appear. The Main Menu consists of the 6 following selections:

PF-24 - CREATE AWARD LETTER. Press PF-24 when initially creating an award letter on a specific claim number and payee code.

PF-23 - MODIFY PENDING LETTER. Press PF-23 to view or to change and/or add new data to a letter pending on the ALTA database.

PF-20 - DELETE PENDING LETTER. Press PF-20 to delete a letter pending on the ALTA database.

PF-6 – BROWSE PENDING MECHANICAL LETTER. Press PF-6 to view the input screens of a pending mechanical letter. PF-5 - BROWSE RELEASED LETTER. Press PF-5 to view the input screens of a released letter.

PF-1 - BROWSE CODE PARAGRAPH LIBRARY. Press PF-1 to view the text of any code paragraph in the ALTA library.

PA-2 - END ALTA SESSION. Press PA-2 to exit from ALTA.

Press the appropriate key. The screen selected will automatically appear.

9.8.3 Creating An Award Letter

To create an award letter, press PF-24 on the MAIN MENU. The CREATE AWARD LETTER screen will then appear.

Enter the following information:

Item	Completion
Prefix	Enter A, D or H.
RRB#	Enter the 6 or 9 digit number. If your entry is a 6-digit number, enter 6 digits and tab over to the payee code entry.
Payee Code	Enter the payee code, from 1 to 9.

Letter Type	Enter one of the following letters:		
	<u>Railroad</u>	<u>SSA</u>	<u>Combined SS/RR</u>
	RL-20	RL-130a	RL-130tc
	RL-23	RL-130b	RL-130uc
	RL-24	RL-130c	RL-130xc
	RL-24b	RL-130r	
	RL-43	RL-130t	
	RL-45	RL-130u	
	RL-119	RL-130x	

Employee's Name – The entry of the employees' name is a requirement. Type the employee's full name as shown on PREH, APPLE or other mainframe system being used. We are no longer printing the RRB Claim number or Social Security numbers on ALTA letters. We will use the employee name on the letters to find the RRB Claim Number using the ALPHA look-up on RRAILS or the EDM system on RRAPID. Information of the ALPHA look-up on RRAILS can be found in FOM1 1596.51 and information on access to Employee and Employer Information on the EDM system can be found in RCM 9.9.3.

Capitalize the 1st letter of each portion of the employee's name. 20 positions are allowed for the name.

Review all entries and press the ENTER key to activate the edit process. See RCM 9.8.12 for a description of the edit process.

If you discover an error before pressing the ENTER key, return the cursor to the incorrect item and type in the correct entry. Hitting either a forward or backward TAB or NEW LINE KEY may move the cursor.

If an invalid entry has been made, an error message will appear. ALTA can only indicate one invalid entry at a time. Therefore, after one invalid item has been corrected, the system may identify another item needing correction. The fields are edited in the same sequence that the user enters them. Correct all the invalid entries and press the ENTER key after each correction.

NOTE: The RRB number is not checked for accuracy. Therefore, it is important that the number entered is correct.

If the data passes the edits, it will be stored and the next appropriate screen, based on the type of letter chosen as shown on the chart below, will appear.

Letter Type	Screen to Follow
RL-24, RL-24b, RL-45	CP Select/Overview
RL-20, RL-23, RL-43 & RL-119	Payment Summary Selection
RL-130a, RL-130b, RL-130c,	SSA Payment Summary
RL-130r, RL-130t, RL-130u,	
RL-130tc, RL-130uc	
RL-130x, RL-130xc	SSA OPO Payment Summary

Once the edits have cleared and you have left the CREATE AWARD LETTER screen, you cannot return to the CREATE AWARD LETTER screen or use the MODIFY PENDING LETTER screen to correct the Prefix, RRB #, PC or Letter Type. If any of these 4 entries is incorrect, the letter must be deleted using the DELETE PENDING LETTER screen and then a new record created.

NOTE: You can return to the CREATE AWARD LETTER screen to add an Employee's Name entry or to change an Employee's Name entry previously made. To do this - access the CREATE AWARD LETTER screen, enter the Prefix, RRB #, PC, Letter Type and the new or corrected Employee's Name. Press the ENTER key. The message RR or SS LETTER ALREADY ON THIS RECORD; HIT PF 23 TO MODIFY OR PF 20 TO DELETE will be displayed but the employee's name entry on all letters on the claim number entered will reflect the new Employee's Name entry. Press PA1 to return to the MAIN MENU or PA2 to exit ALTA if your action is complete.

9.8.4 Selecting A Payment Summary

The Payment Summary Selection Screen automatically appears if you selected Letter Type RL-20, RL-43 or RL-119 on the Create Award Letter Screen. The Prefix, RRB #, Payee Code, Letter Type and Employee's Name will be pre-filled with entries from the CREATE screen.

There are two entries on this screen. Type in the appropriate number (e.g., "01" for a tier 1, "08" for a tier 1 and Supp or "12" for a partial annuity payment summary) and press ENTER. In the Payment Summary item, you must select the opening paragraph and headings required by your payment summary. The payment summary headings chosen must be representative of all the tiers that the annuitant is eligible for even if the tier amount is zero. In the Payment Summary Source item, you must tell the system

where the payment summary rate-breaks are to come from (RHF and/or examiner) and how they are to be composed. The Rate History File (RHF) will store the latest effective date and rates in retirement cases and the latest 3 effective dates and rates in survivor cases. The user must enter any prior dates and rates on the appropriate payment summary screen.

Payment Summary - Enter one:

<u>All RR AWD Letters</u>	<u>RL-20 AWD Letters Only</u>	RL-23 Letters Only
01-T1	08-T1/SUPP	13-RL-23
02-T2	09-T2/SUPP	
03-T1, T2	10-T1,T2/SUPP	
04-T1, T2, VDB	11-T1,T2,VDB/SUPP	
05-SUPP	12-PARTIAL	
06-O/M		
07-NONE		

Payment Summary Source - Enter one:

1-(R/S):	1 date break from RHF, prior date breaks from examiner
2-(R/S):	1 date break from RHF
3-(SURV):	2 date breaks from RHF
4-(SURV):	3 date breaks from RHF
5-(SURV):	3 date breaks from RHF, prior date breaks from examiner
6-(R/S/RL23):	All date breaks from examiner

If Payment Summary 07 (NONE) or 12 (PARTIAL) is selected, do not complete the Payment Summary Source entry.

Review all entries and press the ENTER key to activate the edit process. See RCM 9.8.12 for a description of the edit process. If the data passes the edits, it will be stored and the next appropriate screen will appear.

If you selected Payment Summary 07 (NONE) or 12 (PARTIAL), the CODE PARAGRAPH SELECTION/OVERVIEW screen will automatically appear.

If you selected Payment Summary 13 (RL-23), you must select Payment Summary Source 6 (all rate breaks from examiner.) We cannot secure date breaks from Rate History in Court Ordered Property Division awards.

If you selected Payment Summary Source 2, 3 or 4 (all date-breaks from RHF), the CODE PARAGRAPH SELECTION/OVERVIEW screen will automatically appear.

If you selected Payment Summary Source 1, 5 or 6, a PAYMENT SUMMARY screen with the headings you selected in the Payment Summary entry will automatically appear. If you selected PAYMENT SUMMARY 08, 09, 10 or 11, the SUPP payment summary screen will appear first and then, when you complete your data entry, you will select the regular payment summary screen by pressing PF18.

NOTE: If you exit the system with PA2 (End ALTA Session) before completing the PAYMENT SUMMARY SELECTION screen, you will return to this screen when you re-enter ALTA through the MODIFY PENDING LETTER screen. Whenever completion of the PAYMENT SUMMARY SELECTION screen is required (i.e., your letter is a RL-20, RL-43 or RL-119), the CP SELECT/OVERVIEW screen cannot be accessed until the entries on the PAYMENT SUMMARY screen are completed. If the PAYMENT SUMMARY SELECTION screen appeared due to an erroneous letter selection on the CREATE AWARD LETTER screen, you must use the DELETE AWARD LETTER screen to delete the entire record before you begin again.

9.8.5 Completing A RR Payment Summary Screen

The PAYMENT SUMMARY screen requested will be automatically displayed if Payment Summary Source code 1, 5 or 6 on the PAYMENT SUMMARY SELECTION screen is selected. The PAYMENT SUMMARY screen which appears will have the Prefix, RRB #, PC, Letter Type and Employee's Name entries pre-filled. Also displayed will be the previously selected Payment Summary Source code and its description, as seen on the PAYMENT SUMMARY SELECTION screen (e.g., 5-(SURV): 3 date breaks from RHF, prior date breaks from examiner.)

If you selected PAYMENT SUMMARY 08, 09, 10 or 11, the SUPP payment summary screen will appear first and then, when you complete your data entry, you will move to the regular payment summary screen by pressing PF18. Completion of regular and supp payment summary screens are pretty much the same. It is important to note, however, that the Supp will generally have fewer date breaks than will the regular annuity payment summary. Since Rate History will pick up only the current date break of the award, make sure the beginning date break of the Supp award is entered on-line if it is not the current rate.

If the wrong payment summary had been selected or if the Payment Summary Source needs to be changed, press CLEAR at this point to return to the PAYMENT SUMMARY SELECTION screen.

Completion of a PAYMENT SUMMARY screen consists of typing in effective dates and tier/annuity amounts, up to 12 occurrences, under the appropriate column heading. The cursor will be positioned at the first Effective Date entry. Enter the MM-DD-YY of the earliest date break. Date-breaks must be entered in ascending order from the earliest date-break to the latest. Use a preceding zero for months and days less than 10. When this entry is complete, the cursor will move to the first tier or annuity amount entry.

Seven positions are allowed for rates. You must line up the dollar portion of the rate with the pre-filled decimal. If a cents amount is required, type over the decimal and enter the cents amount (e.g., a rate of 20.53 can be entered by hitting the space bar twice and entering 20.53.) ALTA will automatically print \$ signs on the letter.

The cursor moves from the left to right and from top to bottom, as you complete the entry fields. If all positions are not used in a rate field, you must tab to the next entry field. Continue typing in all the rate breaks. Stop at the last rate break prior to the first rate break that will be mechanically picked up (if applicable) from your award form.

Review all entries and press the ENTER key to activate the edit process. See RCM 9.8.12 for a description of the edit process. If any data entered is invalid, an error message will appear. The cursor will position itself under the entry that triggered the error message. Correct the invalid entry and press the ENTER key again to reactivate the edit process. Continue this procedure until all the errors have been corrected.

When the data entered has cleared all edits, the data will be stored and the message "DATA HAS BEEN ACCEPTED: SELECT NEXT FUNCTION" will be displayed. Print the PAYMENT SUMMARY screen at this point for a folder record.

NOTE: Review RCM 9.8.12 on payment summary edits. The ENTER key should only be pressed after all entries have been completed. Since all of the numerous payment summary edits are activated whenever ENTER is pressed, this will reduce the amount of unnecessary computer response time.

Errors can be corrected at any time prior to exiting from the screen. Therefore, if an error is detected after the edits have cleared and the screen has been printed, you can still tab to the incorrect entry and change it. When your corrections are complete, press ENTER again. Get a new printout of the screen when the message "DATA HAS BEEN ACCEPTED: SELECT NEXT FUNCTION" is displayed.

When you are ready to continue, if you selected PAYMENT SUMMARY 01, 02, 03, 04, 05, 06, 13, press PF-19 to go to the CP SELECT/OVERVIEW screen. If you selected PAYMENT SUMMARY 08, 09, 10 or 11, press PF-18 to go to the regular payment summary screen you selected.

9.8.6 Completing A SSA Payment Summary (Recurring)

If you selected letter type RL-130a, RL-130b, RL-130c, RL-130r, RL-130t, RL-130u, RL-130tc or RL-130uc on the CREATE AWARD LETTER screen, the SSA PAYMENT

SUMMARY screen will be displayed automatically. Completion of the SSA PAYMENT SUMMARY screen is mandatory for the SSA letters listed above. The screen will have the Prefix, RRB #, PC, Letter Type, and Employee's Name entries pre-filled. Enter the following information:

Item	Completion
Type of Benefit	Enter the Type of Benefit. "Retirement", "Disability", etc. Twenty characters are allowed. Use upper and lower case letters. Do not abbreviate your entry.
Effective Date	Enter MM/DD/YY beginning with the earliest date break. Precede months and days less than 10 with a zero.
Monthly Rate	Enter the monthly rate up to 7 numeric positions. Use the space bar to line up dollar amounts less than four with the pre-filled decimal.

NOTE: Unlike RR award forms, payment summary information on Form RR-1e is not keypunched. Therefore, the user must enter all effective dates and rates to appear on the letter on-line.

The cursor moves from left to right and from top to bottom of the screen. For example, when the first line of entries is complete, the cursor will go to the effective date field on the 2nd line. Continue entering effective dates and monthly rates in ascending date order from the earliest to the latest as needed.

Review all entries and press the ENTER key to activate the edit process. See RCM 9.8.12 for a description of the edit process. If any data entered is invalid, an error message will appear. The cursor will position itself under the entry that triggered the error message. Correct the invalid entry and press the ENTER key again to reactivate the edit process. Continue this procedure until all errors have been corrected.

When the data entered has cleared all edits, the data will be stored and the message "DATA HAS BEEN ACCEPTED: SELECT NEXT FUNCTION" will be displayed. Print the SSA PAYMENT SUMMARY screen at this point for a folder record.

Errors can be corrected at any time prior to exiting from the screen. Therefore, if an error is detected after the edits have cleared and the screen has been printed, you can still tab to the incorrect entry and change it. When your corrections are complete, press ENTER again. Get a new printout of the screen when the message "DATA HAS BEEN ACCEPTED: SELECT NEXT FUNCTION" is displayed.

When you are ready to continue your RL-130 series letter, press PF19 to go to the CP SELECT/OVERVIEW screen. When you are ready to continue with a RL-130 TC or UC letter, press PF18 to go to the PAYMENT SUMMARY SELECTION screen to enter your RR payment summary data. Enter this data following the procedures in sections 9.8.4,

Selecting a Payment Summary, and 9.8.5, Completing a RR Payment Summary Screen. When you complete your RR payment summary entries, press PF-19 to go to the CP SELECT/OVERVIEW screen.

9.8.7 Completing A SSA OPO Payment Summary Screen

If you selected letter type RL-130x or RL-130xc on the CREATE AWARD LETTER screen, the SSA OPO PAYMENT SUMMARY screen will be displayed automatically. Completion of this screen is mandatory for the RL-130x and RL-130xc letters. The screen will have the Prefix, RRB #, PC, Letter Type, and Employee's Name entries pre-filled. Enter the following information:

Item	Completion
Name of Wage Earner	Enter the name of the wage earner on whom the benefit is based. Use upper and lower case letters as appropriate. Twenty characters are allowed for the name. If fewer positions are needed, tab to next entry.
Period Covered by This Award	Enter the MM/DD/YY the accrual period began and the MM/DD/YY it ended. Precede months and days less than 10 with zero.

Review all entries and press the ENTER key to activate the edit process. See RCM 9.8.12 for a description of the edit process. If any data entered is invalid, an error message will appear. The cursor will position itself under the entry that triggered the error message. Correct the invalid entry and press the ENTER key again to reactivate the edit process. Continue this procedure until all errors have been corrected.

If the data is valid or when all edits have been cleared, the data will be stored and the message "DATA HAS BEEN ACCEPTED: SELECT NEXT FUNCTION" will be displayed. Print the screen at this point for a folder record.

Errors can be corrected at any time prior to exiting from the screen. Therefore, if an error is detected after the edits have cleared and the screen has been printed, you can still tab to the incorrect entry and change it. When your corrections are complete, press ENTER again. Get a new printout of the screen when the message "DATA HAS BEEN ACCEPTED: SELECT NEXT FUNCTION" is displayed.

When you are ready to continue, press PF19 to go to the CP SELECT/OVERVIEW screen. If you are completing a RL-130xc combined award letter, press PF18 to go to the PAYMENT SUMMARY SELECTION screen to enter your RR payment summary data. Enter this data following the procedures in sections 9.8.4, Selecting a Payment Summary and 9.8.5, Completing a RR Payment Summary Screen.

When you complete your RR payment summary entries, press PF-19 to go to the CP SELECT/OVERVIEW screen.

NOTE: Do not create a SS OPO letter (RL-130X or RL-103XC) if no SS accrual is being paid out.

9.8.8 Completing The CP Selection/Overview Screen

When this screen is accessed, the Prefix, RRB #, PC, Letter Type and Employee's name entries will be pre-filled. This screen is used to select and enter code paragraphs, access other screens for data entry and to provide an overview and folder record of the data entered on the letter. The body of the screen consists of two columns: ITEM and DESCRIPTION. The ITEM column will display identifying numbers or symbols of the input. The DESCRIPTION column will display the corresponding item's description and any applicable code paragraph (CP) inserts.

- A. How Payment Summary Data Will Be Summarized on the Overview Screen - When the OVERVIEW screen is accessed during creation of an RL-20, RL-23, RL-43, RL-119 or an SS award letter, the payment summary name and description as selected on the PAYMENT SUMMARY SELECTION screen will be summarized and displayed on the OVERVIEW screen. See examples below:

1. Railroad Payment Summaries

EX 1. Payment Summary Selection Screen: (code 03) T1, T2 payment summary (code 2) 1 date break from RHF

OVERVIEW screen will display:

ITEM	DESCRIPTION
PS 03.2	T1, T2 - 1 date break from RHF

EX 2. Payment Summary Selection Screen: (code 07) None

OVERVIEW screen will display:

ITEM	DESCRIPTION
PS 07.0	No payment summary

EX 3. Payment Summary Selection Screen: (code 04) T1/T2/VDB PMT SUM: (code 6) All date-breaks from examiner

OVERVIEW screen will display:

ITEM	DESCRIPTION
PS 04.6	T1, T2, VDB - all date breaks from examiner

EX 4. Payment Summary Selection Screen: (code 13) RL-23 PMT SUM:
(code 6) All date-breaks from examiner

OVERVIEW screen will display:

ITEM	DESCRIPTION
PS 13.6	COPD - all date breaks from examiner

2. Social Security Payment Summaries

ITEM	DESCRIPTION
PS SS	SSA Payment Summary
PS SS	SSA OPO Payment Summary

NOTE: Once the CP SELECTION/OVERVIEW SCREEN is accessed, Payment Summary data can only be changed by using the Modify Pending Letter function. From the OVERVIEW screen the Modify Pending Letter Screen can be accessed by hitting PF23. The Modify Pending Letter screen can also be accessed using the Main Menu.

B. How to Enter Code Paragraphs

1. Entering Code Paragraphs - Entries are made next to the ENTER CODE PARAGRAPH item located at the bottom of the screen. The cursor will be located under the first data entry position. Enter the code paragraph number selected and press the ENTER key to activate the edit process.

- If a valid code paragraph (CP) requiring no inserts is entered, the CP number will be displayed in the ITEM column and a brief CP description will be displayed in the DESCRIPTION column.

The cursor will be reset at the first position of the entry field. To add an additional CP, simply enter another number and press ENTER.

- If a valid CP requiring inserts is entered, the CODE PARAGRAPH INSERTS screen will automatically appear. When that screen is completed, the insert information entered will be brought to the OVERVIEW screen and displayed. The CP number will be displayed in the ITEM column. Next to it, a brief CP description and the numbered inserts for that CP will be displayed in the DESCRIPTION column.

Make your entries using the appropriate upper and lower case letters, i.e., capitalize proper names, names of states, etc.

See RCM 9.8.12 for a description of the edit process. If any data entered is invalid, an error message will appear. The cursor will position itself under the entry that triggered the error message.

2. Completing the REASON FOR THE ADJUSTMENT PROMPT - The RL-119 letter requires that you complete a "reason for the adjustment" (RFA) entry before you go on to enter any miscellaneous CP entries. To complete this prompt you can use a code or special paragraph. The point is to enter the primary reason why you are processing an award. The paragraph you enter here will be given special prominence in the letter. (It will follow opening CP 1600, 1601, 1629 or 1630 and precede the payment summary).

When you type in your RFA CP or SP, tab to the reason for the adjustment prompt. This prompt will be pre-filled with a "N" for NO. Change this prompt to a "Y" and press ENTER. A "Y" will be displayed along with the CP/SP ITEM number and DESCRIPTION.

An error message will appear when you attempt to validate the RL-119 letter if a RFA CP/SP is not entered or if more than one RFA CP/SP is entered.

3. Completing a Combined Award Letter - On RL-130tc, 130uc and 130xc letters, enter the CP's pertaining to the SS adjustment first and then, the RR adjustment CP's. (For example, enter SS CP 1508.1, Additional SS Earnings Considered, SS CP 1506.1, SS increase; Specified Amt of RR O/P Recovered, and then, enter RR CP 1705, SS Benefit Increase-100% offset.
- C. How to Enter Special Paragraphs - ALTA allows for the creation of 2 compositions 5 lines of up to 70 characters each. If there is no code paragraph for the information needed on a letter, enter SP1 to compose a special paragraph. ALTA will display the COMPOSE SPECIAL PARAGRAPH screen (described in 9.8.10). When entering a special paragraph, you must use upper and lower case letters. Use appropriate capitalization, that is, capitalize the first word of sentences and all proper names. When that screen has been completed,

return to the OVERVIEW screen. Whenever a second special paragraph is needed, enter SP2. ALTA will again display the COMPOSE SPECIAL PARAGRAPH screen for data entry. If two special paragraphs have been created in succession, the OVERVIEW screen will display:

Item	Description
SP1	Compose Special Paragraph - 1
SP2	Compose Special Paragraph - 2

NOTE: The actual wording of the special paragraph will not appear on the OVERVIEW screen.

D. Reserved— ALTA letters are imaged. Letters can be viewed on WorkDesk. Copies cannot be requested on ALTA.

E. Miscellaneous

1. How to Access Multiple Pages on Overview Screen - The OVERVIEW screen is page-able to allow more space for data entry. A page number will be displayed in the lower right portion of the screen. If your entries fill up the first page of the OVERVIEW screen, they will automatically be posted to the second page. Though data may be posted to a page different than the one you are on, that later page will not be displayed automatically. When necessary, use PF8 to access page 2 and subsequent pages of the OVERVIEW screen. Once a page is accessed, you will remain on that page for all entries except code paragraphs with inserts. ALTA always returns to page 1 of the OVERVIEW screen from the CODE PARAGRAPH INSERTS screen.

To view multiple pages:

- 1) Press PF8 to display the next page, or
 - 2) Press PF7 to display the preceding page.
2. How to Modify and Delete Entries Displayed on the Overview Screen
 - To modify the inserts previously entered in a CP, type in the CP number you want to modify and press PF3 (MODIFY ITEM). The CODE PARAGRAPH INSERTS screen will automatically be displayed and the cursor will be set at the first insert entry. If necessary, move the cursor to the incorrect item and type in the corrected insert. Press

ENTER to return to the OVERVIEW screen when all corrections have been completed. The corrected insert(s) will be displayed on the OVERVIEW screen.

- To modify a special paragraph previously entered, type in SP1 or SP2 (as appropriate) and press PF3 (MODIFY ITEM). The COMPOSE SPECIAL PARAGRAPH screen will appear. Type over the incorrect text; press ENTER. Print the corrected COMPOSE SPECIAL PARAGRAPH screen for a folder record before continuing on with your next ALTA action.
- To delete a CP, enter the CP number in the ENTER CODE PARAGRAPH entry item and press PF4 (DELETE ITEM). The CP number, description and inserts (if any) will be deleted from the OVERVIEW screen. The remaining CP's, if any, will move up. The cursor will reset at the first position of the CP entry item.
- To delete a special paragraph previously entered, type in SP1 or SP2 (as appropriate) and press PF4 (DELETE ITEM). The SP item deleted and its description will be deleted from the OVERVIEW screen. If two special paragraphs (SP1 and SP2) have been created and SP1 is deleted, the SP2 designation will be changed to SP1 automatically.

If you hit PF3 or PF4 after entering a CP number that has not been previously entered, you will get an error message.

- F. How to complete the Appeals Rights Prompt - After all data entries have been completed on a RL-20, RL-24, RL-43, RL-45 or RL-119 ALTA award letter, you must complete the APPEALS RIGHTS? Y/N prompt. When you press the TAB key at this point, the cursor will jump to this item pre-filled with a "Y" - yes. If you have one of the situations mentioned in RCM 6.1 procedure that do not require an appeals rights paragraph, enter a "N" or "n" in this item. The cursor will jump to the next entry and code paragraph 199 will not be included in the award letter.

If the letter requires appeals rights, TAB through this item to the validation prompt. The appropriate version of code paragraph 199 will be automatically included in the letter.

This prompt will not appear on any letters other than those mentioned above.

- G. How to Validate the Letter - After all data entries have been completed, each letter must be validated on the OVERVIEW screen. This tells the system that the letter is finished and ready to be mailed. To validate a letter, tab to the "N" in the "LETTER VALIDATED FOR RELEASE?" item if necessary, type in "Y" or "y" and press the enter key to activate the edit process.

If the data passes all edits, the message: LETTER READY FOR RELEASE: SELECT NEXT FUNCTION will be displayed. Print the OVERVIEW screen at this point for a folder record.

If any additions/corrections are made to the letter after it has been validated, the validation code automatically reverts to an "N". Revalidate the letter with a "Y" or "y" whenever necessary.

Press the appropriate PF key to exit ALTA or to begin your next ALTA action.

9.8.9 Completing Code Paragraph Inserts

This screen is automatically displayed after a code paragraph number that requires inserts has been entered on the OVERVIEW screen. The Prefix, RRB #, and Payee Code entries will be pre-filled. As a reminder, the code paragraph number and description will be displayed. Insert prompts will guide you as to what to enter for the insert. The insert prompts will be listed in numerical order below the description. Each insert prompt will be followed by a line for data entry. Make your entries using the appropriate upper and lower case letters.

If necessary, review the text of the code paragraph by using ALTA's Code Paragraph Library. The library can be accessed from the OVERVIEW screen by pressing PF1. In general, enter dates in numeric. ALTA will convert the month and year as follows: 06-07-88 will appear on the letter as June 7, 1988. The usual editing for dates will be done, i.e., only 1 through 12 for month and 1 through 31 for days will be allowed. On the letter, the year will be shown as 4 characters. You must complete all positions when dates are requested. Months and days under 10 must be filled with a preceding zero. Spaces between dates can be dashes or slashes only. (ex: 06-07-88 or 06/07/88)

Inserts that have been identified as being all numeric or all alphas only allow those characters.

Inserts that are money amounts allow numeric and decimals only. You must enter a decimal followed by two numbers (zeros, if appropriate). Do not enter the \$ sign. ALTA will precede these entries with a \$ sign on the letter.

The cursor will be set at the first position of the first insert. Type in the insert. If more than one insert is required, tab the cursor from one entry to the next.

Complete all the inserts before pressing the ENTER key. Review all entries and press the ENTER key to activate the edit process. See RCM 9.8.12 for a description of the edit process. If the data you entered is valid, the data will be stored and the OVERVIEW screen will be automatically displayed. If the data is invalid, an error message will appear. Correct the invalid entry and press the ENTER key. Repeat, if necessary, until all the data is valid.

You can exit from the code paragraph insert screen prior to completion of all data by pressing the CLEAR key. If this is done, both the code paragraph number and any inserts will be automatically erased and you will be automatically returned to the OVERVIEW screen. The incomplete code paragraph will not appear in the OVERVIEW screen.

9.8.10 Composing Special Paragraphs

Entering SP1 or SP2 on the OVERVIEW screen accesses this screen. The Prefix, RRB #, Payee Code, Letter Type, and Employee's Name, if any, entries will be pre-filled. This screen tracks entry and modification of a special paragraph by recording the user ID and entry/modification date next to the "LAST MODIFIED BY" item at the top left of the screen. This item will be updated each time the screen is modified. However, the "Date Entered" displayed on the Modify Pending Letter and Delete Pending Letter screens for a pending letter never changes. These 2 screens always show the date the letter was originally entered.

When the screen is displayed, the cursor will be positioned below the first position of special paragraph (SP1). Type in your text using the appropriate capitalization i.e., capitalize the first word of each sentence and all proper names. When your entry is complete, press ENTER. The message DATA HAS BEEN ACCEPTED: SELECT NEXT FUNCTION will be displayed. If you only plan to compose one special paragraph, print a copy of the screen at this time for a folder record. If you plan a second special paragraph, press ENTER but print the screen only after the second special paragraph is completed.

Press CLEAR to return to the OVERVIEW screen.

If a second special paragraph is desired, enter SP2 in the OVERVIEW screen. When you return to the COMPOSE SPECIAL PARAGRAPH screen, the cursor will be set at the first position of the SP2 entry. When your entry is complete, follow the procedure above.

The special paragraph(s) will appear on the letter exactly as it is entered on the screen.

NOTE: You can enter multiple paragraphs on a single set of 5 lines by skipping a line between the statements. Keep in mind that ALTA always prints a blank line between SP1 and SP2 or the next selected code paragraph.

9.8.11 Copies

ALTA letters are imaged. Letters can be viewed on WorkDesk. Copies cannot be requested on ALTA.

9.8.12 How ALTA Edits Data On-Line

ALTA performs numerous up-front edits to prevent erroneous data from being entered into the database. The ENTER key must be pressed to activate the edit process. If the data entered is valid, both the data will be stored and the next appropriate screen will be displayed automatically or a confirmation message will appear indicating the action taken while the system awaits the next command. ALTA edits the screen item by item. The edit process stops when the first invalid entry is found. The cursor then sets itself at the invalid item. The erroneous data field will be highlighted in red reverse-video (blocked), and a descriptive edit message will be displayed in red. See Exhibit 1 for the ALTA edit messages and their meanings.

Errors are corrected by typing over the erroneous entry with the correct information. After correcting the first invalid field, press ENTER to reactivate the edit process. Continue this until you have cleared all the edits.

9.8.13 Pending Transactions

Letters will be held on the database until the voucher clears, until both SS and RR voucher clear for combined award letters or for at least 120 days from the date originally entered, whichever is earlier. When the voucher(s) clear(s) and the letter is released or rejected, the screens used in creating the letter are moved to the Browse released letters file (see Section 9.8.16). Letters that have not matched with a voucher after at least 120 days will be automatically purged from the database. In the case of combined letters, letters that have not matched with the second voucher after at least 120 days will be automatically purged. A listing will be produced monthly detailing these purged cases. You can modify or delete a letter at any time until the last voucher clears or the letter is purged. The following sections detail these functions.

9.8.14 Modifying A Pending Letter

To modify or to view an award letter pending on the database, you must request the MODIFY PENDING LETTER screen. To access this screen from the MAIN MENU or CREATE AWARD LETTER screen, press PF-23.

If the MODIFY PENDING LETTER screen is accessed from the CREATE screen, the top entries (Prefix, RRB #, and Payee Code) will be pre-filled. The bottom of the screen will display all letters pending on that payee code. If the MODIFY PENDING LETTER screen is accessed from the MAIN MENU, enter the following information:

Item	Completion
Prefix	Enter A, D or H.

RRB #	Enter the 6 or 9 digit number. If your entry is a 6 digit number, enter 6 digits and tab over to the next entry.
Payee Code	Enter the payee code from 1 to 9.

NOTE: A payee code entry is not mandatory. If a payee code is not entered, the screen will display all the letters pending on the database under the claim number entered. If a payee code is entered, the screen will display only the letters under the claim number and payee code requested.

The cursor will be set at the "SELECT ONE OF THE FOLLOWING LETTERS" entry. Enter the number corresponding to the letter you want to modify and press the ENTER key to activate the edit process.

If the data is valid, ALTA will display the appropriate screen as shown on the chart in section 9.8.3. The screens will appear in the same sequence and function as they did during the Create mode. To access the screen you need, traverse any earlier screens automatically displayed by hitting ENTER or the appropriate PF key. In the Modify mode, the original entries will be displayed. To modify an entry, simply type over it. Tab over entries that do not need to be changed. Press ENTER to activate the edit process. When all entries are complete, you must re-validate the letter on the OVERVIEW screen. Also, secure new printouts of changed screens.

NOTE: A letter's "Date Entered" displayed on the Modify Pending Letter screen is never updated. This screen always shows the date a letter was originally entered, regardless of whether or not it was later modified.

9.8.15 Deleting A Pending Letter

To delete an award letter pending on the database, you must request the DELETE PENDING LETTER screen. To access this screen from the MAIN MENU or CREATE AWARD LETTER screen, and press PF-20.

If the DELETE PENDING LETTER screen is accessed from the CREATE screen, the top entries (Prefix, RRB #, and Payee Code) will be pre-filled. The bottom half of the screen will also show all the letters pending on the pre-filled claim number and payee code.

If the DELETE screen is accessed from the MAIN MENU, enter the following information:

Item	Completion
------	------------

Prefix	Enter A, D or H.
RRB #	Enter the 6 or 9 digit number. If your entry is a 6 digit number, enter 6 digits and tab over to the payee code entry.
Payee Code	Enter the payee code from 1 to 9.

NOTE: A payee code entry is not mandatory. If a payee code is not entered, the screen will display all the letters pending on the database under the claim number entered. If a payee code is entered, the screen will display only the letters under the claim number and payee code requested.

The cursor will be set at the "SELECT ONE OF THE FOLLOWING LETTERS" entry. Select and type in the number of the letter you want to delete and press the ENTER key.

If your entry is valid, the following message will be displayed:

HIT PF-4 TO COMPLETE DELETION; HIT PF-19

TO VIEW CP SELECT/OVERVIEW

Press PF-19 if you wish to review the OVERVIEW screen before deleting the letter. Press PF-4 if you wish to delete the letter. The message "RECORD HAS BEEN DELETED" will be displayed when PF-4 is pressed. Printouts of the screens used in creating the deleted letter should be destroyed.

9.8.16 The Browse Released Letter Screen

The screens used in creating award letters will remain on the database, available for viewing, at least 120 days after the voucher has cleared and the letter is released. In the case of combined award letters RL-130tc, uc and xc, the screens will remain on the database for browsing at least 120 days after the last voucher has cleared and the letter released. After 60 days, these screens will begin to be purged from the database. Screens for released letters and rejected letter information will be purged at the end (around the 26th) of the 2nd month following the date the letter was released/rejected. For example, a letter released on 11-25-02 will pend until 3-31-03 at which time it will be purged while a letter released on 11-27-02 will be purged on 4-31-03. The date the letter was released is the voucher date of the manual award. To view the data entry screens for released award letters, press PF-5. The BROWSE RELEASED LETTER screen will then appear. Enter the following information:

Item	Completion
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Prefix	Enter A, D or H.
RRB #	Enter the 6 or 9 digit number. If your entry is a 6-digit number, enter 6 digits and tab over to the payee code entry.
Payee Code	Enter the payee code from 1 to 9.

NOTE: A payee code entry is not mandatory. If a payee code is not entered, the screen will display all the released letters pending on the database under the claim number entered. If a payee code is entered, the screen will display only the letters under the claim number and payee code requested.

Review all entries and press the ENTER key to activate the edit process. See RCM 9.8.12 for a description of the edit process.

If you discover an error before pressing the ENTER key, return the cursor to the incorrect item and type in the correct entry. Hitting either a forward or backward TAB or NEW LINE key should move the cursor.

If the data is valid or after all edits have been cleared, ALTA will display all the letters pending under the record requested. Rejected letters (i.e., partially or wholly printed and referred out) will also be displayed on the BROWSE RELEASED LETTER screen. The voucher date of the rejected letter will be shown under the date released and "REJECT" will be shown after it. The input screens for rejects are not available for viewing.

The cursor is set at the "SELECT ONE OF THE FOLLOWING LETTERS" entry. Enter the number corresponding to the letter you want to BROWSE and press the ENTER key. ALTA will edit your entry in this item. If all edits clear, ALTA will display the BROWSE OVERVIEW screen.

9.8.17 The Browse Overview Screen

This screen will display all data contained on the CP SELECT/OVERVIEW screen used in creating the letter. The body of the screen consists of two columns: ITEM and DESCRIPTION. The ITEM column will display identifying numbers or symbols for the input. The DESCRIPTION column will display the corresponding item's description and any applicable CP inserts.

For recurring award letters, the payment summary is the first listing on Browse Overview screen. (Payment Summaries are not provided on ALTA for manual railroad one-payment-only awards.)

The ALTA system can access the Rate History File (RHF) to obtain limited payment summary data. Rates and their corresponding effective dates available from voucher

input sheets do not have to be input to ALTA by the examiner when creating a letter, minimizing the number of screen entries. In retirement cases, only the latest rate can be picked up from RHF; in survivor cases, up to the three latest rates may be secured from the RHF. The description of the payment summary indicates the letter's source for the effective dates and rates (e.g., T1, T2 - 1 date-break from the RHF). Rates filled from the RHF will not be displayed on subsequent Browse Payment Summary screens; only rates entered on-line by the examiner will be displayed on the Browse Payment Summary screens.

For regular RR or SS award letters, if the Browse Overview screen's description indicates that a payment summary was completed on-line (e.g., T1, T2 - 3 date-breaks from RHF, prior date-breaks from examiner), pressing PF17 will take you to a SS payment summary and pressing PF18 will take you to a RR PAYMENT SUMMARY screen. (See Section 9.8.18). If a dual RR payment summary number 08, 09, 10 or 11 was selected, the RESPONSES section at the bottom of the screen will be slightly different. Press PF15 to view the SUPP ANN PAYMENT SUMMARY screen or press PF18 to view the RR PAYMENT SUMMARY screen. When you complete your viewing of the PAYMENT SUMMARY screen, press PF19 to return to the BROWSE OVERVIEW screen.

For combined award letters, press PF-17 to view the SS payment summary and/or press PF-18 to view the RR payment summary.

If the screen indicates that a special paragraph has been composed, pressing PF21 will take you to the BROWSE SPECIAL PARAGRAPHS screen. The text of one or two special paragraphs will be displayed. To return to the BROWSE OVERVIEW screen, press PF19.

To view the text of a code paragraph displayed on the BROWSE OVERVIEW screen, press PF1. You will be switched to the BROWSE CODE PARAGRAPH LIBRARY screen. Follow the procedure in RCM 9.8.20, to view the text of any code paragraph on ALTA. To return to the BROWSE OVERVIEW screen, press PF19.

The BROWSE OVERVIEW screen is page-able to allow more space for data display. A page number will be displayed at the lower right portion of the screen.

To view multiple pages:

- 1) Press PF8 to display the next page, or
- 2) Press PF7 to display the preceding page.

9.8.18 The Browse Payment Summary Screens

Through the BROWSE OVERVIEW screen, you can access the following BROWSE PAYMENT SUMMARY SCREENS:

BROWSE T1 PAYMENT SUMMARY

BROWSE T2 PAYMENT SUMMARY

BROWSE T1, T2 PAYMENT SUMMARY

BROWSE T1, T2, VDB PAYMENT SUMMARY

BROWSE SUPPLEMENTAL PAYMENT SUMMARY

BROWSE SPECIAL GUARANTY PAYMENT SUMMARY

BROWSE SSA OPO PAYMENT SUMMARY

BROWSE SSA PAYMENT SUMMARY

As discussed in Section 9.8.17, the Browse Payment Summary screen displays only the rates entered on-line by the examiner. If necessary, use the Payment Summary Item and Description shown on the Browse Overview screen to determine which rates were shown on the letter but not displayed on this screen.

Responses for all the Browse Payment Summary Screens will be:

PF19 Browse Overview

PA1 Main Menu

PA2 End ALTA Session

9.8.19 The Browse Special Paragraph Screen

To view the wording of the special paragraph(s), press the PF21 key. The Browse Special Paragraphs screen will be displayed.

Responses for the Browse Special Paragraphs Screen will be:

PF1 Browse Code Paragraph Library

PF19 Browse Overview

PA1 Main Menu

PA2 End ALTA Session

9.8.20 Browse Code Paragraph Library

To view a code paragraph available on the ALTA database, request the BROWSE CODE PARAGRAPH LIBRARY screen. To access this screen from the MAIN MENU,

CP SELECT/OVERVIEW, BROWSE OVERVIEW, or BROWSE SPECIAL PARAGRAPHS screens, press PF1.

When the screen appears the cursor will be set at the ENTER CODE PARAGRAPH item. To view the text of a code paragraph, type in the code paragraph number. Enter decimals in the code paragraph number, if applicable (e.g., 1824.1). Enter alpha characters in case shown in RCM 10.5 e.g., 404a, 404b. Press the ENTER key.

ALTA will edit the entry and when edits clear, display the CP requested. The first line will display the CP number followed by a short description. The text of the CP begins on the second line. If the CP contains inserts, the type of insert will be indicated as follows: examiner completed inserts will be numbered (1.), (2.), (3.), etc., automatically completed inserts will be indicated by the designations (CHICO) or (RHI) depending on the file used to complete the insert.

When the CP is displayed, the CP number in the entry item will be automatically erased and the cursor will be reset for the next CP entry. If the CP entered is not in the ALTA library, the message: CODE PARAGRAPH NOT IN LIBRARY will be displayed. In this case, the CP number will not be erased, but the cursor will be reset for a new entry. Review your entry and type in the correct code paragraph number.

The BROWSE CODE PARAGRAPH LIBRARY screen is page-able to allow more space for data display. A page number will be displayed at the lower right portion of the screen.

To view multiple pages, if any:

- 1) Press PF8 to display the next page, or
- 2) Press PF7 to display the preceding page.

9.8.21 ALTA Daily Manual Award Activity Listing

Given that file copies of award letters will not be routinely produced under ALTA, the ALTA Activity Listing is designed to simplify pulling cases that have cleared vouchering. It is also used to identify cases that require special handling of ALTA rejects.

This listing while similar to the current Xeroxed DAISY listing shows manual award activity only. Related ALTA activity is indicated next to each claim that has been accepted (paid).

Because the listing is sorted according to the Units' voucher number assignments, each Unit will receive a listing of its own manual award activity.

A. Rejected Awards

1. Regular ALTA Letters

Related ALTA Activity will not be shown for awards that reject. Furthermore, rejected awards will not be included in the ALTA Balance Counts Report. For each Unit, the rejected awards will be listed in claim number order following all paid awards on the ALTA Activity Listing.

2. Combined ALTA Letters

Combined award letters, RL-130TC, RL-130UC and RL-130XC, will be handled differently. Until both vouchers clear DAISY, they will not be posted on this listing. Rather, notice of DAISY reject and related ALTA activity will be documented by referral, see RCM 9.8.22A.

B. Accepted Awards

The following messages will be displayed for cases that have been accepted:

- ALTA - Match, Letter Released

The accepted award (or awards if a combined letter is involved) has matched a claim number and payee code entered in ALTA. All edits have cleared and the letter was released.

- ALTA - Match, Reject LTR RLSD

For combined letters, this message indicates that all edits pertaining to the letter in question have cleared, but the companion letter has rejected. A reject letter and referral have been produced.

- ALTA - Not Applicable

The accepted award met the criteria for a STAZA letter. No reject referral will be produced.

NOTE: STAZA cases will not be included in the ALTA Balance Counts Report.

- ALTA - No Match

A separate ALTA reject referral will be produced. (See detailed explanation of reject referrals in 9.8.22.)

- ALTA - Reject, No Validation

A separate ALTA reject referral will be produced. (See detailed explanation of reject referrals in 9.8.22.)

- ALTA - Reject, RH Data Miss/Invld.

A separate ALTA reject referral will be produced. (See detailed explanation of reject referrals in 9.8.22.)

9.8.22 ALTA Reject Referrals

- A. General - ALTA will produce referrals for four categories of cases. The following are the messages that are displayed on the referrals and the conditions that produce them. The first three categories listed below apply to all cases; the fourth category applies only to combined letter processing.

1) ALTA, No Match

The accepted award did not find a matching claim number and payee code entered in ALTA and the manual award did not meet the criteria for a STAZA letter. No letter was released by ALTA.

One of the following situations may have occurred:

- a) The User entered the wrong claim number and/or payee code, or
- b) The User neglected to enter a letter into ALTA, or
- c) The case did not require an award letter (e.g.: transfer of funds only) or,
- d) The award letter was typed outside the ALTA program.

Units should match the referral to the file and determine the proper handling. If it is determined that a letter must be manually released, a copy should be made for the F/O and file.

2) ALTA- Reject, No Validation

The accepted case has matched a claim number and payee code entered in ALTA. All edits have cleared but the letter was not released because the "letter validated for release" on-line entry was not completed. The letter will be printed and forwarded with the referral to the originating unit for proper handling.

3) ALTA - Reject, RH Data Miss/Invld.

The accepted case has matched a claim number and payee code entered in ALTA. Edits prevented the letter from being completed properly. The letter will be printed, excluding the portion of the letter where the error was detected, and forwarded with the referral to the originating Unit for completion, and release.

4) Combined Letter Referrals

a. ALTA - Match, DAISY Reject; Voucher Data Place on Hold File

The accepted DAISY voucher has matched a claim number payee code and combined letter pending on ALTA. The second voucher needed to complete the ALTA letter has rejected in DAISY. The data required to complete the ALTA letter has been placed on a hold file to pend correction of the rejected voucher.

Units should match the referral to the file on a priority basis and determine the proper handling. The rejected award should be mechanically corrected as soon as possible using ONCORR. If it is determined that the rejected voucher will not be re-vouchered, a manual letter must be completed for the voucher which did clear. Manual letters should be prepared as soon as possible after the referral is received.

b. ALTA - Match, DAISY No Match; Voucher Data Placed on Hold File

The accepted DAISY voucher has matched a claim number, payee code and combined letter pending on ALTA. The second voucher needed to complete the ALTA letter did not come through on DAISY on the same run.

Units should match the referral to the file on a priority basis and determine the proper handling. Determine whether to wait for the second voucher to clear or whether, if the missing voucher is not being re-vouchered, a manual letter should be released for the voucher which cleared.

c. ALTA Combo Award No Match Referral Combined Letter and Voucher Data Deleted/Purged

This referral will be produced whenever the voucher needed to complete a pending ALTA letter is not matched before the pending ALTA letter is deleted by examiner action or purged by the monthly ALTA purge program.

This referral is a folder record. It documents the fact that a pending letter was deleted or purged and, therefore, cannot be used again. Combined letter referrals a. and b., above, will have been released previously, check to make sure the actions required by those referrals has been completed.

B. Payment Summary Edits - When ALTA is requested to mechanically pick-up date breaks from the award form to be printed on the letter and an error is detected during the end-of-line editing process, a referral message will be printed and editing terminated for that portion of the letter. The payment summary heading

selected on-line and any date breaks entered on-line will, nonetheless, be printed on the letter. The rejected letter will leave lines for manual completion of the payment summary.

The following shows edits which are performed and the reject messages that may appear under the category of "RH Data Missing/Invalid."

- PAYMENT SUMMARY - TOTAL RATE DOES NOT EXCEED ZERO, COL.A.

Column A refers to the latest date-break on the award form G-357 or G-364.1. This message occurs when the on-line payment summary selection was other than O/M or SUPP and the Rate History File shows the total rate (G-357 item 27 or G-364.1 item 113) as zero or blank.

- PAYMENT SUMMARY - TOTAL RATE DOES NOT EXCEED ZERO, COL.B.

Column B refers to the 2nd latest date-break on the award form G-364.1. This message occurs when the Rate History File shows the total rate (G-364.1 item 113) as zero or blank.

- PAYMENT SUMMARY - TOTAL RATE DOES NOT EXCEED ZERO, COL.C.

Column C refers to the 3rd latest date-break on the award form G-364.1. This message occurs when the Rate History File shows the total rate (G-364.1 item 113) as zero or blank.

- PAYMENT SUMMARY - SUM OF TIERS SELECTED DOES NOT EQUAL TOTAL RATE, COL.A.

Column A refers to the latest date-break on the award form G-357 or G-364.1. This message occurs when the on-line payment summary selection was other than O/M or SUPP and, in Rate History, the total of the selected tiers (G-357 items 24, 25, and 26) or (G-364.1 items 87, 110 and 112) does not add up to the total rate (G-357 item 27) or (G-364.1 item 113). Note that if a tier sheet is submitted showing a net tier amount different than what appears on the G-357 or G-364.1, the information on the tier sheet is used in Rate History, and therefore, used in ALTA's calculation check.

- PAYMENT SUMMARY - SUM OF TIERS SELECTED DOES NOT EQUAL TOTAL RATE, COL.B.

Column B refers to the 2nd latest date-break on the award form G-364.1. This message occurs when, in Rate History, the total of the selected tiers (G-364.1 items 87, 110 and 112) does not add up to the total rate (G-364.1 item 113). Note that if a tier sheet is submitted showing a net tier amount different than what appears on the G-357 or G-364.1, the information on the tier sheet is used in Rate History, and therefore, used in ALTA's calculation check.

- PAYMENT SUMMARY - SUM OF TIERS SELECTED DOES NOT EQUAL TOTAL RATE, COL.C.

Column C refers to the 3rd latest date-break on the award form G-364.1. This message occurs when, in Rate History, the total of the selected tiers (G-364.1 items 87, 110 and 112) does not add up to the total rate (G-364.1 item 113). Note that if a tier sheet is submitted showing a net tier amount different than what appears on the G-357 or G-364.1, the information on the tier sheet is used in Rate History, and therefore, used in ALTA's calculation check.

- O/M PAYMENT SUMMARY SELECTED, O/M RATE DOES NOT EXCEED ZERO.

This refers to the latest date-break on the award form G-357. This occurs when the on-line selection was O/M and the Rate History File shows the O/M rate item 28 as zero or blank.

- PAYMENT SUMMARY SELECTED INCONSISTENT WITH TYPE OF PAYMENT.

This occurs when the on-line payment summary selection was SUPP and the award form G-357 submitted shows a "Type of payment" other than "SUPP ONLY."

- PAYMENT SUMMARY SOURCE SELECTED INCONSISTENT WITH TYPE OF AWARD FORM.

This occurs when the on-line payment summary source selection requested ALTA to use more than one date-break from RHF, and the award form submitted was G-357. The RHF picks up only one date break, the latest, from the G-357.

- PAYMENT SUMMARY - EFF. DATES NOT IN ASCENDING ORDER.

This occurs when the effective dates in Rate History are not in ascending date order, or when the effective dates entered on-line, together with the Rate History effective dates are not in ascending date order.

- PAYMENT SUMMARY - LATEST EFF. DATE EXCEEDS LETTER ENTRY DATE BY 60 DAYS.

This occurs when the latest effective date in Rate History is more than 60 days from the date the letter was entered on ALTA.

- C. Code Paragraph Edits - Certain code paragraphs require insert data from the Rate History or CHICO files. If that data is missing or invalid, a referral under the category of "RH Data Missing/Invalid" will be produced. The reject message will identify the problem code paragraph number.

9.8.23 ALTA Balance Counts Report

A Balance Count Report will be produced with every ALTA Daily Manual Award Activity Listing.

The purpose of this report is to compare the number of manual awards vouchered with the corresponding output produced by ALTA. This report balances the following counts:

- Total ALTA Awards

This is the total number of manual awards vouchered on the Daisy run excluding rejected awards and accepted awards that have been identified as STAZA awards.

- Letters Released

This is the total number of award letters completed and released for mailing.

- No Matching ALTA Letter

This is the total number of awards that did not match a transaction pending in ALTA. Referrals will be produced and sent to the appropriate Unit for handling.

- ALTA Letter Reject, No Validation or RH Data Miss/Invl

This is the total number of award letters produced but not released because of missing/invalid information in Rate History, or because the letter was not validated on-line for release. These letters, along with their referrals, will be sorted and sent to the appropriate Unit for correction and release.

- In Balance

A "yes" will be printed if the sum total of "Letters Released," "No Matching ALTA Letter" and "ALTA Letter Rejects" equals the number of "Total ALTA Awards." Otherwise, a "No" will be printed.

- Combination Voucher/Letter Counts

This part of the report displays the following counts for combined letters:

- Total ALTA Awards

This is the total number of accepted manual awards completing ALTA award letters. It includes vouchers processed on the DAISY run and voucher data that resided in the hold file. It only includes vouchers which matched on a combined letter pending on ALTA.

- Letters Released

This is the total number of award letters completed and released for mailing.

- ALTA Letter Reject, No Validation or RH Data Miss/Invl

This is the total number of reject ALTA letters produced.

9.8.24 ALTA Referral Message Counts

This report is a list of all referral messages produced by ALTA's end-of-line edits. Each message is followed by the frequency of the error in the Daisy run.

9.9.1 Employer Status List Overview

The Bureau of the Actuary maintains an Employer Status List (ESL). The list contains the employers that were determined to be covered under the Railroad Retirement Act since 1936. Refer any questions concerning the list to the Bureau of the Actuary.

9.9.2 Employment Data Maintenance (EDM) Overview

Employment Data Maintenance (EDM) is a data base system that captures and maintains employment data for individuals who worked for employers covered under the Railroad Retirement Act.

EDM maintains the following types of employment data for railroad employees: actual and deemed railroad service months, compensation, miscellaneous compensation, military service and SSA wage/SEI data. EDM also maintains railroad employer specific information, such as name, address and status. The railroad contact officials for A&T are also included.

While the primary users of the EDM system will be A&T, other headquarters and field users can utilize the system to inquire into the service and earnings records of railroad employees as an aid to answering inquiries and expediting disability freeze determinations. No spouse or survivor information is contained in EDM.

EDM replaces wholly or in part the following master tape files:

- SSA MEF (Master Earnings File) - Wages reported to SSA for employees with 120 or more RR service months.
- SCORE - Service and Compensation of railroad employees.
- SPREM – Miscellaneous compensation reported as railroad earnings by railroads, the Disability, Survivor, Unemployment Benefit Division (DSUBD) or insurance companies.
- CUTBACK - Railroad earnings in excess of the annual Tier I and Tier II maximums.
- Employer File - Detailed information about railroad employers covered at EDM's implementation.
- Railroad Contact Official File - Detailed information about railroad contact officials.
- SSA 37-52 Wage QBD File - Wages and quarterly breakdown for 1937 through 1952.

These files have been converted from magnetic tape to a data base environment to allow on-line access.

EDM also provides military service dates and creditability determinations as soon as that information becomes available or is developed, thereby avoiding delays and eliminating the need for manual re-entry on subsequent requests for G-90's or PIA calculations. The data base is built in retirement cases as the M/S data leaves the SEARCH system, or when it is processed from data input on APPLE.

SSA will provide RRB with weekly updates of wages/SEI information for RR employees whom either:

- Worked after 1995 or
- Have 108 railroad service months or more.

This will save time in paying cases since the wage data stored in EDM can be provided as soon as it is requested through SEARCH and the TRIC systems.

EDM will produce a referral for RASI when earnings are posted after the claims processing begins.

Expedited data similar to service and compensation data now supplied on Form G-563 is available on EDM. However, EDM does not replace Form G-90. The system will not mechanically compute a PIA, AMC, RLS or Tier 2 contribution. It does not send computations to the Research Master Benefit File.

There are 4 basic types of screens within the EDM system. The four types are:

- Menu screens
- Inquiry screens
- Selection Directory screens
- Maintenance screens (Reserved for authorized users only)

Menu screens allow you to go from screen to screen within the system to access the screen that you wish to view.

Inquiry screens allow you to view information which already exists on the database.

The Selection Directory screens, explained in CCOM 1 are valuable tools when the user is not sure about the exact RRB claim number or Social Security Number, railroad employee name, railroad name or RRB 4-digit employer number (formerly BA number). Maintenance screens can only be accessed by authorized A&T or P&S users. They allow the user to:

- Enter data and create new data base information for the first time on-line;
- Create batches of transactions for overnight processing;

- Modify data on records that already exist on the system;
- Delete records that already exist on the system;

On most screens, other than the menu screens, one or more fields usually appear that are considered "key search fields." In EDM, the key search fields are usually either the RRB employer number-4 digit (formerly BA number) and the railroad name or the employee's social security number. The search based on the railroad employee's name can only be made from the EMPLOYEE SELECTION DIRECTORY. The search fields are required for processing on the first screen you access after the INQUIRY MENU. The data will pre-fill for any other screen which you request for the same employee.

9.9.3 How to Access Employee and Employer Information

After you have signed on with your password, access the Employment Data Maintenance (EDM) Inquiry System by typing "EDMA" in response to the query line: V10 ENTER NEXT TASK CODE. Press the ENTER key. The EDM MAIN MENU SCREEN will appear. The cursor rests at the first submenu selection. To make a selection, move the cursor with the Tab key.

The three inquiry options available to the operating units are the INQUIRY MENU, the EMPLOYEE SELECTION DIRECTORY MENU, and the EMPLOYER SELECTION DIRECTORY MENU. Type an "x" in the space to the left of your choice and press ENTER.

If you request the EMPLOYEE DATA MAINT MENU/EMPLOYER DATA MAINT MENU, REPORT CONTROL MENU, or BA-6/LETTERS/REPORT REQUEST options, the screen will display the message "UNACCEPTABLE RESPONSE. PLEASE TRY AGAIN." These screens are only available to authorized A&T and P&S users.

To return to the INQUIRY MENU, press the CLEAR key. To return to the MAIN MENU from any other EDM screen, press the PA1 key. To exit EDM from any EDM screen, press PA2.

9.9.4 Standard Keys and Cursor Movement

The Programmed Function (PF) keys for EDM operate similarly to the way they do for the other database systems with the exception of PF-6 and PF-13 thru PF-21. The standard keys used for EDM inquiry are described below:

KEY	FUNCTION
PA1	Return to EDM main menu
PA2	Quit EDM, return to sign off screen

CLEAR	Return to INQUIRY MENU
ENTER	Perform the selection with an "x" to the left of the item.

NOTE: The ENTER key is only used on the main menu and submenu. Other screens require a PF key to process your selection. The red user message on each screen will help you to determine the proper key. When the ENTER key is used and is not appropriate, the screen will display the message: "INVALID RESPONSE - PRESS THE APPROPRIATE PF KEY."

KEY	FUNCTION
PF6	Erase or refresh screen data and allow for the entry of new SSN or railroad employer data. For example, this allows you to call up data for a series of SSN's in the same screen category without returning to the MAIN MENU.
PF7	Go to previous page. If a screen is page able, PF7 will scroll to the previous page. The scroll range is limited to the first page viewed (i.e. if the first page viewed is page 4, PF-7 will not scroll back to pages 1-3). When the first page in the scroll range is reached, PF 7 will continue to display that page again and again. Refer to the instructions for the applicable screens to extend the scroll range.
PF8	Go to next page. If a screen is page-able, PF8 will scroll to the following page. The scroll function has a limited number of pages in each scroll range. When the last page in the range is reached, PF 8 will continue to display that page again and again. Refer to the instructions for the applicable screens to extend the scroll range.
PF13 thru PF19	Used to make a directory selection and to move between various screens. Follow the directions at the bottom of your screen.
ALT and PF23	Enhance the cursor to facilitate entry of search keys.
Search Keys	These are the employee's SSN, the RRB employer number-4 digit (formerly BA number) or the railroad's name.

Cursor may be positioned with the return key, tab key or cursor movement (arrow) keys. Use of the tab key is preferred. It automatically moves the cursor to the next selection item. It will also by-pass items that do not need to be completed.

9.9.5 Contact Official Database

A. Each railroad employer, employer organization, and employee organization designates one or more individuals as contact officials. The names and addresses of these contact officials are maintained using the Employment Data Maintenance Applications. Refer to CCOM, Section 307 for instructions on accessing this database.

B. When a Railroad Employer Notifies You of a Change in Contact Official:

If someone from the RRB is notified by an employer that there is a change in a contact official, the information should be forwarded to the Quality Reporting and Service Center (QRSC) in A&T. Provide the following information:

- Employer number (BA number)
- Employer's full name
- Contact official's name, title, address, telephone number, fax number and e-mail address.
- Contact official's function or forms they handle such as: Forms BA-4, ID-2u, ID-30b, G-251, etc.

9.9.10 EDM Main Menu Display

The EDM MAIN MENU screen is a list of options available on the EDM. The EDM MAIN MENU screen includes 7 submenu screens. The selections are displayed in descending order as follows:

INQUIRY MENU (RBD access)

EMPLOYEE DATA MAINT MENU (A&T and P&S use only)

EMPLOYER DATA MAINT MENU (A&T and P&S use only)

EMPLOYEE SELECTION DIRECTORY (RBD access)

EMPLOYER SELECTION DIRECTORY (RBD access)

REPORT CONROL MENU (A&T and P&S use only)

BA-6/LETTERS/REPORT REQUEST (A&T and P&S use only)

RBD users only have access to the INQUIRY MENU and related screens, the EMPLOYEE SELECTION DIRECTORY and the EMPLOYER SELECTION DIRECTORY. The remaining screens are for authorized A&T and P&S users only. See

Exhibit 1 for a flow chart of the EDM screens. See Exhibits 2 through 15 for a sample of the submenu screens available to RBD users.

The cursor rests at the first submenu option. Use the TAB key to move the cursor. Type an "X" in front of the submenu option that you wish to view and depress the ENTER key. The submenu screen that you selected will appear.

If you attempt to select a submenu option for which you do not have access, (i.e., the EMPLOYEE DATA MAINT MENU), the screen will display the message:
"UNACCEPTABLE RESPONSE. PLEASE TRY AGAIN."

9.9.11 EDM Inquiry Menu

The EDM INQUIRY MENU screen lists the 14 submenu task options included on the INQUIRY MENU. There are also 2 subordinate screens not listed on the INQUIRY MENU: EE MULTI ACCOUNTS screen and MILITARY SERVICE INFO screen. These subordinate screens can only be accessed as explained in RCM 9.9.13 and RCM 9.9.15. (See Exhibits 2 through 13 for samples of the INQUIRY screens.)

The cursor positions itself at the submenu sections in descending order as follows:

EMPLOYEE DEMOGRAPHIC INFO (RBD ACCESS)

EE SERVICE AND RUIA INFO (RBD ACCESS)

MISCELLANEOUS SCORE INFO (RBD ACCESS)

CREDITABLE S&E YEARLY TOTALS (RBD ACCESS)

EE S&E TOTALS (RBD LIMITED USE)

S&E YEARLY LEDGER (RBD LIMITED USE)

SERVICE MONTHS DETAIL (RBD ACCESS)

EMPLOYER INFORMATION (RBD ACCESS)

EMPLOYER CONTACT OFFICIAL (RBD ACCESS)

ANNUAL RPT PKG DIRECTORY (RBD LIMITED USE)

ADJSTMNT RPT PKG DIRECTORY (A&T AND P&S USE ONLY)

OUT OF BAL BATCH DIRECTORY (A&T AND P&S USE ONLY)

SUSPENDED TRANS DIRECTORY (A&T AND P&S USE ONLY)

REPORT PACKAGE STATUS (A&T AND P&S USE ONLY)

RBD users only have access to the first 10 screens listed. Access to the last 4 screens is reserved for A&T and P&S users only.

Use the TAB key to move the cursor. Type an "X" in front of the inquiry screen that you wish to view and depress the ENTER key. The screen that you selected will appear.

It is not necessary to return to the INQUIRY MENU to request a new screen. Screen movement options available for each screen are listed in the RESPONSES area at the bottom of the screen. Movement from screen to screen is controlled by the use of Program Function (PF) and Program Access (PA) keys.

Use the following link to locate the EDM screen descriptions in CCOM 1.

9.10.1 Introduction

The Federal Financial System (FFS) is an integrated financial management system designed specifically for federal agencies. FFS enables agencies such as the Railroad Retirement Board to comply with federal laws and regulations in tracking and accounting of revenue. FFS is maintained by the bureau of fiscal operations.

The Program Accounts Receivable System (PARS) is a subsystem of FFS. Through the establishment and maintenance of tables and documents in PARS, an accounts receivable record for each overpaid annuitant under both the Railroad Retirement Act and the Railroad Unemployment and Sickness Insurance Act is created. Input of specific information into PARS allows the system to address a variety of operational and administrative functions. PARS provides for:

- Automation of tracking and maintenance of accounts receivable that originate from benefit overpayments.
- Automation of billing and follow-up functions including installment bills.
- Automation of the calculation and collection of interest, penalties and administrative charges where applicable.
- Automation of processing cash receipts and maintenance of accounts receivable offset information.
- Referral of uncollectable receivables to other agencies for collection.
- Reports concerning activities within the accounts receivable area.

Sections 9.10.3 through 9.10.161 explain how to create or change accounts receivable records on PARS. Sections 9.10.200 through 9.10.230 describe situations in which an accounts receivable record needs to be established or corrected.

9.10.2 Operation Of PARS

Overpayments to annuitants involving railroad retirement annuity or supplemental annuity funds are recorded and tracked in PARS. In the future, Medicare overpayments will also be entered into PARS. Data entry, approval and scheduling are done on-line.

PARS includes a variety of on-line processes for maintaining overpayment records after they have been entered into the system. Current balances are available along with a history of recovery actions. Tables exist which track the printing and release of follow-up overpayment letters and recovery by partial or full withholding. Information contained in PARS can be viewed by both headquarters and field office personnel.

9.10.3 PARS Data Entry

The first step in creating a PARS accounts receivable record is to establish two identification and information tables. These are the payor (PAYR) and the payor debtor information table (PDIT). Completing these two tables creates a unique identifier for the individual payor/debtor involved and each overpayment attributed to that individual.

To enter overpayment and recovery information requires the creation of a document. Each document consists of three different entry screens called the startup screen, input screen and line screen. Overpayment and recovery information is entered on-line and then edited for errors. After the edits are completed, the document is placed in a hold status on a suspense file. The document will remain on the suspense file until all detected errors are corrected and it is approved and scheduled for processing.

9.10.4 Glossary Of Terms

The Program Accounts Receivable system uses terms and phrases which may be unfamiliar to the claims examiner. This section provides a list of some of these terms and their meaning in relation to PARS.

- Accounts Receivable - A record of who owes what to the RRB and the reason for the overpayment.
- Action - A command entered on all PARS screens which instructs the system as to the type of processing desired.
- Action Out Code - This is a three position code which describes how an open accounts receivable record is being reduced or offset. A complete list of valid action out codes is displayed on the ACOT table screen. For ORSP purposes, the first two positions of this code are always numeric while the final position is an alphabetic character.
- Add - The process of establishing table data to identify the name and address of the person responsible for repayment of a debt, the name of the overpaid annuitant and other pertinent information concerning an accounts receivable record.
- Approval - The process of verifying that data entered on a screen to create a document is correct. This is analogous to authorization of manual award forms or due process letters.
- Billing Document - The method used in PARS to establish an accounts receivable record. Through completion of a variety of data entry screens, a record is established which provides the amount, type, and cause of an overpayment as well as other pertinent information.
- Cancel - The removal of information entered into an accounts receivable record through a processed billing or cash receipt document.

- Cash Receipt Document - The method used in PARS to reduce or eliminate the amount of an open balance on an accounts receivable record. A cash receipt document is completed regardless of the method of recovery, be it by check, money order, tolerance, annuity withholding, waiver, etc.
- Change - The process of correcting or altering certain information contained on PARS table screens. Some fields cannot be altered once they have been established and require cancellation of the record if changes are needed.
- Debtor - The name of the annuitant or former annuitant who is/has been overpaid.
- Delete - For PARS billing and cash receipt documents, delete is the removal of information scheduled to be entered into an accounts receivable record which has not yet been processed. For PARS table screens, this is the method used to remove information established in an accounts receivable record as if it had never existed.
- Division - A four position code completed on data entry screens which identifies the RRB organization responsible for the transaction. Currently, four such codes are possible.
 - 2000 ORSP
 - 2500 BDMO
 - 8000 BUSI
 - 1600 BFO
- Document Identification Number - The alpha/numeric code which keeps each transaction unique so that both accounts receivable and cash receipt records can be accessed for correction, modification, maintenance or inquiry.
- Key - A code entered on the PARS table screens which enables the system to locate specific individuals or accounts receivable records.
- Mode - A one position code on PARS document screens which tells the system the type of activity that is being attempted. The three codes used by claims examiners are:
 - C-Correction -Used when correcting, modifying or deleting information from previously 2completed document screens,
 - D-Data Entry -Used when initially completing a document screen,
 - S-Scan -Used when viewing existing documents.

- **Modify** - The process of changing certain information on previously processed billing and cash receipt documents. Some fields cannot be changed once they have been processed and require cancellation of the entire document if changes are needed.
- **Payor** - The individual who is responsible for repayment of a debt to the RRB. This may be a person who has current entitlement, a representative payee, an executor of an estate, etc.
- **Payor Number** - This is a reference which identifies the RRB claim in which an overpayment exists. It is composed of the prefix and claim number. Serial claim numbers are preceded with zeros. The final position is an identifier which makes the code unique to each payor within the same claim number.
- **Quick Edit** - This is a function of the PAR system whereby information entered to establish or modify either a billing document or cash receipt document is edited. This process does not guarantee the document will not reject from processing once it has been scheduled. However, the various error and warning messages generated by this function alert the user to potential problems. A listing of messages generated by Quick Edit is provided in Appendix A.
- **Schedule** - The process used to alert the PAR system that all data entry items on billing and cash receipt documents have been completed and are correct. The information entered is ready to generate a billing document or post a recovery action.

NOTE: It is essential that scheduling of a billing document coincides with the release of an overpayment notice. Interest, penalty and administrative charges accrue and are assessed and dunning notices are released based on the date a billing document is scheduled for processing in the PAR system.

- **Table** - These are a series of screens in PARS which provide for three basic functions:
 - **Data Entry** - These screens allow for direct on-line data entry of information to establish an accounts receivable record and post recovery actions.
 - **Information** - These screens provide details concerning the status of a given accounts receivable record. When processed, billing and cash receipt document information is displayed on a PARS table.
 - **Reference** - Lists of codes and abbreviations and their meanings used to complete PARS data entry screen.

RCM 9.10.6 provides a list of the tables ORSP personnel will encounter in establishing and maintaining accounts receivable records and gives a brief summary of the information contained on each table.

- Table ID - This is a four position acronym which designates each individual table within the PAR system. The TABLEID is required to access a particular table, either for data entry or reference purposes. RCM 9.10.6 provides a list of tables along with the four character acronym which makes up the TABLEID. The TABLEID is referred to as the table code name in the data entry portion of this chapter.
- Transaction Code - This is a two position code which designates the type and origin of a document being generated. Claims examiners will be concerned with the following:
 - B2 - Billing document created by ORSP
 - C2 - Cash receipt document created by ORSP
 - B5 - Billing document created by BDMO
 - C5 - Cash receipt document created by BDMO
 - WR - Cash receipt documents created in write-off to uncollectable processing.
- Unapplied Cash - Receipts which are processed through PARS in which no accounts receivable record has been established or if it has been established, the open balance is zero.

9.10.5 General Screen Description

Each table screen in the PAR System is divided into four sections, each having a distinct function. These sections are:

- Action line,
- Key line,
- Data area, and
- Message area.

These sections appear on each of the table screens as shown below.

SEE EXHIBIT 1

Document screens are formatted in the same manner as table screens except there is no key line on a document screen. The function of the action line, data area and message area on a document screen is the same as that described for a table screen.

A. Action Line - The action line, located at the top of each table screen, is used to define the type of processing the user wants to accomplish. Three basic types of action are available. These are:

- Retrieval actions which enable the user to access and scan tables or specific records based on key fields,
- Maintenance actions which enable the user to add, modify, correct and delete data from table and document screens, and
- Control actions which enable the user to move from table to table, advise the system that data entry is complete, schedule documents for processing and exit from tables.

The action line also displays the four character identifier for the table screen you are viewing or moving to. In addition, your PARS user identification code and password must be entered on the action line before you can access or enter any information on a table screen.

B. Key Line - The key line, which is the second section of each table screen, displays the table name and between one and four components known as keys. Entering the required keys enables the PAR system to locate specific individuals or accounts receivable records stored in the system. Examples of key data components, which cannot be modified or corrected once they have been established in the PAR system, are PAYOR NUMBER, BILLING DOCUMENT ID and CASH RECEIPT ID. If errors are detected in a key, all table and document records containing the incorrect key must be deleted and reestablished using the correct key.

C. Data Area - The data area of each table screen contains the information pertinent to the table identified on the action line. There are two types of tables; input tables which are completed by the examiner and reference tables which do not require any examiner completion. Input data areas are used to establish, maintain, modify, correct and close out an open accounts receivable record. Reference data areas provide a source for determining the status of a specific accounts receivable record or provide lists of explanations for codes used in data entry.

D. Message Area - Located along the bottom of each screen is an area reserved for messages. These messages indicate when all required entries on an input screen have been completed and the table has been established. If any errors are detected or fields requiring an entry are left blank, this information will be displayed in the message area. In the case of reference tables which are displayed on multiple screens, the message area will alert the viewer when the end of the table has been reached.

9.10.6 PAR Tables

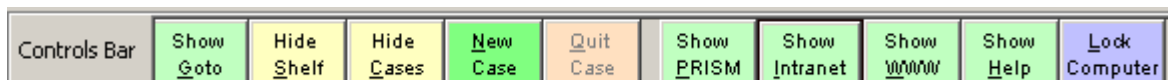
The following table provides the acronym and describes the types of PAR tables that are used by ORSP.

ACRONYM	DESCRIPTION
ARCL	Accounts Receivable Case History Line Inquiry Table
ARHT	Accounts Receivable Header Inquiry Table
CAUS	Cause of Overpayment Reference Table
SRCE	Source Data Reference Table
TYOP	Type of Overpayment Reference Table
ACOT	Action Out Reference Table
OBDT	Outstanding Billing Documents Reference Table
UNCL	Uncollectible Table

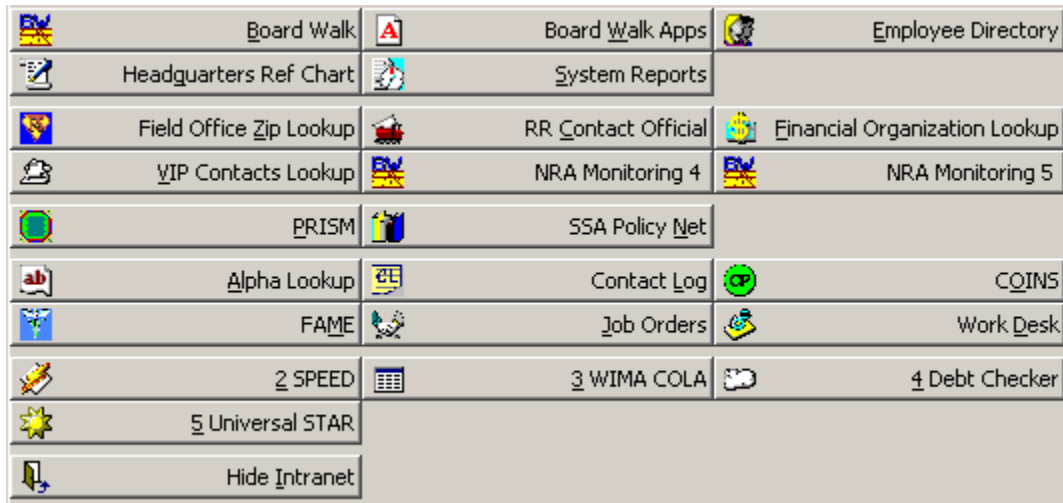
9.10.7 DebtChkr

DebtChkr is an on-line database file which enables examiners to ascertain whether RRA, RUIA, Medicare and uncollectible overpayments exist. Examiners should use DebtChkr before paying out an accrual.

The DebtChkr icon can be found on the RRAILS and Mainframe toolbar. The Mainframe icon is not operational. Use the RRAILS icon. Select **“Show Intranet”**.



Select **“Debt Checker”** from the menu.



When activated the following screen will appear:

Debt Checker

Search Criteria

RRB Claim Number:

Capture Action

Enter the claim number and press “**Look Up**”. DebtChkr will convert a six digit claim number to nine digits and will search A and D prefixes. DebtChkr will scan the ARCL, OBDT and UNCL PARS tables to see if an overpayment exists. If one or more debts are found, DebtChkr will provide the PARS screen for each debt. When an overpayment is found, the accrual due should be used to offset or reduce the overpayment on record.

Below is an example of the PARS screen DebtChkr returns when a debt is found. In this case the debt was written off but can now be recovered from an accrual due.

PAR searched 1/12/2007

novakmv

Debtor Name: BONNIE YAZZIE

Claim Number: 525527814

=====

ACCOUNT NUM BILLING DOC ID REOPEN AMOUNT LAST ACTIV WO DATE WRITEOFF BAL

525527814 B8 525527814UN 0.00 08 05 1,154.61

ORIG DEBT: 1,154.61 08 11 05 CAUS: 170 SRC: PUNC TYPE: S20 ACTO: 18A

ACCOUNTS RECEIVABLE CASE HISTORY LINE INQUIRY TABLE

ACCOUNT #: 525527814 BILLING DOC ID: B8 525527814UN

DEBTOR NAME: BONNIE YAZZIE

BD

TRANS LINE AC TR ACT ST/ TRANS DOCUMENT LINE

DATE NO CD TP OUT DEST AMOUNT BALANCE ID NO

08 11 2005 001 BD RS 1,154.61 1,154.61 B8 525527814UN 001

08 15 2005 AR CHIB 1,154.61 1,154.61

08 19 2005 001 WO WS 18A -1,154.61 0.00 W8 05231190717 001

DebtChkr allows the following functions which can be found on the toolbar titled “Capture Action”.

- Arrow Keys – Increase or decrease the height of the screen display.
- Clear – Press “Clear” and the previous claim number is erased.
- Save – Press “Save” if you need to save this document. Follow the prompts.
- Print – Press “Print” if you need a copy of this document for your files.
- Exit – Press “Exit” to close DebtChkr.

9.10.10 Account Receivable Case History Line Table (ARCL) Screen Description

The Accounts Receivable Case History Line Table (ARCL) contains a detailed history for each account. This screen provides a line-by-line accounting of all activity for a particular account. This screen has a seven line capacity.

A sample of the screen without entries follows.

SEE EXHIBIT 2

The lines on the screen for a document are in order from earliest to most recent. Therefore, the screen initially accessed may not show the current overpayment status. Examiners can page through the screens by pressing the ENTER key. The PAR

System is not capable of alerting users that additional pages exist on a given document. Therefore, examiners should always check for an additional page if the screen currently being viewed has seven line entries. If no other pages exist for a particular document, the paging action will take you to the next numerically sequenced payor number. For example, an overpayment document with payor number A I23456789 M will follow one with payor number A I23456789 A.

It is possible for two or more overpayment documents to exist on PAR for one claim number. Two or more overpayment documents with the same payor number will be listed in billing document order. Examiners should be sure they are aware of all overpayments posted to a claim number by 1) paging through ARCL until a new payor number is reached or 2) checking the Outstanding Billing Document Table (OBDT) which lists overpayments in payor number order.

The system does not have any backward paging capabilities. If you have paged out of a desired document, it can be re-accessed by:

- 1) Entering an N in ACTION and pressing ENTER.
- 2) A blank screen will appear, re-enter the payor number and press ENTER.

OR

- 1) Enter an S in ACTION.
- 2) Move the cursor to the last position of the payor number.
- 3) By pressing the space bar, erase the contents of the last position and the billing document number.
- 4) Press ENTER. The first ARCL record for this payor number will appear. If necessary, continue pressing ENTER until the desired document appears.

The following is a breakdown of all data that appears on the ARCL screen.

SCREEN DESCRIPTION ARCL

FIELD NAME	DESCRIPTION
PAYOR NUMBER	RRA OVERPAYMENTS

	In this field, the payor refers to the debtor. The first 10 positions of the payor number are the prefix and claim number for the account. The last position (separated from the claim number) identifies the overpaid person. In survivor cases the payee code is used as the identifier. In retirement cases an 'A' identifies an employee, an 'M' a spouse and an 'X' a divorced spouse.	
	Examples:	Retirement - A123456789 A
		Survivor - A123456789 1
	In the event that a record needs to be created for a second spouse or divorced spouse, the next letter of the alphabet is used. Thus, a second spouse would have 'N' in the last position of the payor code, a second divorced spouse 'Y.'	
	NOTE: If a payor number has a numeric character in the last position and a previous retirement overpayment exists for the number, the payor number with the alpha character will be numerically sequenced on ARCL before the payor number with the numeric character in the final position.	
	For example, an overpayment document with payor number A123456789 1 will follow one with payor number A123456789 A.	
	A 'G' in the last position refers to a garnishment payment. A 'P' in this position refers to a partition payment.	
	MEDICARE DEBTS	
	In this field, the payor refers to the railroad claim number and prefix of the railroad claim number on which the debt was incurred. The 10 position railroad claim number and prefix is followed by a numeric character which represents the number of specific records under this PAYOR number. Six digit numbers are preceded by zeros. Example: 725148398A 1.	
	NOTE: If further information is needed regarding Medicare account receivable records refer to RCM 3.12.	
	BUSI DEBTS	
	In this field, the payor refers to the railroad claim number on which the debt was incurred. The 9 position railroad claim number is shown. Prefixes and suffixes are not used on BUSI debts.	
	Example: I23456789	

BILLING DOC ID	Billing Document Identification. The number assigned to the debt. All "BILLING DOC ID" numbers begin with a "B." The second position of the "BILLING DOC ID" number is numeric and a "2" identifies an RRA overpayment, an "8" identifies a BUSI overpayment and a "5" identifies a Medicare debt.	
	For RRA "Billing DOC ID" numbers, the third through the thirteenth positions are described in RCM 9.10.57 beginning on page 122.	
PAYOR NAME	The person from whom the debt is being collected. This may or may not be the same person who incurred the debt.	
TRANS DATE	Transaction date. The system date when the entry was created.	
BD LINE NO	Billing Document Line Number. Indicates the type of debt or charge being posted, as follows:	
	001	Retirement or survivor annuity overpayment
	002	Supplemental annuity overpayment
	997	Interest charges
	998	Administrative cost charges
	999	Penalty charges
AC CD	Activity code. Identifies the type of activity that has taken place on this billing document line. The possible activity codes are:	
	CODE	MEANING
	AC	Administrative Cost
	AR	Account referral (indicates the RRA overpayment has been referred to a collection agency or another federal agency).
	AW	Annuity withholding (partial or full withholding, annuity accrual withheld)
	BA	Modifying billing document (used to correct an amount previously posted or, in returned check situations, this activity code is used when some, but not all outstanding checks have been returned)
	BD	Original entry billing document (used when original debt

		amount is posted)
	CA	Modifying cash receipt (used when a correction is made to a previous cash receipt posting)
	CR	Original entry cash receipt (cash refund)
	DN	Dunning notice generated for release
	IB	Installment bill generated for release
	IC	Interest Charge
	PC	Penalty Charge
	SB	Standard (non-installment) bill generated for release
	SP	Suppressed bill flag processed, no bill generated for released
	WO	Write-off (waiver, tolerance or compromise)
TR TP	Transaction type. An entry will appear in this field when an amount is established, increased or decreased.	
	The transaction types used when an overpayment amount is posted are:	
	RRA OVERPAYMENTS	
	NA	New Account
	CA	Conversion Account (an RRB overpayment that was originally on the previous accounts receivable system and has been brought forward on PARS)
	RA	Reactivated account (an account previously in uncollectible)
	The transaction types shown when an debt amount is decreased (cash receipt posted) are:	
	CC	Cash refund
	AW	Annuity withholding
	WO	Write-off (waiver, tolerance, compromise, uncollectible)

	SW	Write off of charges (interest, penalty and administrative cost).
	The code "AI" indicates that interest, penalty or administrative charges have been added to the RRA overpayment.	
	The transaction type field will be blank for actions which do not establish, increase or decrease the debt (e.g., release of a dunning notice).	
ACTN OUT	Action Out. The activity that reduced or closed out the debt.	
	RRA OVERPAYMENTS	
	11A	Offset - Annuity Accrual
	11B	Offset - Partial W/H
	11C	Offset - Full W/H
	11D	Offset - Lump-Sum
	11E	RRA MECH ADJ/Recovery
	12A	Returned Annuity Check
	12B	Check Reclamation
	12C	Returned EFT
	12D	EFT Reclamation-TFS I33 Recvd
	12E	EFT Reclamation-TFS I35 Recvd
	12F	Limited Payability Cancellation
	13A	Cash Refund
	13B	Credit Card Collection
	13V	VLNTY Pmts - SLCT for IRS
	14A	IRS Collection
	14B	OIG Collection
	14C	Dept. of Justice Collection

	14D	Collection Agency Collection
	15A	Actuarial Adjustment
	16A	Pre-Recovery Waiver, BCS
	16B	Pre-Recovery Waiver, OPR
	16C	Waiver of Principal, ORSP (Full)
	16D	Waiver of Principal, BH&A (Full)
	16E	Waiver of Principal, BOARD (Full)
	16F	Waiver of Principal, Court (Full)
	16G	Waiver of Principal, ORSP (Part)
	16H	Waiver of Principal, BH&A (Part)
	16I	Waiver of Principal, BOARD (Part)
	16J	Waiver of Principal, Court (Part)
	16K	Waiver of Penalty, ORSP
	16L	Waiver of Penalty, BH&A
	16M	Waiver of Penalty, BOARD
	16N	Waiver of Penalty, Court
	16O	Waiver of Admin Cst, ORSP
	16P	Waiver of Admin Cst, BH&A
	16Q	Waiver of Admin Cst, BOARD
	16R	Waiver of Admin Cst, Court
	16S	Waiver of Intrst, ORSP
	16T	Waiver of Intrst, BH&A
	16U	Waiver of Intrst, BOARD
	16V	Waiver of Intrst, Court

	16W	Crissinger-Bodle-Wood Principal
	16X	Blanket Waiver
	17A	Compromise
	18A	Uncollectible - OPR
	18B	Uncollectible - BH&A
	18C	Uncollectible - Reclamation Abandnd
	18D	Uncollectible - Stat of Lim Exp Rclm
	18E	\$500 Waiver/Recon Uncollectible
	18F	Relief from Recovery
	19A	Recovered by BUSI
	21A	Offset-SS Ben-Mech Intrfc Only
	21B	Offset - SSA Benefit - Manual
	22A	Tolerance
	22B	Balance Tolerance
	22C	Tolerance/Blnt Wvr Sit
	23A	Term of Collection Action \$100
	23B	Term Coll/Mech conv \$25 or less
	24A	Non Recov/Establ New Payor/BD
	25A	Cash Rec Posted to Unapplied
	26A	Mod to Zero to Establish New INBT
	27A	Folder Destroyed
	28A	ORSP Overreimbursement
	84A	Mech Conv/Prev Conv Manually
	85A	Previously Recovered

	86A	SS O/P Erroneously entrd as RR
	87B	Insufficient Fnds/Bad Check
	88A	Erroneous Entry
	88B	Erroneous Entry
	88T	Transfer Funds/Unapplied Cash
	89A	Miscalculation
	89B	Miscalculation
	90A	Adjudicative Error
	90B	Adjudicative Error
REF DEST	Referral Destination. An entry in this field indicates the debt has been referred outside the agency, as follows:	
	RRA OVERPAYMENTS	
	DOJ	Department of Justice
	ESTD	Estate Development - OPR
	GENL	Other Development - OPR
	HIRS	Held for IRS referral
	HPCA	Held for Private Collection Agency
	IRSI	Internal Revenue Service-1st
	IRS2	Internal Revenue Service - 2nd Referral
	IRS3	Internal Revenue Service - 3rd Referral
	IRS4	Internal Revenue Service - 4th Referral
	IRS5	Internal Revenue Service - 5th Referral
	IRS6	Internal Revenue Service - 6th Referral
	IRS7	Internal Revenue Service - 7th Referral
	IRS8	Internal Revenue Service - 8th Referral

	IRS9	Internal Revenue Service - 9th Referral
	OIG	Office of Inspector General
	PCA	Private Collection Agency
	PRCL	Proof of Claim - Development Category
	RECL	Reclamation - OPR
	REST	Court Ordered Restitution
	RSOF	Salary Offset
	TIRS	To Be Referred to IRS
	TPCA	To Be Referred to private collection agency
	TRS2	To Be Referred to IRS - 2
	TRS3	To Be Referred to IRS - 3
	TRS4	To Be Referred to IRS - 4
	VIRS	Voluntary Payments Select for IRS
TRANSACTION AMOUNT	The amount of the activity against this billing document line. A negative amount indicates a subtraction from the balance.	
BALANCE	The current outstanding balance for this account.	
DOCUMENT ID	The billing document or cash receipt document to which the information posted on the line relates. Billing documents are preceded with a 'B' and cash receipts with a 'C.' Each debt is assigned a unique identification number. That number first appears when a debt is established. The same billing document ID number will appear if that amount is adjusted for a correction (upward or downward) or if additional costs (interest, penalty, administrative charges) are added to the debt. A cash receipt posting refers not only to a cash refund, but to any action that would offset the overpayment amount (annuity withholding, write-off). This field will remain blank if the activity is not the result of a document transaction.	

	Billing documents that were generated from the accounts receivable mechanical conversion begin with "B2 MC" Recovery documents generated by monthly full or partial withholding begin with "C2 92A ..." where the two numbers after C2 refer to the year and the letter to the month of the payment from which the full or partial withholding amount was credited. Overpayments mechanically generated from an RR-IE Social Security award action begin with B2 SSMR or B2 SSMS (SSMR - Retirement, SSMS - Survivor). Likewise, recoveries generated from an RR-1E begin with C2 SSMR or C2 SSMS. Overpayments and recoveries mechanically generated from a RAIL run begin with B2 RAIL and C2 RAIL respectively.
	Recovery documents relating to BUSI and Medicare debts begin with C8 and C5 respectively.
REF LINE NO	This field displays the document line number of the transaction that is generating the activity.

9.10.50 Accessing PARS And Data Entry

PARS is a separate data base from the one which contains DATA-Q, MOLI or FAST. You must access PARS with the TRAIN logo on the CRT screen. If the TRAIN logo is not displayed on the terminal, type BYE and press ENTER. This action will bring up the TRAIN logo so you can access the PARS data base.

- With the TRAIN logo displayed on the CRT screen, type DATABANK and press ENTER.
 - The message "V2 ENTER NEXT TASK CODE:" will appear.
- Type SIGNON and your user identification code, leaving one space between SIGNON and your ID, and press ENTER.
 - The message "ACFA2032 ENTER PASSWORD=" will appear.
- Type your password and press ENTER. (Your password will not be displayed on the screen.)
 - The message ACFA2032 ENTER PASSWORD="
 - "ACFA2050 SIGN ON COMPLETE"
 - "ACFO 1137 (YOUR ID) LAST SYSTEM ACCESS (TIME/DATE) FROM (TERMINAL)" will appear.

- Press ENTER.
 - The message "V2, ENTER NEXT TASK CODE:" will appear.

9.10.55 Establishing An Accounts Receivable Record

When an annuity overpayment has been identified, an open accounts receivable record is established in PARS by creating a billing document. The steps for creating a billing document are shown below. These screens must be completed in the order in which they are listed.

- PAYOR TABLE (PAYR) screen.
- PAYOR/DEBTOR INFORMATION TABLE (PDIT) screen.
- DATA ENTRY AND CORRECTION STARTUP SCREEN FOR APPLICATION FFS screen.
- BILLING DOCUMENT INPUT screen.
- BILLING DOCUMENT LINE screen.

NOTE: The PAYOR TABLE (PAYR) is a permanent record of the individual from whom RRB is requesting repayment of an open receivable. Once a PAYOR TABLE has been established for an individual, it does not have to be reestablished for each additional receivable identified. If a PAYOR TABLE already exists, begin with the PAYOR/DEBTOR INFORMATION TABLE.

9.10.56 Completing The Payor Table (PAYR) Screen

- A. Accessing the PAYR Screen - Once you have successfully signed on to the PAR System as described in RCM 9.10.50, access to the PAYR screen is accomplished as follows:

- Type MTI, leave one space, then type the table code name PAYR.
- Press ENTER.
- A blank PAYOR TABLE screen will appear.

SEE EXHIBIT 3

- B. Completing the PAYR Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the PAYR screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.
	<ul style="list-style-type: none"> • The ACTION field will be prefilled with an S, which signifies Scan Record.
	<ul style="list-style-type: none"> • Type A for Add Record over the S.
	<ul style="list-style-type: none"> • The cursor will advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four character PARS user identification code and your four character PARS password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.
PAYOR NUMBER:	<p>Enter the prefix followed by the claim number. Precede 6 digit claim numbers with zeros. The last position of the PAYOR NUMBER is used to keep the code unique. The following are to be used as identifiers:</p> <ul style="list-style-type: none"> • Retirement Cases, <ul style="list-style-type: none"> • A - Employee • M - Spouse • X - Divorced Spouse • Survivor Cases, <ul style="list-style-type: none"> • Use the payee code assigned to the annuitant. • For a lump-sum death payment, residual lump sum or annuities unpaid at death which were paid to a non-annuitant who is later determined not to be entitled to these funds, select an alpha character between B and L. • Legal Process Cases,

CAPTION	ENTRY
	<ul style="list-style-type: none"> • P - Partition • G - Garnishment <p>The cursor will advance to the next field.</p>
PAYOR NAME:	<p>Enter the name of the individual to whom the overpayment letter is being sent. A maximum of 30 characters can be entered in this field. If all positions are used, the cursor will advance to the next field. If fewer than 30 characters are entered, use the TAB key to advance to the next field.</p> <p>NOTE: This field may contain an employee's, spouse's, widow's or representative payee's name. This field may contain a title such as Adm: Valley Nursing Home. It may contain the name of an individual who notified RRB of the death of an annuitant, or contain "Family or Friends" in cases where contact is unknown.</p> <p>SPECIAL SITUATIONS:</p> <ul style="list-style-type: none"> • Reclamation. In cases where reclamation of payment(s) is being processed, enter RECLAMATION in this field. • Development. In cases where development or investigative action is being taken to determine who is responsible for repayment, enter DEVELOPMENT in this field.
ADDR LINE 1:	<p>Enter the first line of the address where the overpayment letter is being sent. <u>DO NOT</u> enter a group mark. In representative payee situations, <u>DO NOT</u> enter FOR and the annuitant's name on this line. In Family and Friends situations, <u>DO NOT</u> enter OF and the deceased annuitant's name on this line. A line is provided on the PDIT screen for this entry and is explained in RCM 9.10.57. A maximum of 30 characters can be entered in this field. Use the TAB key to advance to the next field.</p> <p>EXCEPTION: If RECLAMATION or DEVELOPMENT was entered in the PAYOR NAME field, enter an asterisk (*) in the first position of this field. Use the TAB key to advance to the next field.</p>
PAYOR TYPE:	Always enter an A in this field. The cursor will advance to

CAPTION	ENTRY
	the next field.
ADDR LINE 2:	Enter the remaining portion of the address where the overpayment letter is being sent. A maximum of 30 characters can be entered in this field. If this line is not needed to continue the address from ADDR LINE 1, make no entry in this field. Use the TAB key to advance to the next field. <u>DO NOT</u> enter the city, state, and ZIP code on this line.
PHONE NUMBER:	Make no entry in this field. Use the TAB key to advance to the next field.
ADDR LINE 3:	<p>Enter the city, state and ZIP code where the overpayment letter is being sent.</p> <p>City Enter the city name in the first 19 positions of ADDR LINE 3. If all positions are used, the cursor will advance to the state field, otherwise use the TAB key to advance the cursor.</p> <p>State Enter the official state abbreviation. A complete list of abbreviations is shown in RCM 10.2, Appendix B. The cursor will advance to the ZIP code field.</p> <p>ZIP Code This field is designed for the ZIP+4 configuration. <u>Only</u> complete the first five positions. Use the TAB key to advance to the next field.</p> <p>EXCEPTION 1: If RECLAMATION or DEVELOPMENT was entered in the PAYOR NAME field, an asterisk (*) <u>must</u> be entered in the first position of the city, state and ZIP code fields. Use the TAB key to advance to the first position of each field.</p> <p>EXCEPTION 2: For foreign address cases <u>ONLY</u>, enter the street address, city and province on ADDR LINE 1 and 2. Enter the country name in the first 19 positions of ADDR LINE 3. The first position of <u>BOTH</u> the state field and ZIP code field <u>must</u> contain an asterisk (*). Use the TAB key to advance to the first position of these fields after the country name has been entered.</p>

CAPTION	ENTRY
GROUP BILLS:	Make no entry in this field. Use the TAB key to advance to the next field.
CONTACT:	Make no entry in this field. Use the TAB key to advance to the next field.
GROUP DUNN:	Make no entry in this field. Use the TAB key to advance to the next field.
COMMENTS:	Make no entry in this field. Use the TAB key to advance to the next field.
CUST ACCT:	Make no entry in this field. Use the TAB key to advance to the next field.
AR CONTACT:	Make no entry in this field. Use the TAB key to advance to the next field.
PROVIDOR IND:	Always enter a B in this field.

- C. Exiting from the PAYR Screen - After completing the PROVIDOR IND field, review the information you have entered on the PAYR screen to verify these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.
1. Establishing the PAYOR TABLE - When all required entries have been completed and all information is correct, press ENTER. The message *LO30 ALL LINES ADDED will be displayed in the message area of the screen indicating the PAYOR TABLE has been established. In addition, the captions GROUP BILLS: and GROUP DUNN: will contain N's. These fields have been prefilled by the system.
 2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry or correct any entry as indicated. Continue to press ENTER and make any required corrections until the message *LO30 ALL LINES ADDED is displayed in the message area of the screen. It is important that all errors are corrected and all required entries are completed on the PAYR screen because subsequent screens are dependent on a PAYOR TABLE being established.

An example of a completed PAYOR TABLE for an overpaid employee appears below:

SEE EXHIBIT 4

An example of a completed PAYOR TABLE where an overpayment has been identified but DEVELOPMENT action is required appears below:

SEE EXHIBIT 5

Once DEVELOPMENT action has been completed and the name and address of the individual responsible for repaying the debt has been determined, this information must be entered in the PAYOR NAME, ADDR LINE 1:, ADDR LINE 2: and ADDR LINE 3: fields.

An example of a completed PAYOR TABLE where a representative payee is involved appears below:

SEE EXHIBIT 6

An example of a completed PAYOR TABLE with a foreign address appears below:

SEE EXHIBIT 7

9.10.57 Completing The Payor/Debtor Information Table (PDIT) Screen

A. Accessing the PDIT Screen - After completing and entering the PAYR screen as described in RCM 9.10.56, the cursor will be positioned in the ACTION field on the action line of the screen. To access the PDIT screen:

- Type N for Next Screen in the ACTION field. The cursor will advance to the TABLEID field.
- Type PDIT in the TABLEID field.
- Press ENTER.
- A blank PAYOR/DEBTOR INFORMATION TABLE screen will appear.

SEE EXHIBIT 8

B. Completing the PDIT Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	<p>When the PDIT screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.</p> <ul style="list-style-type: none"> • The ACTION field will be prefilled with an S, which signifies Scan Record. • Type A for Add Record over the S. • The cursor will advance to the TABLEID field.
TABLEID:	<p>The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.</p>
USERID:	<p>The USERID field will contain your PARS identification code and PARS password. (Your password will not be displayed on the screen.) Use the TAB key to advance to the next field.</p>
PAYOR CODE:	<p>Enter the PAYOR CODE for this overpayment exactly as it was entered on the PAYR screen. The cursor will advance to the next field.</p>
BILLING DOC ID:	<p>The Billing Document Identification code on the PDIT screen is made up of a combination of 13 letters and numbers. The first two positions are referred to as the TRANS CODE on subsequent screens and in error and referral messages. The remaining 11 positions of this field are referred to as the DOCUMENT NUMBER on subsequent screens. Enter the code as follows:</p> <ul style="list-style-type: none"> • Positions 1-2. <u>Always</u> enter B2 in the first two positions of this field. The cursor will advance to position 3.
BILLING DOC ID (Cont.):	<ul style="list-style-type: none"> • Positions 3-4. Enter your unit designation determined as follows: <ul style="list-style-type: none"> BC Beneficiary Compliance Section CB Combined Benefits Section CI Congressional Inquiry Section HA Bureau of Hearings and Appeals

CAPTION	ENTRY
	<p>MP Methods and Procedures</p> <p>OP Overpayment Recovery Section</p> <p>PE Program Evaluation Section</p> <p>PS Payment Services Unit</p> <p>RB Retirement Backlog Task Force</p> <p>RI Initial Claims Section</p> <p>RP Retirement Post Section</p> <p>RS Reconsideration Section</p> <p>SI Survivor Initial Section</p> <p>SP Survivor Post Section</p> <p>These organization codes are also displayed on the PARS SORG TABLE screen.</p> <ul style="list-style-type: none"> • Positions 5-7. Enter your three position examiner number or your initials, determined by your unit's policy. • Positions 8-10. Enter the sequential day of the year you are establishing this accounts receivable record. If the day contains fewer than three digits, enter zeros in positions 8 and 9 as necessary. <p>EXAMPLE: January 20 is entered as 020; December 28 is entered as 362. The sequential date can be found in the lower left hand corner of most desk calendars.</p> <ul style="list-style-type: none"> • Positions 11-12. Enter the last two digits of the current year.
BILLING DOC ID (cont.):	<ul style="list-style-type: none"> • Position 13. The final position is a counter. The counter is determined from the number of separate PARS accounts receivable records you establish each day. <p>EXAMPLE: The first receivable is 1; the second is 2, etc.</p> <p>If more than 9 PARS accounts receivable records are established on one day, alpha characters may be used.</p>

CAPTION	ENTRY
	Upon completion of the Billing Document Identification code field, the cursor will advance to the next field.
STATUS:	Make no entry in this field. Use the TAB key to advance to the next field.
EE NAME:	<p>Enter the name of the railroad employee on whose account the overpayment occurred. This entry <u>must</u> be formatted last name followed by a comma and space, first name and middle initial. A maximum of 30 characters can be entered in this field. Use the TAB key to advance to the next field.</p> <p>EXAMPLE: JONES, JOHN A</p>
RRBCN:	Enter the prefix and claim number of the railroad employee. After the prefix has been entered, the cursor will advance to the claim number field. Precede serial claim numbers with zeros. The cursor will advance to the next field.
SSN:	Enter the railroad employee's social security number <u>only</u> if the claim number is not the employee's SSN. The cursor will advance to the next field. If this entry is not required, use the TAB key to advance to the next field.
PAYOR RRBCN:	<p>Complete this field as follows:</p> <ul style="list-style-type: none"> • Payor is the employee. Make no entry in this field. Use the TAB key to advance to the next field. • Payor is an annuitant but is not the employee. <ul style="list-style-type: none"> • Enter the symbol and prefix of the annuitant whose name appears in the PAYOR NAME field. If the symbol and prefix contain fewer than three positions, use the space bar to move to the proper position. The cursor will advance to the claim number portion of this field. • Enter the annuitant's claim number. <p>Precede serial claim numbers with zeros. The cursor will advance to the next field.</p> <ul style="list-style-type: none"> • Payor is not receiving an annuity. Make no entry in this field. Use the TAB key to advance to the next field.

CAPTION	ENTRY
EOA:	Enter an "X" in this field if the individual responsible for repaying the debt is entitled to an annuity on another account number. If this item is completed, the cursor will advance to the next field. If the PAYOR is not entitled on another account number, use the TAB key to advance to the next field.
PAYOR NAME:	<p>Complete this item for the following two situations only. If neither of these apply, use the TAB key to advance to the next field.</p> <ul style="list-style-type: none"> • Representative payee. If a representative payee's name or title was entered in the PAYOR NAME field on the PAYOR TABLE screen, enter FOR and the overpaid annuitant's name in this field. Use the TAB key to advance to the next field. • Family or Friends. If Family or Friends was entered in the PAYOR NAME field on the PAYOR TABLE screen, enter OF and the deceased annuitant's name in this field. Use the TAB key to advance to the next field.
SSN:	Enter the PAYOR'S own social security number. If the PAYOR is the employee or if the social security number is not known, leave this item blank. If this item is completed, the cursor will advance to the next field. If this item is not completed, use the TAB key to advance to the next field.
DEBTOR NAME:	<p>Complete this field as follows:</p> <ul style="list-style-type: none"> • Debtor and Payor <u>are</u> the same. If the overpaid annuitant (Debtor) and the person to whom the overpayment letter is being sent (Payor) are the same, make no entry in this field. Use the TAB key to advance to the next field. • Debtor and Payor <u>are not</u> the same. If the overpaid annuitant (Debtor) and the person to whom the overpayment letter is being sent (Payor) are not the same, enter the name of the overpaid annuitant (first, middle initial, last name separated by spaces.) Because a maximum of 20 characters can be entered in this field, it may be necessary to use an initial for the first name also. If all positions are used, the cursor will advance to

CAPTION	ENTRY
	the next field, otherwise use the TAB key to advance the cursor.
RRBCN:	<p>If the debtor <u>is</u> the employee or the PAYOR, make no entry in this field. Use the TAB key to advance the cursor to the next field.</p> <p>If the debtor is <u>not</u> the employee or the PAYOR, complete this field as follows:</p> <ul style="list-style-type: none"> • Enter the symbol and prefix of the claim number of the individual whose name appears in the DEBTOR NAME field. If the claim number does not have a symbol, or the symbol contains fewer than two positions, use the space bar to move to the proper position. The cursor will advance to the claim number field. • Enter the claim number of the individual whose name appears in the DEBTOR NAME field. Precede serial claim numbers with zeros. The cursor will advance to the next field.
SSN:	Enter the debtor's own social security number only if the DEBTOR NAME field contains an entry. If this item is completed, the cursor will advance to the next field. If an entry is not required, use the TAB key to advance to the next field.
OTHER PAYOR NAME #1, #2:	<p>It usually becomes necessary to seek recovery from one or more annuitants in addition to the primary PAYOR/DEBTOR when the full amount of an overpayment cannot be recovered within 48 months or before loss of entitlement. If recovery from one or more annuitants is not in force, go to Section C of this chapter. If recovery from one or more annuitants is in force, complete these fields as follows:</p> <ul style="list-style-type: none"> • OTHER PAYOR NAME #1: Enter the first name, middle initial and last name of an annuitant other than the PAYOR/DEBTOR from whom recovery is being made. A maximum of 25 characters can be entered in this field. If all positions are used, the cursor will advance to the next field, otherwise use the TAB key to advance the cursor. • OTHER PAYOR NAME #2: Enter the first name, middle

CAPTION	ENTRY
	initial and last name of a second annuitant other than the PAYOR/DEBTOR from whom recovery is being made. A maximum of 25 characters can be entered in this field. If all positions are used, the cursor will advance to the next field, otherwise use the TAB key to advance the cursor.
OTHER PAYOR RRBCN #1:	Enter the symbol, prefix and RRB claim number of the individual whose name was entered in OTHER PAYOR NAME #1. If the claim number does not have a symbol or the symbol contains fewer than two positions, use the space bar to move to the proper position. After completion of the symbol and prefix field, the cursor will advance to the claim number field. Precede serial claim numbers with zeros. The cursor will advance to the next field.
EOA:	Enter an X in this field if the individual whose name and claim number entered in OTHER PAYOR NAME #1 and OTHER PAYOR RRBCN #1 is entitled to an annuity on another railroad retirement account. If this item is completed, the cursor will advance to the next field, otherwise use the TAB key to advance the cursor.
OTHER PAYOR RRBCN #2:	Enter the symbol, prefix and RRB claim number of the individual whose name was entered in OTHER PAYOR NAME #2. If the claim number does not have a symbol or the symbol contains fewer than two positions, use the space bar to move to the proper position. After completion of the symbol and prefix field, the cursor will advance to the claim number field. Precede serial claim numbers with zeros. The cursor will advance to the next field.
EOA:	Enter an X in this field if the individual whose name and claim number entered in OTHER PAYOR NAME #2 and OTHER PAYOR RRBCN #2 is entitled to an annuity on another railroad retirement account.

The following example shows a completed PAYOR/DEBTOR INFORMATION TABLE for an overpaid employee:

SEE EXHIBIT 9

- C. Exiting from the PDIT Screen - After completing the last required entry on the PDIT screen, review the information you have entered to verify these entries are

correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.

1. Establishing the PAYOR/DEBTOR INFORMATION TABLE - When all required entries have been completed and all information is correct, press ENTER. The message *LO30 ALL LINES ADDED will be displayed in the message area of the screen indicating the PAYOR/DEBTOR INFORMATION TABLE has been established. In addition, the PAYOR NAME: and PAYOR ADDR: fields completed on the PAYOR TABLE will now be displayed on this screen as well.
2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry as indicated. Continue to press ENTER and make any required corrections until the message *LO30 ALL LINES ADDED is displayed in the message area of the screen. It is important that all errors are corrected and all required entries are completed on the PDIT screen because subsequent screens are dependent on a PAYOR/DEBTOR INFORMATION TABLE being established.

The following example shows a completed PAYOR/DEBTOR INFORMATION TABLE where DEVELOPMENT action is required:

SEE EXHIBIT 10

The following example shows a completed PAYOR/DEBTOR INFORMATION TABLE where a representative payee is involved:

SEE EXHIBIT 11

The following example shows a completed PAYOR/DEBTOR INFORMATION TABLE where another payor and claim number have been identified and entered on the screen:

SEE EXHIBIT 12

9.10.58 Completing The Startup Screen

Following the completion of the PDIT screen as described in RCM 9.10.57, the next step in establishing an accounts receivable record is the completion of the DATA ENTRY AND CORRECTION STARTUP SCREEN FOR APPLICATION FFS.

- A. Accessing the STARTUP Screen - To access the STARTUP screen from the PDIT screen, take the following actions:

- Using the TAB key, position the cursor in the ACTION field on the action line of the PDIT screen.
- Type E for Exit in the ACTION field.
- Press ENTER, the message "V2 ENTER NEXT TASK CODE" will appear.
- Type DDB.
- Press ENTER.
- A blank STARTUP screen will appear.

SEE EXHIBIT 13

- B. Completing the STARTUP Screen - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
MODE OF	Enter a D for Data Entry. The cursor will
OPERATION:	advance to the next field.
DOCUMENT ID:	<p>Enter the document identification code under the captions displayed as follows:</p> <ul style="list-style-type: none"> • TRAN - <u>Always</u> enter B2. The cursor will advance to the DIVISION field. • DIVISION - <u>Always</u> enter 2000. The cursor will advance to the ID NUMBER field. • ID NUMBER - <u>Always</u> complete this field exactly as positions 3 through 13 of the BILLING DOC ID field on the PDIT screen. The cursor will advance to the next field.
BATCH ID:	<ul style="list-style-type: none"> • TRAN - Make no entry in this field. Use the TAB key to advance to the next field. • DIVISION - Make no entry in this field. Use the TAB key to advance to the next field.

CAPTION	ENTRY
	<ul style="list-style-type: none"> ID NUMBER - Make no entry in this field. Use the TAB key to advance to the next field.
USER ID:	<p>Enter your four character PARS user identification code and your four character PARS password. (Your PARS password will not be displayed on the screen.)</p> <p>The cursor will advance to the next field.</p>

An example of a completed STARTUP screen appears below.

SEE EXHIBIT 14

- C. Exiting from the STARTUP Screen - After you have entered your PARS user identification code and PARS password, review the information you have entered on the STARTUP screen to verify these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information. When all information is correct, press ENTER. The BILLING DOCUMENT INPUT SCREEN will appear.

9.10.59 Completing The Billing Document Input Screen

- A. Accessing the BILLING DOCUMENT INPUT Screen - Following completion and entering of the STARTUP screen as described in RCM 9.10.58, the BILLING DOCUMENT INPUT SCREEN displayed below will appear.

SEE EXHIBIT 15

The MODE, DOCID and USERID field on the action line of this screen will be prefilled from these entries on the STARTUP screen.

- B. Completing the BILLING DOCUMENT INPUT Screen - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields beginning with the DOC DATE in the BILLING DOCUMENT INPUT section and will move through the screen in the following order.

CAPTION	ENTRY
DOC DATE:	Make no entry in this field. Use the TAB key to advance to the next field.
ACCTG PRD:	Make no entry in this field. Use the TAB key to advance to

CAPTION	ENTRY
	the next field.
TRANS TYPE:	<p>Enter one of the following two position codes depending on the type of accounts receivable record you are establishing. The cursor will advance to the next field.</p> <ul style="list-style-type: none"> • NA - New Account. This code is used for any overpayment which is <u>not</u> on the "old" accounts receivable system. • RA - Reactivated Account. This code is used for any overpayment transferred from the uncollectable accounts and entered on PARS. • CO - Conversion Case. This code is used for any overpayment which is entered on PARS from the "old" accounts receivable system.
BUDGET FY:	Make no entry in this field. Use the TAB key to advance to the next field.
ACTION:	Enter E for Entry. The cursor will advance to the next field.
DOCUMENT TOTAL:	Enter the amount of the overpayment for the accounts receivable record you are establishing. <u>DO NOT</u> include SSA amounts in this total. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> use a dollar sign. Use the TAB key to advance to the next field.
FUND:	Make no entry in this field. Use the TAB key to advance to the next field.
DOC TYPE:	Make no entry in this field. Use the TAB key to advance to the next field.
COMMENTS:	In combined RR and SSA payment situations where an outstanding payment(s) is being requested or reclaimed, enter SS, space and the total amount of outstanding SSA benefits. Complete this entry to two decimal places but <u>DO NOT</u> use a dollar sign EXAMPLE: SS 484.00. Use the TAB key to advance to the next field.
BILL PRINT FLAG:	<p>Enter one of the following one position codes. The cursor will advance to the next field.</p> <ul style="list-style-type: none"> • Current entitlement - Enter an N, indicating no bill will be

CAPTION	ENTRY
	<p>printed, in this field.</p> <p>NOTE: Cases referred to OPR for release of the overpayment letter, cases where Reclamation, Development or Family or Friends was entered as the PAYOR NAME and Conversion Cases where a new overpayment letter detailing interest and penalty charges will not be released are treated as current entitlement cases.</p> <ul style="list-style-type: none"> • Non-current entitlement - Enter an S, indicating the printing of the bill will be suppressed, in this field. <p>EXCEPTION: Non-current entitlement cases where the overpayment letter is referred to the field office for release or delivery are treated as current entitlement cases.</p>
COLLECTION:	Make no entry in this field. Use the TAB
DUE DATE	key to advance to the next field.
INTEREST RATE:	Make no entry in this field. Use the TAB key to advance to the next field.
TEXT TYPE:	Make no entry in this field. Use the TAB key to advance to the next field.
DUNNING FLAG:	<p>Completion of this field is determined as follows:</p> <ul style="list-style-type: none"> • Current entitlement - Always enter an N (no dunning). Check that this field is correctly completed in these cases. If this field is erroneously left blank the system will furnish a default entry of Y. <p>NOTE: Cases referred to OPR for release of the overpayment letter, cases where Reclamation, Development, or Family or Friends was entered as the PAYOR NAME are treated as current entitlement cases.</p> <ul style="list-style-type: none"> • Non-current entitlement - Enter a Y (yes, release dunning when criteria are met) in the field. <p>EXCEPTION: Non-current entitlement cases where the overpayment letter is referred to the field office for release or delinquent are treated as current entitlement cases.</p>
WAIVER FLAG:	Completion of this field is determined as follows:

CAPTION	ENTRY
	<ul style="list-style-type: none"> Current entitlement - Enter an A. Use the TAB key to advance to the next field. <p>NOTE: Cases referred to OPR for release of the overpayment letter, cases where Reclamation, Development or Family or Friends was entered as the PAYOR NAME and Conversion Cases where a new overpayment letter detailing interest and penalty charges will not be released are treated as current entitlement cases.</p> <ul style="list-style-type: none"> Non-current entitlement - Make no entry in this field. Use the TAB key to advance to the next field. <p>EXCEPTION: Non-current entitlement cases where the overpayment letter is referred to the field office for release or delivery are treated as current entitlement cases.</p>
PAYOR NUMBER:	Enter the PAYOR NUMBER exactly as it was established and entered on the PAYOR TABLE screen. (See RCM 9.10.56.) The cursor will advance to the next field.
PAYOR NAME:	Make no entry in this field. Use the TAB key to advance to the next field.
ADDRESS:	Make no entry in this field. Use the TAB key to advance to the next field.
CITY:	Make no entry in this field. Use the TAB key to advance to the next field.
STATE:	Make no entry in this field. Use the TAB key to advance to the next field.
ZIP:	Make no entry in this field. Use the TAB key to advance to the next field.
CAUSE OF OVERPAYMENT:	<p>Enter the three position code from the list below which describes the event which resulted in the overpayment.</p> <p>01A Death - Check(s) O/S</p> <p>01B Death - EFT(s) O/S</p> <p>01C No CC - Spouse Check(s) O/S</p>

CAPTION	ENTRY
	01D No CC - Spouse EFT(s) O/S 02A Excess Earnings 02B Excess Earnings - Linquist 03A SSA Initial 03B SSA Adjustment 04A Last Person Service 04B Employer Service 05A Marriage 06A Not Full-Time Student 07A Child Not In Care 08A VA Benefit 09A Non-Covered Service Pension 09B Public Service Pension 09C Recurring RR Pension/Supp Offset 10A Erroneous Award 11A Computation Error 12A Divorce 13A Partial Exceeds Final 14A Decrease in Family Members - O/M 14B Increase in Family Members Entitlement 15A Erroneous Vesting Determination 15B WF/T2 Recalculation 16A Worker's Comp/PDB 17A M/S Erroneously Included in RR Comp

CAPTION	ENTRY
	18A Felony Imprisonment, Non-Pay Provision 19A Alien Non-Pay Provision/Deportation 20A RRA Maximum Applies 21A Erroneous Wages/Compensation Reported on EE's Wage Record 22A DOB Change 23A Child Attained Age 16 23B Child Attained Age 18 24A Erroneous ABD/OBD 25A Entitlement on Other RR Account Number 26A Original and Duplicate Check Cashed 28A Recovery from Disability NOTE: The PARS CAUS TABLE contains a complete list of cause of overpayment codes, including those used by the sickness and unemployment benefits division (SUBD).

An example of a completed BILLING DOCUMENT INPUT SCREEN appears below.

SEE EXHIBIT 16

- C. Exiting from the BILLING DOCUMENT INPUT Screen - After completing the CAUSE OF OVERPAYMENT field, review the information you have entered on the BILLING DOCUMENT INPUT screen to verify these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information. When all information is correct, press ENTER. The BILLING DOCUMENT LINE SCREEN will appear.

9.10.60 Completing The Billing Document Line Screen

- A. Accessing the BILLING DOCUMENT LINE Screen - Following completion and entering of the BILLING DOCUMENT INPUT SCREEN described in RCM 9.10.59, the BILLING DOCUMENT LINE SCREEN displayed below will appear.

SEE EXHIBIT 17

The MODE, DOCID and USERID fields on the action line of this screen will be prefilled from these entries you completed on the STARTUP screen.

- B. Completing the BILLING DOCUMENT LINE Screen - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields beginning with LINE NO and will move through the screen in the following order.

CAPTION	ENTRY
LINE NO:	<p>Enter one of the following three position codes depending on the type of overpayment. The cursor will advance to the next field.</p> <ul style="list-style-type: none"> • 001 Railroad Retirement Annuity overpayment. • 002 Supplemental Annuity overpayment. <p>NOTE: If the Supplemental Annuity is the only overpayment on the account, enter the pertinent data in the upper portion of the BILLING DOCUMENT LINE screen using LINE NO: 002.</p>
BFY:	Make no entry in this field. Use the TAB key to advance to the next field.
FUND:	<p>Enter one of the following four position codes depending on the type of overpayment. The cursor will advance to the next field.</p> <ul style="list-style-type: none"> • *PAR Railroad Retirement Annuity overpayment. (001 entered in LINE NO: field) • 8012 Supplemental Annuity overpayment. (002 entered in LINE NO: field)
TRAN TYPE:	Make no entry in this field. Use the TAB key to advance to the next field.
ORG/SUB:	<p>Complete this item as follows:</p> <ul style="list-style-type: none"> • Enter 2000 in the first four positions of this field. Use the

CAPTION	ENTRY
	<p>TAB key to advance the cursor to the final two positions of this field.</p> <ul style="list-style-type: none"> Enter your two position unit designation determined from the list below. The cursor will advance to the next field. <p>BC Beneficiary Compliance Section</p> <p>CB Combined Benefits Section</p> <p>CI Congressional Inquiry Section</p> <p>HA Bureau of Hearings and Appeals</p> <p>MP Methods and Procedures</p> <p>OP Overpayment Recovery Section</p> <p>PE Program Evaluation Section</p> <p>PS Payment Services Unit</p> <p>RB Retirement Backlog Task Force</p> <p>RI Initial Claims Section</p> <p>RP Retirement Post Section</p> <p>RS Reconsideration Section</p> <p>SI Survivor Initial Section</p> <p>SP Survivor Post Section</p>
PROGRAM:	Make no entry in this field. Use the TAB key to advance to the next field.
REV SRCE/SUB:	Make no entry in this field. Use the TAB key to advance to the next field.
TEXT TYPE:	Make no entry in this field. Use the TAB key to advance to the next field.
JOB NO:	Make no entry in this field. Use the TAB key to advance to the next field.
BOC/SUB:	Enter 4220 in the first four positions of this field. Use the

CAPTION	ENTRY
	TAB key to advance to the next field.
REPT CAT:	Make no entry in this field. Use the TAB key to advance to the next field.
INTREST RATE:	Make no entry in this field. Use the TAB key to advance to the next field.
GL ACCT:	Make no entry in this field. Use the TAB key to advance to the next field.
AMOUNT:	<p>Enter the amount of the overpayment attributable to the codes entered next to the LINE NO and FUND captions above. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> enter a dollar sign. Use the TAB key to advance to the next field.</p> <p>EXAMPLE: A deceased employee who was entitled to a supplemental annuity, has one outstanding payment. The combined amount of the regular and supplemental annuity will be entered in the DOCUMENT TOTAL field on the BILLING DOCUMENT INPUT screen. However, on this screen, the amount of the regular annuity will be entered when the LINE NO is 001 and the FUND is *PAR. The amount of the supplemental annuity will be entered when the LINE NO is 002 and the FUND is 8012.</p>
I/D:	Make no entry in this field. Use the TAB key to advance to the next field.
DESC:	Make no entry in this field. Use the TAB key to advance to the next field.
REF TC:	Make no entry in this field. Use the TAB key to advance to the next field.
REF NUMBER:	Make no entry in this field. Use the TAB key to advance to the next field.
REF-LINE:	Make no entry in this field. Use the TAB key to advance to the next field.
ADV:	Make no entry in this field. Use the TAB key to advance to the next field.
TRAV TYPE:	Make no entry in this field. Use the TAB key to advance to

CAPTION	ENTRY
	the next field.
SOURCE:	<p>Enter the four position code from the list below which best describes how the overpayment was discovered. The cursor will advance to the next field.</p> <p>001A Annual Earnings Policing (G-19)</p> <p>001B EDP RET/SUR Earnings Policing (805)</p> <p>001C Aged Monitoring (G-19c)</p> <p>001D PSP Entitlement (G-208)</p> <p>001E LPS Monitoring (G-19L)</p> <p>001F Rep Payee Monitoring</p> <p>001G Student Monitoring</p> <p>001H Non-Resident Alien Monitoring</p> <p>001I Continuing Disability and Employment Report (G-254)</p> <p>001J DPS EDP Policing</p> <p>001K Parental Custody Monitoring</p> <p>002A D/O Notification</p> <p>002B Annuitant/Self Notification</p> <p>002C Third Party Notification</p> <p>003A Uncollectable Accounts Receivable Match</p> <p>004A Disability Freeze Program</p> <p>005A CMS Death Match</p> <p>006A VA/Military</p> <p>007A SSA Computer Interchange</p> <p>007B SSA/CHICO Death Match</p>

CAPTION	ENTRY
	<p>007C SSA CS Audit/RR Cert Audit</p> <p>007D SSA Other</p> <p>008A Other Government Agency not Specifically Listed</p> <p>009A OIG</p> <p>010A Quality Assurance Review (BQA)</p> <p>011A PES</p> <p>012A Research Referral</p> <p>013A RRB Mechanical Adjustment Reject</p> <p>013B Retirement Adjustment to Include LAG (RAIL)</p> <p>014A EDP Referral</p> <p>015A RASI Referral</p> <p>016A TRIC/G-90 Referral (Mechanically Generated)</p> <p>017A Manual Review of File</p> <p>018A Returned Payments (Checks/EFT)</p> <p>019A Uncashed Check Investigation</p> <p>020A Undeliverable Mail Investigations (Not Checks)</p> <p>021A Fraud/Non-Entitlement (OPR)</p> <p>NOTE: The PARS SRCE TABLE contains a complete list of source codes, including those used by the sickness and unemployment benefits division (SUBD).</p>
TYPE OF OVERPAYMENT:	Enter the three position code from the list below which describes the type of overpayment. The cursor will advance to the next field.
	<p>01A Employee - Aged</p> <p>01B Employee - O/M</p>

CAPTION	ENTRY
	<p>01C Employee T&P Disability</p> <p>01D Employee Occupational Disability</p> <p>02A Spouse - Aged</p> <p>02B Spouse with Dependent Child</p> <p>02C Spouse - Divorced</p> <p>03A Widow(er) - Aged</p> <p>03B Widow(er) - Disabled</p> <p>03C Surviving Divorced Spouse - Aged</p> <p>03D Surviving Divorced Spouse - Disabled</p> <p>03E Remarried Widow(er) - Aged</p> <p>03F Remarried Widow(er) - Disabled</p> <p>04A Widow(er)'s - Young Mothers/Fathers</p> <p>04B Remarried Widow(er)'s - Young Mother/Father</p> <p>04C Surviving Divorced Young Mother/Father</p> <p>05A Child - Minor</p> <p>05B Child - Disabled</p> <p>05C Child - Student</p> <p>06A Parents</p> <p>07A RLS</p> <p>08A LSDP</p> <p>09A Separation Allowance - LSP</p> <p>10A Supplemental Annuity</p> <p>11A Joint and Survivor Annuity</p> <p>12A Tax Refund (Retirement)</p>

CAPTION	ENTRY
	13A Assignment/Legal Process NOTE: The PARS TYOP TABLE contains a complete list of type of overpayment codes, including those used by the sickness and unemployment benefits division (SUBD).
ACTION OUT:	Make no entry in this field. Use the TAB key to move to the next field if necessary.

Each BILLING DOCUMENT LINE screen will accommodate entries for two different funds. Therefore, for an employee annuitant, both a regular annuity overpayment and a supplemental annuity overpayment can be entered using the same BILLING DOCUMENT LINE screen.

If both sections of this screen must be completed, use the TAB key to advance the cursor from the ACTION OUT field in the top portion of the screen. The cursor will advance to the LINE NO field in the bottom portion of the screen. If both a regular annuity and supplemental annuity overpayment exist, complete each entry on the lower portion of the screen as described for each caption above.

- C. Exiting from the BILLING DOCUMENT LINE Screen - After completing the TYPE OF OVERPAYMENT field, either in the top portion of the screen or at the bottom of the screen if both LINE NOS are completed, review the information you have entered on the BILLING DOCUMENT LINE screen to verify these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.

An example of a completed BILLING DOCUMENT LINE SCREEN appears below:

SEE EXHIBIT 18

An example of a completed BILLING DOCUMENT LINE SCREEN, with both a regular annuity overpayment and a supplemental annuity overpayment appears below:

SEE EXHIBIT 19

9.10.61 Quick Edit Function

The Quick Edit function is used to edit entries you have completed on the BILLING DOCUMENT INPUT and BILLING DOCUMENT LINE screens. This function also

signals the PAR System that all table and document screens required to establish an accounts receivable record have been completed.

A. Beginning the Quick Edit Process - Following your review of the BILLING DOCUMENT LINE screen and your determination that all required entries are complete and correct, Quick Edit is accomplished as follows:

- Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key (),
 - Release the alternate shift key (Alt).
- Type Q for Quick Edit in the ACTION field.
- Press ENTER.

B. Results of the Quick Edit Process - The PARS System always returns to the initial screen in a document screen series for display of edit, error or acceptance messages.

- The BILLING DOCUMENT INPUT screen will be displayed.
- The MODE field on the action line of the screen will contain a C indicating the system is in the correction mode.
- The letters RH indicating additional handling is required will be displayed under the STATUS caption.
- The current interest rate will be displayed following the INTEREST RATE caption.

1. No Errors Are Detected During Quick Edit - If all required entries on the BILLING DOCUMENT INPUT and BILLING DOCUMENT LINE screens have been completed and the system does not detect any errors, the PAYOR NAME, ADDRESS, CITY, STATE and ZIP fields will be filled with entries you completed on previous screens. In addition, the following three messages will be displayed in the message area at the bottom of the BILLING DOCUMENT INPUT screen:

- A - *CQ93 - DOCUMENT REJECTED
- H - *FO53 - DOCUMENT NOT APPROVED
- H - *S401 - READY FOR APPROVAL

SEE EXHIBIT 20

2. Errors Are Detected - If any errors are detected during the Quick Edit process or any required entries are not complete, an error or warning message(s) will be displayed in the message area of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and make the required corrections.

The ACTION field on the action line of the screen may contain the letters EM. Because a maximum of six edit or error messages can be displayed on a screen, EM indicates there are additional edit or error messages for the screen you are viewing. To view the additional messages, press ENTER. The same screen with the additional edit or error messages will be displayed.

- a. Moving from the BILLING DOCUMENT INPUT Screen to the BILLING DOCUMENT LINE Screen While Performing Quick Edit - Error messages always appear at the bottom of the BILLING DOCUMENT INPUT screen first. To check for any edit or error messages which may be displayed on the BILLING DOCUMENT LINE screen, or to make any corrections to the BILLING DOCUMENT LINE screen which are displayed on the BILLING DOCUMENT INPUT screen:

- Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key (),
 - Release the alternate shift key (Alt).
- Type NS for Next Screen in the ACTION field.
- Press ENTER.

The BILLING DOCUMENT LINE screen containing any additional edit or error messages will be displayed.

- b. Moving from the BILLING DOCUMENT LINE Screen to the BILLING DOCUMENT INPUT Screen While Performing Quick Edit - If it is necessary to return to the BILLING DOCUMENT INPUT screen from the BILLING DOCUMENT LINE screen while in the correction mode of Quick Edit:

- Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key (),
 - Release the alternate shift key (Alt).
- Type NLO for Move to Top of Document in the ACTION field.

NOTE: The third position of this ACTION command is numeric.

- Press ENTER.

The BILLING DOCUMENT INPUT screen will again be displayed.

- C. Exiting from Quick Edit - When all corrections have been made on both the BILLING DOCUMENT INPUT and BILLING DOCUMENT LINE screens, perform the Quick Edit function as described in section A. Continue to make all corrections and perform Quick Edit until the PAYOR NAME, ADDRESS, CITY, STATE and ZIP, as well as the three messages described in section B1 are displayed on the BILLING DOCUMENT INPUT screen.

9.10.62 Holding The Billing Document For Approval

After the Quick Edit function has successfully been performed, the accounts receivable record you have completed must be held for approval. This is accomplished as follows:

- Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key (),
 - Release the alternate shift key (Alt).
- Type H for Hold Document in the ACTION field.
- Press ENTER.

The STARTUP screen with the message A--*CQ8H - DOCUMENT HELD shown in the message area of the screen will be displayed.

SEE EXHIBIT 21

This completes the data entry portion for the establishment of an initial accounts receivable record.

9.10.63 Approval of The Billing Document

Before an accounts receivable record is actually processed and a billing document is established by the PAR System, the data entered on the BILLING DOCUMENT INPUT and BILLING DOCUMENT LINE screens must be approved by an authorizer. If any errors were detected in the calculation of the award, the overpayment amount or the overpayment letter which require correction, DO NOT approve or schedule the billing document. Return the folder to the claims examiner for correction of the PARS document screens, award and/or overpayment letter. Billing documents awaiting approval are housed in the SUSPENSE FILE TABLE (SUSF). Documents requiring approval are designated by the letters HELD in the STAT field and five zeros in the APPRV field on this table.

A. Accessing the SUSF Screen - To access the SUSPENSE FILE TABLE (SUSF) screen, take the following actions:

- Sign on to the PAR System as described in RCM 9.10.50.
- Type MTI, leave one space, then type the table code name SUSF.
- Press ENTER.
- A blank SUSPENSE FILE TABLE screen will appear.

SEE EXHIBIT 22

B. Completing the SUSF Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the SUSF screen is accessed, the cursor will be positioned in the ACTION field which is prefilled by an S, which signifies Scan Record. Use the TAB key to advance to the next field.
TABLE ID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USER ID:	Enter your four character PARS user identification code and your four character PARS password. (Your password will not be displayed on the screen). The cursor will advance to the next field.

CAPTION	ENTRY
BATCH ID:	<p>TRAN - Make no entry in this field. Use the TAB key to advance to the next field.</p> <p>ORG 1 - Make no entry in this field. Use the TAB key to advance to the next field.</p> <p>NUMBER - Make no entry in this field. Use the TAB key to advance to the next field.</p>
DOCUMENT ID:	<p>TRAN - Always enter B2 in the first two positions of the Transaction Code. Use the TAB key to advance to the next field.</p> <p>ORG 1 - Always enter 2000 in this field. The cursor will advance to the next field.</p> <p>NUMBER - Enter the 11 position alpha and numeric code assigned to the billing document which requires approval.</p>

After completing the TRAN, ORG 1 and NUMBER fields under the DOCUMENT ID caption, press ENTER.

- The cursor will return to the ACTION field on the action line of the screen.
- The ACTION field will now contain an R for Refill.
- The billing document you requested will appear on the first data line of the screen.
- In addition to the DOCUMENT ID field which you completed, the STAT, APPRV, ENTRY DATE, LAST DATE, LAST TERMINAL and LAST USER fields will now be prefilled by the PAR System.

SEE EXHIBIT 23

C. Accessing the BILLING DOCUMENT INPUT and LINE Screens for Approval - To access the BILLING DOCUMENT INPUT screen, take the following actions.

- Type S for Scan Record over the R in the ACTION field on the action line of the screen.
- The correct TABLEID and your USERID will be prefilled in these fields.
- Use the NEW LINE key () to advance the cursor to the first position of the first input line on the SUSF TABLE screen.

- Press ENTER.
- The BILLING DOCUMENT INPUT SCREEN will appear.
 - The cursor will be positioned in the ACTION field on the action line of the screen,
 - The ACTION field will be blank,
 - The MODE field will be prefilled with a C for correction mode,
 - The DOCID field will be prefilled with the document number you requested,
 - The letters RH indicating additional handling required will appear under the STATUS caption,
 - Two messages will appear at the bottom of the BILLING DOCUMENT INPUT screen;
 - H--*S401 - READY FOR APPROVAL 1,
 - H--*F053 - DOCUMENT NOT APPROVED.

SEE EXHIBIT 24

- D. Approval Process - Once the billing document requiring approval and scheduling is accessed and visible on the screen, take the following actions.
- Review the information on the BILLING DOCUMENT INPUT SCREEN to verify all entries are correct. Complete or correct any data entry items that do not affect the overpayment amount or award.
 - Type NS for Next Screen in the ACTION field on the action line of the screen.
 - Press ENTER. This will access the BILLING DOCUMENT LINE screen.
 - Review the information on the BILLING DOCUMENT LINE screen to verify all entries are correct. Complete or correct any data entry items that do not affect the overpayment amount or award.
 - Perform the QUICK EDIT function as described in RCM 9.10.61.
 - Correct any data entry errors if possible.
 - If you are unable to correct data entry errors, return document to HOLD until corrective action can be determined.

- If errors exist in fields which are filled from the PAYR or PDIT tables, return to these tables, make data entry corrections and perform QUICK EDIT of the BILLING DOCUMENT INPUT and BILLING DOCUMENT LINE screens again.
- Type A for Approval in the ACTION field on the action line of the screen. Use the NEW LINE key () to move the cursor to the APPRVL field.
- Type Y in the APPRVL field.
- Press ENTER.
- The BILLING DOCUMENT INPUT SCREEN will be displayed with the following two messages in the message area of the screen.
 - A - *S001 - APPROVAL 1 APPLIED.
 - A - *CY41 - APPROVED DOCUMENT.

SEE EXHIBIT 25

9.10.64 Scheduling The Billing Document For PARS Processing

After the billing document has been approved, it must be returned to the SUSPENSE FILE TABLE and scheduled for processing by PARS. This is accomplished as follows.

- Return cursor to the ACTION field on the action line of the screen.
- Type the letter O for Off-line processing.
- Press ENTER. The SUSPENSE FILE TABLE screen will be displayed.

SEE EXHIBIT 26

The document you have just approved will be displayed on the top line in the data area of the screen. The STAT field will still show HELD and the APPRV field will still display five zeros.

To verify the billing document has been approved and scheduled:

- Type N in the ACTION field on the action line of the screen,
- Press ENTER.

A blank SUSPENSE FILE TABLE screen will be displayed.

- The ACTION field will be prefilled with an S for Scan Record,

- Complete the SUSF screen as described in RCM 9.10.63B,
- Press ENTER.

SEE EXHIBIT 27

The approved document will appear on the top line in the data area of the screen. The STAT field will now show SCHED indicating the billing document has been scheduled for processing. The first position of the APPRV field will display a Y, indicating the billing document has been approved.

9.10.70 Establishing A Cash Receipt Document

An open accounts receivable record is offset in PARS by creating a cash receipt document. The cash receipt document is linked to a previously established billing document through the billing document identification number which was assigned to the receivable when the PAYOR/DEBTOR INFORMATION TABLE (PDIT) was completed. The billing statement and notice of delinquent debt released for installment repayment situations have the billing document identification number printed on them. This number is also typed on G-421 series, method of overpayment recovery option forms. Debtors are furnished two copies of these forms with the request to return one copy to the RRB with their payment or selected method of recovery. RCM 9.10.71 provides procedure for securing the billing document identification number when a copy of the notice or form is not returned and a cash receipt document must be prepared without a folder or the folder does not contain a record of this number.

The terms cash receipt or cash refund should not be confused with the term cash receipt document as applied to PARS. The cash receipt document generated in PARS is used to offset an overpayment regardless of the method of recovery.

- A. Creating a Cash Receipt Document Using Document Screens - A cash receipt document for all methods of recovery except for partial or full annuity withholding can be created by completing a cash receipt document screen series. Posting receipts where the receivable has already been reduced to zero or where no billing document exists must be done using this method.

The following screens must be completed in the order listed when this method for posting recoveries is used.

- DATA ENTRY AND CORRECTION STARTUP SCREEN FOR APPLICATION FFS, and
- CASH RECEIPT INPUT SCREEN, and
- CASH RECEIPT LINE SCREEN.

Just as in the creation of a billing document, this series requires quick edit, approval and scheduling for processing in order to generate a cash receipt document in PARS. Procedure for using this method for creating a cash receipt document is provided in RCM 9.10.72 through 9.10.78.

- B. Creating a Cash Receipt Document Using Table Screens - PARS has three table screens which mechanically generate cash receipt documents. The table screen completed depends on the method which will be used to reduce or recover the overpayment. The following PARS tables generate cash receipt documents and are completed for the recovery methods listed below each table name.

1. Cash Collection Input Table (CCIT)

- Cash refund (cash, check or money order)
- Tolerance
- Waiver
- One time annuity withholding
 - Overpaid amount withheld from accrual due
 - Small overpayment recovery situations
- Actuarial Adjustment
- Compromise

Cash receipt documents created in PARS from the completion of the CCIT require approval and scheduling for processing like the cash receipt document created by completing the document screens. Instructions for completing the Cash Collection Input Table are found in RCM 9.10.79. Procedures for approval and scheduling of this PARS generated cash receipt document are located in RCM 9.10.75 through RCM 9.10.78.

2. Recurring Cash Receipt Table (RECR)

- Partial annuity withholding
- Full annuity withholding

Unlike the cash receipt document created from completion of the CCIT, the cash receipt document generated in PARS from completion of the RECR does not require approval and scheduling for processing. Instructions for completing the Recurring Cash Receipt Table are found in RCM 9.10.80.

3. Write-Off Table (WROT)

- Used to transfer amounts from PARS to uncollectible
 - OPR completion only

The cash receipt document generated in PARS from the completion of the WROT does not require approval or scheduling for processing. Instructions for completion of the Write-Off Table are found in

9.10.71 Securing The Billing Document Identification Number

Generally, a copy of the notice or form containing the billing document identification number will be returned with the payment or method of recovery selection. If it is necessary to secure the billing document identification number assigned to the overpayment when the open accounts receivable record was established, scan the ACCOUNTS RECEIVABLE CASE HISTORY HEADER TABLE (ARCH). You must know the employee's RRB claim number in order to scan this table.

A. Accessing the ARCH Screen - The ARCH screen is accessed as follows.

- Sign on to the PAR System as described in RCM 9.10.50.
- Type MTI, leave one space, then type the table code name ARCH.
- Press ENTER.
- A blank ACCOUNTS RECEIVABLE CASE HISTORY TABLE screen will appear.

SEE EXHIBIT 28

B. Completing the ARCH Screen - Because this is an information table, entries can only be made on the action line and key line of the table. Make the following entries next to or below the captions displayed on the action and key lines of the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the ARCH screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen. The ACTION field will be prefilled with an S, which means Scan Record. Use the TAB key to advance to the next field.

CAPTION	ENTRY
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four character PARS user identification code and your four character PARS password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.
PAYOR CODE:	Enter the prefix and claim number of the railroad employee. Precede serial claim numbers with zeros. The cursor will advance to the identifier position of the PAYOR CODE field. <u>DO NOT</u> make any entry in this field.

After completing the PAYOR NUMBER field on the key line of the ARCH screen, press ENTER. An ACCOUNTS RECEIVABLE CASE HISTORY HEADER TABLE for the railroad claim number entered in the PAYOR NUMBER field will be displayed.

The data area of the ARCH screen will be filled with information entered on the PAYOR TABLE, the PAYOR/DEBTOR INFORMATION TABLE and the billing document screens which were completed when the accounts receivable record was established.

- C. Determining the Billing Document Identification Number - The billing document identification number will be displayed under the BILLING DOCUMENT ID caption located on the key line of the screen. Make a note of this number for future use in creating the cash receipt document. If 0.00 is displayed following the ORIG O/P: caption and the message 01-PP30W ARHT TABLE ENTRY NOT FOUND appears in the message area of the screen, a billing document has either not been established under this billing document number and it will be necessary to page through the record as explained below, or the billing document has not yet been processed.

In many cases, only one open accounts receivable record will have been established for a claim number. Where more than one open receivable record exists, by entering only the railroad claim number in the PAYOR CODE field on the key line of the screen, the first open receivable will be displayed. When determining the billing document identification number, it is necessary to page through the record in all cases to verify the number of records that exist and to determine which open accounts receivable record is related to the payment you are processing. To page through the record to get to the applicable billing document, press ENTER. The next ARCH record in sequence will be displayed. You can only page forward. If you pass the record you need, enter an S for Scan Record in the ACTION field on the action line of the screen and re-enter the

claim number in the PAYOR CODE field on the key line of the screen. Press ENTER. The initial record for that claim number will again be displayed on the ARCH screen.

- D. Exiting from the ARCH Screen - The command for leaving the ARCH table is determined by your next task.
1. Moving from the ARCH Table to Another PARS Table Screen - If you want to access another PARS table screen from the ARCH table screen, take the following actions.
 - Position the cursor in the ACTION field on the action line of the screen.
 - Type N for Next Screen in the ACTION field.
 - The cursor will advance to the TABLEID field.
 - Type the table code name you want to access over ARCH.
 - Press ENTER.

A blank screen for the table you requested will be displayed.
 2. Ending the Session - To exit from the ARCH table, take the following actions.
 - Position the cursor in the ACTION field on the action line of the screen.
 - Type E for Exit in the ACTION field.
 - Press ENTER.

The message "V2 ENTER NEXT TASK CODE" will be displayed.

9.10.72 Completing The Startup Screen

Open receivable records are offset in PARS by creating a cash receipt document. The cash receipt document screen series can be used to generate a cash receipt document for all methods of recovery except for partial or full annuity withholding. This is the only method which can be used to post receipts to a receivable where the balance has previously been reduced to zero because of over reimbursement or duplicate recovery. The cash receipt document screen series must also be completed in situations where no billing document exists.

- A. Accessing the STARTUP Screen - To access the STARTUP screen from the message "V2 ENTER NEXT TASK CODE" displayed after successfully signing on to the PARS database as described in RCM 9.10.50, or after exiting from a table screen, take the following actions.

- Type DDB.
- Press ENTER.
- A blank DATA ENTRY AND CORRECTION STARTUP SCREEN FOR APPLICATION FFS will appear.

SEE EXHIBIT 29

- B. Completing the STARTUP Screen - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY														
MODE OF OPERATION:	Enter a D for Data Entry. The cursor will advance to the next field.														
DOCUMENT ID:	<p>Enter the cash receipt document identification code under the captions displayed as follows:</p> <ul style="list-style-type: none"> • TRAN - Always enter C2. The cursor will advance to the DIVISION field. • DIVISION - Always enter 2000. The cursor will advance to the ID NUMBER field. • ID NUMBER - This number is made up of a combination of 11 letters and numbers. Enter the code as follows. <ul style="list-style-type: none"> • Positions 1-2. Enter your unit designation determined as follows: <div data-bbox="673 1451 1240 1898"> <table> <tr><td>BC</td><td>Beneficiary Compliance Section</td></tr> <tr><td>CB</td><td>Combined Benefits Section</td></tr> <tr><td>CI</td><td>Congressional Inquiry Section</td></tr> <tr><td>HA</td><td>Bureau of Hearings and Appeals</td></tr> <tr><td>MP</td><td>Methods and Procedures</td></tr> <tr><td>OP</td><td>Overpayment Recovery Section</td></tr> <tr><td>PE</td><td>Program Evaluation Section</td></tr> </table> </div> 	BC	Beneficiary Compliance Section	CB	Combined Benefits Section	CI	Congressional Inquiry Section	HA	Bureau of Hearings and Appeals	MP	Methods and Procedures	OP	Overpayment Recovery Section	PE	Program Evaluation Section
BC	Beneficiary Compliance Section														
CB	Combined Benefits Section														
CI	Congressional Inquiry Section														
HA	Bureau of Hearings and Appeals														
MP	Methods and Procedures														
OP	Overpayment Recovery Section														
PE	Program Evaluation Section														

CAPTION	ENTRY
	<p>PS Payment Services Unit</p> <p>RB Retirement Backlog Task Force</p> <p>RI Initial Claims Section</p> <p>RP Retirement Post Section</p> <p>RS Reconsideration Section</p> <p>SI Survivor Initial Section</p> <p>SP Survivor Post Section</p>

These organization codes are also displayed on the PARS SORG TABLE screen.

- Positions 3-5. Enter your three position examiner number or your initials, determined by your unit's policy.

CAPTION	ENTRY
DOCUMENT ID (Cont.):	<ul style="list-style-type: none"> • Positions 6-8. Enter the sequential day of the year you are establishing this cash receipt document. If the day contains fewer than three digits, enter zeros in positions 6 and 7 as necessary. <p>EXAMPLE: January 20 is entered as 020; December 28 is entered as 362.</p> <p>The sequential date can be found in the lower left hand corner of most desk calendars.</p> <ul style="list-style-type: none"> • Positions 9-10. Enter the last two digits of the current year. • Position 11. The final position is a counter. The counter is determined from the number of PARS cash receipt documents you establish each day. <p>EXAMPLE: The first cash receipt document is 1; the second is 2; etc.</p>

CAPTION	ENTRY
	<p>If more than 9 PARS cash receipt documents are established on one day, alpha characters may be used.</p> <p>After the ID NUMBER has been completed, the cursor will advance to the next field.</p>
BATCH ID:	<ul style="list-style-type: none"> • TRAN - Make no entry in this field. Use the TAB key to advance to the next field. • DIVISION - Make no entry in this field. Use the TAB key to advance to the next field. • ID NUMBER - Make no entry in this field. Use the TAB key to advance to the next field.
USER ID:	<p>Enter your four character PARS user identification code and your four character PARS password. (Your PARS password will not be displayed on the screen.) The cursor will advance to the next field.</p>

An example of a completed DATA ENTRY AND CORRECTION STARTUP SCREEN FOR APPLICATION FFS appears below.

SEE EXHIBIT 30

- C. Exiting from the STARTUP Screen - After you have entered your PARS user identification code and PARS password, review the information you have entered on the STARTUP screen to verify that these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information. When all information is correct, press ENTER. The CASH RECEIPT INPUT SCREEN will appear.

9.10.73 Completing The Cash Receipt Input Screen

- A. Accessing the CASH RECEIPT INPUT SCREEN - Following completion and entering of the STARTUP screen as described in RCM 9.10.72, the CASH RECEIPT INPUT SCREEN displayed below will appear.

SEE EXHIBIT 31

The MODE, DOCID and USERID fields on the action line of this screen will be prefilled from these entries completed on the STARTUP screen.

- B. Completing the CASH RECEIPT INPUT SCREEN - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first

position of each of the data entry fields beginning with DOC DATE and will move through the screen in the following order.

CAPTION	ENTRY
DOC DATE:	Make no entry in this field. Use the TAB key to advance to the next field.
ACCTG PRD:	Make no entry in this field. Use the TAB key to advance to the next field.
ACTION:	Enter E for Entry. The cursor will advance to the next field.
BUDGET FY:	Make no entry in this field. Use the TAB key to advance to the next field.
FUND:	Make no entry in this field. Use the TAB key to advance to the next field.
TRANS TYPE:	Make no entry in this field. Use the TAB key to advance to the next field.
CASH ACCOUNT:	Make no entry in this field. Use the TAB key to advance to the next field.
DEP NUMBER:	<p>Complete this entry as follows. This field will accommodate an entry of up to 12 positions. If all positions are used, the cursor will advance to the next field, otherwise use the TAB key to advance the cursor.</p> <ul style="list-style-type: none"> • If the method of recovery is by cash, check or money order, enter the certificate of deposit number (CD#). • If the method of recovery is by annuity withholding, waiver, tolerance, etc. (any method other than cash, check or money order,) enter BRC.
DOC TYPE:	Make no entry in this field. Use the TAB key to advance to the next field.
BILL FUND:	Make no entry in this field. Use the TAB key to advance to the next field.

CAPTION	ENTRY
DOCUMENT TOTAL:	Enter the amount of the payment or recovery for the cash receipt document you are establishing. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> use a dollar sign. Use the TAB key to advance to the next field.
DISB OFFICE:	Make no entry in this field. Use the TAB key to advance to the next field.
ACCOMPLISHED	Make no entry in this field.
DATE	An example of a completed CASH RECEIPT INPUT SCREEN appears below.

SEE EXHIBIT 32

- C. Exiting from the CASH RECEIPT INPUT SCREEN - After completing the DOCUMENT TOTAL field, review the three entries you have completed on the CASH RECEIPT INPUT SCREEN to verify that these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information. When all information is correct, press ENTER. The CASH RECEIPT LINE SCREEN will appear.

9.10.74 Completing The Cash Receipt Line Screen

- A. Accessing the CASH RECEIPT LINE SCREEN - Following completion and entering of the CASH RECEIPT INPUT SCREEN as described in RCM 9.10.73, the CASH RECEIPT LINE SCREEN displayed below will appear.

SEE EXHIBIT 33

The MODE, DOCID and USERID fields on the action line of this screen will be prefilled from these entries completed on the STARTUP screen.

- B. Completing the CASH RECEIPT LINE SCREEN - Make the following entries next to the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields beginning with LINE NO and will move through the screen in the following order.

CAPTION	ENTRY
---------	-------

CAPTION	ENTRY
LINE NO:	<p>Enter 001 for the first line you establish for a cash receipt document to offset a specific billing document. Increase this number by one for each succeeding line completed which pertains to the same billing document. This is a three position field. Since it is unlikely that more than a single digit number of lines will be established for any cash receipt document, enter zeros in the first two positions of this field. The cursor will advance to the next field.</p>
REF TC:	<p>Enter B2 in the two positions of this field if a billing document has been established. The cursor will advance to the next field.</p> <p>EXCEPTION:</p> <p>If <u>no</u> billing document has been established, or if the amount outstanding has already been reduced to zero, make no entry in this field. Use the TAB key to advance to the next field.</p>
REF NUMBER:	<p>Enter the 11 position Billing Document Identification code to which this cash receipt document is being posted. The cursor will advance to the next field.</p> <p>EXCEPTION:</p> <p>If <u>no</u> billing document has been established, or if the amount outstanding has already been reduced to zero, make no entry in this field. Use the TAB key to advance to the next field.</p>
REF LINE:	<p>Enter one of the following three position codes which represents the type of overpayment established on the original billing document. The cursor will advance to the next field.</p> <ul style="list-style-type: none"> • 001 Railroad Retirement Annuity overpayment • 002 Supplemental Annuity overpayment • 997 Interest charges • 998 Administrative costs • 999 Penalty charges

CAPTION	ENTRY
	<p>EXCEPTION:</p> <p>If <u>no</u> billing document has been established, or if the amount outstanding has already been reduced to zero, make no entry in this field. Use the TAB key to advance to the next field.</p>
BFY:	<p>Make no entry in this field. Use the TAB key to advance to the next field.</p>
FUND:	<p>Make no entry in this field. Use the TAB key to advance to the next field.</p> <p>EXCEPTION:</p> <p>If <u>no</u> billing document has been established, or if the amount outstanding has already been reduced to zero, enter 8011 in this field. Use the TAB key to advance to the next field.</p>
TRAN TYPE:	<p>Enter one of the following two position codes. The cursor will advance to the next field.</p> <ul style="list-style-type: none"> • CC Cash Collection (cash, check or money order.) • AW Annuity Withholding (small overpayment recovery, overpayment withheld from accrual, actuarial adjustment.) • WO Write-off (waiver, tolerance or compromise.) • UA Unapplied cash (No billing document exists or outstanding amount has already been reduced to zero.) • IP Interest, Penalty or Administrative Costs. (Only use this code when 997, 998 or 999 was entered in REF LINE above.)
BUDGET ORG/SUB:	<p>Make no entry in this field. Use the TAB key to advance to the next field.</p> <p>EXCEPTION:</p>

CAPTION	ENTRY
	<p>If <u>no</u> billing document has been established, or if the amount outstanding has already been reduced to zero, enter 2000 in the first four positions of this field. Use the TAB key to advance to the final two positions of this field. Enter your two position unit designation determined from the list below. The cursor will advance to the next field.</p> <p>BC Beneficiary Compliance Section</p> <p>CB Combined Benefits Section</p> <p>CI Congressional Inquiry Section</p> <p>HA Bureau of Hearings and Appeals</p> <p>MP Methods and Procedures</p> <p>OP Overpayment Recovery Section</p> <p>PE Program Evaluation Section</p> <p>PS Payment Services Unit</p> <p>RB Retirement Backlog Task Force</p> <p>RI Initial Claims Section</p> <p>RP Retirement Post Section</p> <p>RS Reconsideration Section</p> <p>SI Survivor Initial Section</p> <p>SP Survivor Post Section</p>
PROGRAM:	Make no entry in this field. Use the TAB key to advance to the next field.
REV SRCE/SUB:	Make no entry in this field. Use the TAB key to advance to the next field.
TRAVEL TYPE:	Make no entry in this field. Use the TAB key to advance to the next field.
BOC/SUB:	Make no entry in this field. Use the TAB key to advance to the next field.

CAPTION	ENTRY
	<p>EXCEPTION:</p> <p>If <u>no</u> billing document has been established, or if the amount outstanding has already been reduced to zero, enter 4220 in the first four positions of this field. Use the TAB key to advance to the next field.</p>
JOB NUMBER:	Make no entry in this field. Use the TAB key to advance to the next field.
REPT CAT:	Make no entry in this field. Use the TAB key to advance to the next field.
GL ACCT:	Make no entry in this field. Use the TAB key to advance to the next field.
CHECK NUMBER:	Make no entry in this field. Use the TAB key to advance to the next field.
VND/PRV:	Make no entry in this field. Use the TAB key to advance to the next field.
AMOUNT:	<p>Enter the amount of the recovery to be credited to the type of overpayment code entered following the REF LINE caption above. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> enter a dollar sign. Use the TAB key to advance to the next field.</p> <p>EXAMPLE: A cash refund is received for an overpayment of both a regular and supplemental annuity. The combined amount of the regular and supplemental annuity will be entered in the DOCUMENT TOTAL field on the CASH RECEIPT INPUT SCREEN. However, on this screen, the amount of the regular annuity will be entered when the REF LINE is 001. The amount of the supplemental annuity will be entered when the REF line is 002.</p>
I/D:	Make no entry in this field. Use the TAB key to advance to the next field.
P/F:	Make no entry in this field. Use the TAB key to advance to the next field.

CAPTION	ENTRY
ACTION OUT:	<p>Enter the four position code from the list below which best describes how the overpayment was recovered. The cursor will advance to the next field.</p> <p>11A Offset - Annuity Accrual</p> <p>11B Offset - Partial W/H</p> <p>11C Offset - Full W/H</p> <p>11D Offset - Lump-Sum</p> <p>12A Returned Annuity Check</p> <p>12B Check Reclamation</p> <p>12C Returned EFT Payment</p> <p>12D EFT Reclamation - TFS 133 Received</p> <p>12E EFT Reclamation - TFS 135 Received</p> <p>12F Limited Payability Cancellation</p> <p>13A Cash Refund</p> <p>13B Credit Card Collection</p> <p>14A IRS Collection</p> <p>14B OIG Collection</p> <p>14C Department of Justice Collection</p> <p>14D Collection Agency Collection</p> <p>15A Actuarial Adjustment</p> <p>16A Pre-Recovery Waiver - BCS</p> <p>16B Pre-Recovery Waiver - OPR</p> <p>16C Waiver of Principal - BRC (Full)</p> <p>16D Waiver of Principal - BHA (Full)</p>

CAPTION	ENTRY
	16E Waiver of Principal - Board (Full) 16F Waiver of Principal - Court (Full) 16G Waiver of Principal - BRC (Partial) 16H Waiver of Principal - BHA (Partial) 16I Waiver of Principal - Board (Partial) 16J Waiver of Principal - Court (Partial) 16K Waiver of Penalty - BRC 16L Waiver of Penalty - BHA 16M Waiver of Penalty - Board 16N Waiver of Penalty - Court 16O Waiver of Administrative Costs - BRC 16P Waiver of Administrative Costs - BHA 16Q Waiver of Administrative Costs - Board 16R Waiver of Administrative Costs - Court 16S Waiver of Interest - BRC 16T Waiver of Interest - BHA 16U Waiver of Interest - Board 16V Waiver of Interest - Court 16W Crissinger - Bodle - Wood Principle 17A Compromise 19A Recovered by RUIA 21A Offset - SSA Benefit - Mechanical Interface Only 21B Offset - SSA Benefit-Manual 22A Tolerance

CAPTION	ENTRY
	22B Balance Tolerance - BRC
	23A Termination of Collection Action - \$100.00
	24A Not Recoverable - New Payor/BD Established
	25A Cash Receipt Posted to Unapplied
	87B Insufficient Funds - Bad Check (Correction Code)
	88B Erroneous Entry (Modification of Cash Receipt)
	88T Transfer Funds/Unapplied Cash
	89B Miscalculation (Modification of Cash Receipt)
	90B Adjudicative Error (Modification of Cash Receipt)

NOTE: The PARS ACOT Table contains a complete list of action out codes, including those used by the bureau of sickness and unemployment benefits division (SUBD).

Each CASH RECEIPT LINE SCREEN will accommodate entries for two separate lines of activity. If both sections of this screen must be completed, use the TAB key to advance the cursor from the ACTION OUT field in the top portion of the screen. The cursor will advance to the LINE NO field in the bottom portion of the screen. Complete each entry on the lower portion of the screen as described for each caption above.

Because of interest, penalty and administrative charges, situations exist where multiple lines of activity must be completed for a cash receipt document. Following completion of the bottom half of the first CASH RECEIPT LINE SCREEN, additional lines are accessed by pressing ENTER. A blank CASH RECEIPT LINE screen will appear. The MODE, DOCID and USERID fields on the action line of this screen will be prefilled with the information you entered on the STARTUP screen. The cursor will place you in the first position of each of the data entry fields beginning with LINE NO. Complete the required entries for each line of activity as described above. Continue to press ENTER to access additional blank CASH RECEIPT LINE SCREENS until sufficient lines of activity have been completed to record the entire payment.

- C. Exiting from the CASH RECEIPT LINE SCREEN - After completing the ACTION OUT field on the last required line of activity, review the information you have entered on the CASH RECEIPT LINE SCREEN to verify that these entries are

correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.

An example of a completed CASH RECEIPT LINE SCREEN appears below:

SEE EXHIBIT 34

9.10.75 Quick Edit Function

The Quick Edit function is used to edit entries you have completed on the CASH RECEIPT INPUT SCREEN and CASH RECEIPT LINE SCREEN. This function also signals the PAR System that all document screens required to establish a cash receipt document have been completed.

A. Beginning the Quick Edit Process - Following your review of the CASH RECEIPT LINE SCREEN and your determination that all entries are complete and correct, Quick Edit is accomplished as follows:

- Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key (),
 - Release the alternate shift key (Alt).
- Type Q for Quick Edit in the ACTION field.
- Press ENTER.

B. Results of the Quick Edit Process - The PAR System always returns to the initial screen in a document screen series for display of edit, error or acceptance messages.

- The CASH RECEIPT INPUT SCREEN will be displayed.
- The MODE field on the action line of the screen will contain a C indicating the system is in the correction mode.
- The letters RH indicating additional handling is required will be displayed under the STATUS caption.

1. No Errors Are Detected During Quick Edit - If all required entries on the CASH RECEIPT INPUT SCREEN have been completed and the system does not detect any errors, the following three messages will be displayed in the message area at the bottom of the CASH RECEIPT INPUT SCREEN:

- A-*CQ93 - DOCUMENT REJECTED
- H-*FO53 - DOCUMENT NOT APPROVED
- H-*S401 - READY FOR APPROVAL

NOTE: The above messages will appear if no errors are detected on the CASH RECEIPT INPUT SCREEN but errors may still exist on the CASH RECEIPT LINE SCREEN. Therefore, it is essential to page to the CASH RECEIPT LINE SCREEN for display of any error messages. This is accomplished by typing NS for Next Screen in the ACTION field on the action line of the screen and pressing ENTER. Because the system will remain in correction mode, any errors detected in LINE screen entries will be displayed in the message area at the bottom of the screen. If no errors are detected, the message area will be blank.

SEE EXHIBIT 35

2. Errors Are Detected During Quick Edit - If any errors are detected during the Quick Edit process or any required entries are not complete, an error or warning message(s) will be displayed in the message area of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and make the required entries.

The ACTION field on the action line of the screen may contain the letters EM. Because a maximum of six edit or error messages can be displayed on a screen, EM indicates there are additional edit or error messages for the screen you are viewing. To view the additional messages, press ENTER. The same screen with the additional edit or error messages will be displayed.

- a. Moving from the CASH RECEIPT INPUT SCREEN to the CASH RECEIPT LINE SCREEN While Performing Quick Edit - Error messages always appear at the bottom of the CASH RECEIPT INPUT SCREEN first. To check for any edit or error messages which may be displayed on the CASH RECEIPT LINE SCREEN, or to make any corrections to the CASH RECEIPT LINE SCREEN which are displayed on the CASH RECEIPT INPUT SCREEN:
 - Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key (),

- Release the alternate shift key (Alt).
- Type NS for Next Screen in the ACTION field.
- Press ENTER.

The CASH RECEIPT LINE SCREEN containing any additional edit or error messages will be displayed.

- b. Moving from the CASH RECEIPT LINE SCREEN to the CASH RECEIPT INPUT SCREEN While Performing Quick Edit - If it is necessary to return to the CASH RECEIPT INPUT SCREEN while in the correction mode of Quick Edit:

- Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key (),
 - Release the alternate shift key (Alt).
- Type NLO for Move to Top of Document in the ACTION field.

NOTE: The third position of this ACTION command is numeric.

- Press ENTER.

The CASH RECEIPT INPUT SCREEN will again be displayed.

- C. Exiting from Quick Edit - When all corrections have been made to the CASH RECEIPT INPUT SCREEN and CASH RECEIPT LINE SCREEN, perform the Quick Edit function as described in section A. Continue to make all corrections and perform Quick Edit until the three messages described in section B1 are displayed in the message area of the CASH RECEIPT INPUT SCREEN.

9.10.76 Holding The Cash Receipt Document For Approval

After the Quick Edit function has successfully been performed, the cash receipt document you have completed must be held for approval. This is accomplished as follows:

- Position the cursor in the ACTION field on the action line of the screen.
 - Press and hold down an alternate shift key (Alt),
 - Press the cursor home key (),

- Release the alternate shift key (Alt).
- Type H for Hold Document in the ACTION field.
- Press ENTER.

The STARTUP screen with the message A-*CQ8H-DOCUMENT HELD shown in the message area of the screen will be displayed.

SEE EXHIBIT 36

This completes the data entry portion for the establishment of a cash receipt document by means of completion of the cash receipt document screen series.

9.10.77 Approval Of The Cash Receipt Document

Before a cash receipt document is actually processed and established by the PAR System, the data entered on the CASH RECEIPT INPUT SCREEN and CASH RECEIPT LINE SCREEN must be approved by an authorizer. Cash receipt documents awaiting approval are housed in the SUSPENSE FILE TABLE (SUSF). Documents requiring approval are designated by the letters HELD in the STAT field and five zeros in the APPRV field on this table.

A. Accessing the SUSF Screen - To access the SUSPENSE FILE TABLE (SUSF) screen, take the following actions:

- Sign on to the PAR System as described in RCM 9.10.50.
- Type MTI, leave one space, then type the table code name SUSF.
- Press ENTER.
- A blank SUSPENSE FILE TABLE screen will appear.

SEE EXHIBIT 37

B. Completing the SUSF Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the SUSF screen is accessed, the cursor will be positioned in the ACTION field which is prefilled with an S, which means Scan Record. Use the TAB key to advance to the next field.

CAPTION	ENTRY
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four character PARS user identification code and your four character PARS password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.
BATCH ID:	<p>TRAN - Make no entry in this field. Use the TAB key to advance to the next field.</p> <p>ORG 1 - Make no entry in this field. Use the TAB key to advance to the next field.</p> <p>NUMBER - Make no entry in this field. Use the TAB key to advance to the next field.</p>
DOCUMENT ID:	<p>TRAN - Always enter C2 in the first two positions of the Transaction Code. Use the TAB key to advance to the next field.</p> <p>ORG 1 - Always enter 2000 in this field. The cursor will advance to the next field.</p> <p>NUMBER - Enter the 11 position alpha and numeric code assigned to the cash receipt document which requires approval.</p>

After completing the TRAN, ORG 1, and NUMBER fields under the DOCUMENT ID caption, press ENTER.

- The cursor will return to the ACTION field on the action line of the screen.
- The ACTION field will now contain an R for Refill.
- The cash receipt document you requested will appear on the first data line of the screen.
- In addition to the DOCUMENT ID field which you completed, the STAT, APPRV, ENTRY DATE, LAST DATE, LAST TERMINAL and LAST USER fields will now be prefilled by the PAR System.

SEE EXHIBIT 38

- C. Accessing the CASH RECEIPT INPUT SCREEN and CASH RECEIPT LINE SCREEN for Approval - To access the CASH RECEIPT INPUT SCREEN, take the following actions.

- Type S for Scan Record over the R in the ACTION field on the action line of the screen.
- The correct TABLEID and your USERID will be prefilled in these fields.
- Use the NEW LINE key () to advance the cursor to the first position of the first data line on the SUSF table screen.
- Press ENTER.
- The CASH RECEIPT INPUT SCREEN will be displayed.
 - The cursor will be positioned in the ACTION field on the action line of the screen,
 - The ACTION field will be blank,
 - The MODE field will be prefilled with a C for Correction Mode,
 - The DOCID field will be prefilled with the cash receipt document number you requested,
 - The letters RH indicating additional handling required will be displayed under the STATUS caption,
 - Two messages will appear in the message area at the bottom of the CASH RECEIPT INPUT SCREEN;
 - H-*S401-READY FOR APPROVAL 1,
 - H-*F053-DOCUMENT NOT APPROVED.

SEE EXHIBIT 39

- D. Approval Process - Once the cash receipt document requiring approval and scheduling is accessed and visible on the screen, take the following actions.
- Review the information on the CASH RECEIPT INPUT SCREEN to verify all entries are correct. Complete or correct any data entry items as necessary.
 - Type NS for Next Screen in the ACTION field on the action line of the screen.
 - Press ENTER. This will access the CASH RECEIPT LINE SCREEN.
 - The FUND:, BUDGET ORG/SUB:, BOC/SUB: and VND/PRV: on each line of activity will be filled from information entered into the PAR System when the billing document was established.

- Review the information on the CASH RECEIPT LINE SCREEN to verify all entries are correct. Complete or correct any data entry items as necessary.
- Perform the Quick Edit function as described in RCM 9.10.75.
 - Correct any data entry errors if possible.
 - If you are unable to correct data entry errors, return the cash receipt document to HOLD until corrective action can be determined.
- Type A for Approval in the ACTION field on the action line of the screen. Use the NEW LINE key () to move the cursor to the APPRVL field.
- Type Y in the APPRVL field.
- Press ENTER.
- The CASH RECEIPT INPUT SCREEN will be displayed showing the following two messages in the message area at the bottom of the screen.
 - A-*S001-APPROVAL 1 APPLIED.
 - A-*CY41-APPROVED DOCUMENT.

SEE EXHIBIT 40

9.10.78 Scheduling The Cash Receipt Document For PARS Processing

After the cash receipt document has been approved, it must be returned to the SUSPENSE FILE TABLE and scheduled for processing by PARS. This is accomplished as follows.

- Return the cursor to the ACTION field on the action line of the screen.
- Type the letter O for Off-line processing.
- Press ENTER. The SUSPENSE FILE TABLE screen will be displayed.

SEE EXHIBIT 41

The cash receipt document you have just approved will be displayed on the top line in the data area of the screen. The STAT field will still show HELD and the APPRV field will still display five zeros.

To verify the cash receipt document has been approved and scheduled:

- Type N for Next Screen in the ACTION field on the action line of the screen.
- Press ENTER. A blank SUSPENSE FILE TABLE screen will be displayed.
 - The ACTION field will be prefilled with an S for Scan Record,
 - The TABLEID field will contain the correct table code name,
 - The USERID field will contain your PARS user identification code and password.
- Position the cursor on the first line of the data area of the screen.
 - Type C2 in the TRANS field under the DOCUMENT ID caption. Use the TAB key to advance to the next field.
 - Type 2000 in the ORG 1 field. The cursor will advance to the next field.
 - Type the 11 character alpha and numeric cash receipt document number you have just approved in the NUMBER field.
- Press ENTER.

SEE EXHIBIT 42

The approved cash receipt document will appear on the top line in the data area of the screen. The STAT field will now show SCHED indicating the cash receipt document has been scheduled for processing. The first position of the APPRV field will display a Y, indicating the cash receipt document has been approved.

9.10.79 Creating A Cash Receipt Document Using The Cash Collection Input Table (CCIT) Screen

A cash receipt document is mechanically produced by PARS for the following recovery methods by completing the CASH COLLECTION INPUT TABLE (CCIT).

- Cash refund (cash, check or money order, reclamation credit - SF 1081, TFS 133, TFS 135).
- Tolerance.
- Actuarial Adjustment.
- Waiver.
- One time annuity withholding.
 - Overpaid amount was withheld from an accrual due,

- Small overpayment recovery situation.
- Compromise.

Creating a cash receipt document through completion of a CCIT screen has several advantages. When recovering both a regular and supplemental annuity overpayment, the cash receipt document generated in PARS by the CCIT will automatically allocate the recovery between the two accounts. In non-current entitlement situations, where interest, penalty and administrative changes are involved, a CCIT generated PARS cash receipt document will distribute funds to these accounts in the order required by law. The balance of the payment will then be credited to the principal. Another advantage in creating a cash receipt document from the CCIT screen is that less data entry fields require completion.

Both the PAYOR CODE and the BILLING DOCUMENT IDENTIFICATION NUMBER assigned to the overpayment when the accounts receivable record was established must be known to complete a CCIT screen. If a copy of the notice or form containing these identifiers does not accompany a payment or method of recovery selection and the folder does not contain the information, or the CCIT screen is being completed without a folder, RCM 9.10.71 provides instructions for securing these keys.

A. Accessing the CCIT Screen - The CCIT screen is accessed as follows:

- Sign on to the PAR System as described in RCM 9.10.50.
- Type MIT, leave one space, then type the table code name CCIT.
- Press ENTER.
- A blank CASH COLLECTION INPUT TABLE screen will appear.

SEE EXHIBIT 43

B. Completing the CCIT Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	<p>When the CCIT screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.</p> <ul style="list-style-type: none"> • The ACTION field will be prefilled with an S, which means Scan Record.

CAPTION	ENTRY
	<ul style="list-style-type: none"> • Type A for Add Record over the S. • The cursor will advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four character PARS user identification code and your four character PARS password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.
CR DOC ID:	<p>The Cash Receipt Document Identification code on the CCIT screen is made up of a combination of 13 letters and numbers. The first two positions are referred to as the TRANS CODE on error and warning messages. The remaining 11 positions are referred to as the DOCUMENT NUMBER. Complete this field as follows:</p> <ul style="list-style-type: none"> • Positions 1-2. <u>Always</u> enter C2 in the first two positions of this field. The cursor will advance to position 3. • Positions 3-4. Enter your unit designation determined as follows: <ul style="list-style-type: none"> BC Beneficiary Compliance Section CB Combined Benefits Section CI Congressional Inquiry Section HA Bureau of Hearings and Appeals MP Methods and Procedures OP Overpayment Recovery Section PE Program Evaluation Section PS Payment Services Unit RB Retirement Backlog Task Force RI Initial Claims Section

CAPTION	ENTRY
	<p>RP Retirement Post Section</p> <p>RS Reconsideration Section</p> <p>SI Survivor Initial Section</p> <p>SP Survivor Post Section</p> <p>These unit designation codes are also displayed on the PARS SORG TABLE screen.</p>
CR DOC ID:	<ul style="list-style-type: none"> • Positions 5-7. Enter your three position examiner number or your initials, determined by your unit's policy. • Positions 8-10. Enter the sequential day of the year you are establishing this cash receipt document. If the day contains fewer than three digits, enter zeros in positions 8 and 9 as necessary. <p>EXAMPLE: January 20 is entered as 020; December 28 is entered as 362. The sequential date can be found in the lower left hand corner of most desk calendars.</p> <ul style="list-style-type: none"> • Positions 11-12. Enter the last two digits of the current year. • Position 13. The final position is a counter. The counter is determined from the number of separate PARS cash receipt documents you establish each day. <p>EXAMPLE: The first cash receipt document is 1; the second is 2, etc.</p> <p>If more than 9 PARS cash receipt documents are established on one day, alpha characters may be used.</p> <p>Upon completion of the CASH RECEIPT DOCUMENT IDENTIFICATION code field, the cursor will advance to the next field.</p>
TOTAL PAYMENT	Enter the total amount of the remittance or recovery. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> use a dollar sign. Use the TAB key to advance to the next field.
PAYOR	Enter the Payor Number which was established on the billing

CAPTION	ENTRY
NUMBER	document when the accounts receivable record which is being offset by this cash receipt document was established. The cursor will advance to the next field. This field was previously titled PAYOR CODE.
RECEIVED DATE:	Make no entry in these fields. Use the TAB key to advance to the next field.
DIVISION:	Always enter 2000 in this field. The cursor will advance to the next field.
DEPOSIT #:	<p>Complete this entry as follows. This field will accommodate an entry of 12 positions. If all positions are used, the cursor will advance to the next field, otherwise use the TAB key to advance the cursor.</p> <ul style="list-style-type: none"> • If the method of recovery is by cash, check or money order, enter the certificate of deposit number (CD#). • If the method of recovery is by annuity withholding, waiver, tolerance, reclamation credit, etc. (any method other than cash, check or money order,) enter BRC.
TRANS TYPE:	<p>Enter one of the following two position codes depending on the method of recovery. The cursor will advance to the next field.</p> <ul style="list-style-type: none"> • CC Cash Collection (cash, check or money order, reclamation credit). • AW Annuity Withholding (overpayment recovered from accrual, partial or full annuity withholding, actuarial adjustment). • W Write Off (waiver, tolerance, compromise). O
ACTION OUT:	<p>Enter the three position code from the list below which best describes how the overpayment was recovered. The cursor will advance to the next field.</p> <p>11A Offset - Annuity Accrual</p> <p>11B Offset - Partial W/H</p> <p>11C Offset - Full W/H</p>

CAPTION	ENTRY
	11D Offset - Lump Sum 12B Check Reclamation 12D EFT Reclamation - TFS 133 Received 12E EFT Reclamation - TFS 135 Received 12F Limited Payability Cancellation 13A Cash Refund 13B Credit Card Collection 14A IRS Collection 14B OIG Collection 14C Department of Justice Collection 14D Collection Agency Collection 15A Actuarial Adjustment 16A Pre-Recovery Waiver - BCS 16B Pre-Recovery Waiver - OPR 16C Waiver of Principal - BRC (Full) 16D Waiver of Principal - BHA (Full) 16E Waiver of Principal - Board (Full) 16F Waiver of Principal - Court (Full) 16G Waiver of Principal - BRC (Partial) 16H Waiver of Principal - BHA (Partial) 16I Waiver of Principal - Board (Partial) 16J Waiver of Principal - Court (Partial) 16K Waiver of Penalty - BRC 16L Waiver of Penalty - BHA

CAPTION	ENTRY
	16M Waiver of Penalty - Board 16N Waiver of Penalty - Court 16O Waiver of Administrative Costs - BRC 16P Waiver of Administrative Costs - BHA 16Q Waiver of Administrative Costs - Board 16R Waiver of Administrative Costs - Court 16S Waiver of Interest - BRC 16T Waiver of Interest - BHA 16U Waiver of Interest - Board 16V Waiver of Interest - Court 16W Crissinger - Bodle - Wood Principle 17A Compromise 19A Recovered by RUIA 21A Offset - SSA Benefit - Mechanical Interface Only 21B Offset - SSA Benefit - Manual 22A Tolerance 22B Balance Tolerance - BRC 23A Termination of Collection Action - \$100.00 24A Not Recoverable - New PAYOR/BD Established 25A Cash Receipt Posted to Unapplied 87B Insufficient Funds - Bad Check (Correction Code) 88B Erroneous Entry (Modification of Cash Receipt) 88T Transfer Funds/Unapplied Cash 89B Miscalculation (Modification of Cash Receipt)

CAPTION	ENTRY
	<p>90B Adjudicative Error (Modification of Cash Receipt)</p> <p>NOTE: The PARS ACOT TABLE contains a complete list of action out codes, including those used by the bureau of sickness and unemployment benefits division (SUBD).</p>
REFERENCE BILL DOC ID:	<p>Enter the Billing Document Identification Number which was assigned when the accounts receivable record, which is being offset by this cash receipt document, was established. <u>Always</u> enter B2 in the first two positions of this field. The cursor will advance to the remaining 11 positions. Upon completion of the document number field, the cursor will advance to the next field.</p> <p>NOTE: <u>Always</u> enter the REFERENCE BILL DOC ID on line 01. Lines 02 through 07 are reserved for RUIA use only.</p>
AMOUNT RECEIVED:	<p>Enter the same amount as was entered in the TOTAL PAYMENT field above. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> use a dollar sign. The cash receipt document generated by PARS will create the appropriate lines of activity from the information contained in the billing document.</p> <p>NOTE: <u>Always</u> enter the AMOUNT RECEIVED on line 01. Lines 02 through 07 are reserved for RUIA use only.</p>

- C. Exiting from the CCIT Screen - After completing the AMOUNT RECEIVED field, review the information you have entered on the CCIT screen to verify that these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.
1. Establishing the CASH COLLECTION INPUT TABLE - When all required entries have been completed and all information is correct, press ENTER. The message *L030 ALL LINES ADDED will be displayed in the message area of the screen indicating the CASH COLLECTION INPUT TABLE has been established.
 2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area at the bottom of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry as indicated. Continue to

press ENTER and make any required corrections until the message *L030 ALL LINES ADDED is displayed in the message area of the screen. It is important that all errors are corrected and all required entries are completed on the CCIT screen. PARS will not mechanically generate a cash receipt document as long as errors are present.

The following example shows a completed CASH COLLECTION INPUT TABLE.

SEE EXHIBIT 44

- D. Approving the Cash Receipt Document Generated from Completion of the CCIT Screen - Cash receipt documents generated in PARS from completion of CCIT screens require approval and scheduling for processing. Generally, a cash receipt document which is created through CCIT completion one day will appear on the DOCUMENT SUSPENSE FILE INQUIRY (SUSF) table the following day.

The approval and scheduling process for cash receipt documents generated from CCIT screen completion is the same as for the cash receipt document created through document screen series completion. Refer to RCM 9.10.77 and 78 for instructions on the approval and scheduling process.

9.10.80 Creating A Cash Receipt Document Using The Recurring Cash Receipt Table (RECR) Screen

Where partial or full annuity withholding is the method which will be used to offset an open accounts receivable record, a cash receipt document is generated through completion of the RECURRING CASH RECEIPT TABLE (RECR) screen. Unlike cash receipt documents created through completion of the document screen series or those mechanically generated from CCIT, cash receipt documents created from RECR do not require approval or scheduling for processing.

Both the PAYOR NUMBER and the BILLING DOCUMENT IDENTIFICATION NUMBER assigned to the overpayment when the accounts receivable record was established must be known to complete a RECR screen. If a copy of the G-421 series, method of recovery selection does not contain these identifiers or the folder does not contain this information, RCM 9.10.71 provides instructions for securing these keys.

It is essential that the RECR screen be completed timely because the date entered in the OFFSET BEGIN DT field can only be the current or a future date. If the RECR screen is not completed until after withholding is in force, paragraph E of this section provides instructions for this situation.

- A. Accessing the RECR Screen - The RECR screen is accessed as follows.
- Sign on to the PAR System as described in RCM 9.10.50.
 - Type MTI, leave one space, then type the table code name RECR.

- Press ENTER.
- A blank RECURRING CASH RECEIPT TABLE screen will appear.

SEE EXHIBIT 45

- B. Completing the RECR Screen - Make the follow entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	<p>When the RECR screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.</p> <ul style="list-style-type: none"> • The ACTION field will be prefilled with an S, which means Scan Record. • Type A for Add Record over the S. • The cursor will advance to the TABLEID field.
TABLEID:	<p>The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.</p>
USERID:	<p>Enter your four character PARS user identification code and your four character PARS password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.</p>
PAYOR NUMBER:	<p>Enter the Payor Number which was established on the billing document when the accounts receivable record, which is being offset by partial or full annuity withholding, was established. The cursor will advance to the next field. This field was previously titled PAYOR CODE.</p>
BILLING DOC ID:	<p>Enter the Billing Document Identification Number which was assigned when the accounts receivable record, which is being offset by partial or full annuity withholding was established. <u>Always</u> enter B2 in the first two positions of this field. The cursor will advance to the remaining 11 positions. Upon completion of the document number field, the cursor will advance to the ACTION OUT field.</p>

CAPTION	ENTRY
ORIG O/P FOR OFFSET:	This item is completed from information contained within PARS. The cursor will skip over this field.
CURRENT	BALANCE: This item is completed from information contained within PARS. The cursor will skip over this field.
ACTION OUT:	<p>Enter one of the following codes which describes how recovery is being made.</p> <ul style="list-style-type: none"> • 11B Partial annuity withholding. • 11C Full annuity withholding.
CURRENT OFFSET AMT:	<p>Enter the recurring withholding amount. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> enter a dollar sign. Use the TAB key to advance to the next field.</p>
OFFSET BEGIN DT:	<p>Enter the month, day and year of the check issue date partial or full annuity withholding is effective. Precede single digit month and day entries with a zero. EXAMPLE: 03 01 90.</p> <p>NOTE: The OFFSET BEGIN DT entered in this field <u>cannot</u> be prior to the calendar date on which the RECR screen is completed. It <u>can</u> be a future date. If annuity withholding is to be effective with the payment issued on July 1, the RECR screen can be completed on July 1 or anytime prior with an OFFSET BEGIN DT of 07 01. If annuity withholding was effective with the payment issued on July 1, but the RECR screen was not established by that date, 08 01 must be entered in the OFFSET BEGIN DT field. Paragraph E of this section provides instructions for special handling when the RECR screen is completed after withholding is in effect.</p>
LAST OFFSET MADE DT:	This item is completed from information contained within PARS. The cursor will skip over this field.
TRANS TYPE:	Always enter the letters AW in this field. The cursor will advance to the next field.
ORIG OFFSET MONTHS:	Enter the number of months partial or full annuity withholding will be in force. This is a three position field. Inasmuch as withholding will rarely be in force for more than 48 months, enter zeros in the first two positions as necessary.

CAPTION	ENTRY
	EXAMPLES: 048, 007. The cursor will advance to the HOLD IND field.
APPLIED OFFSET MONTHS:	This item is completed from information contained within PARS. The cursor will skip over this field.
HOLD IND:	Make no entry in this field. Use the TAB key to advance to the next field. If withholding must be suspended for any reason, see paragraph E of this section for special instructions.
CASH ACCT:	Make no entry in this field. Use the TAB key to advance to the next field.
ARCHIVE FLAG:	Make no entry in this field when the RECR screen is being established. This field is only completed once partial or full annuity withholding has been completed and the CURRENT BALANCE field on this screen has been reduced to zero. Paragraph D of this section provides instructions for completing this entry once recovery through annuity withholding has been completed.

- C. Exiting from the RECR Screen - After completing the ORIG OFFSET MONTHS field, review the information you have entered on the RECR screen to verify that these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.
1. Establishing the RECURRING CASH RECEIPT TABLE - When all required entries have been completed and all information is correct, press ENTER. The message *LO30 ALL LINES ADDED will be displayed in the message area of the screen indicating the RECURRING CASH RECEIPT TABLE has been established. Approval and scheduling of the RECR screen are not necessary. Pressing ENTER and having the above message displayed on the screen will establish this table in PARS. Each month, a cash receipt document will be mechanically generated for the withholding amount entered in the CURRENT OFFSET AMT field until the open balance has been reduced to zero.
 2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area at the bottom of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s)

or position(s) and complete the required entry as indicated. Continue to press ENTER and make any required corrections until the message *LO30 ALL LINES ADDED is displayed in the message area of the screen. It is important that all errors are corrected and all required entries are completed on the RECR screen. PARS will not mechanically process and generate a recurring cash receipt document as long as errors are present.

The following example shows a completed RECURRING CASH RECEIPT TABLE.

SEE EXHIBIT 46

The ORIG O/P FOR OFFSET, CURRENT BALANCE, HOLD IND, ARCHIVE FLAG, PEN %, ADMN COST and INT % fields in the data area of the screen will be filled with information derived from the PAR System.

- D. Archiving the RECURRING CASH RECEIPT TABLE - The final cash receipt document generated from the RECR table will be for the remaining amount of the open balance. Once the CURRENT BALANCE field has been reduced to zero, and the claim is recertified to remove partial or full annuity withholding, the RECURRING CASH RECEIPT TABLE must be archived. This is accomplished as follows:

- Sign on to the PAR System as described in RCM 9.10.50.
- Type MTI, leave one space, then type the table code name RECR.
- Press ENTER. A blank RECURRING CASH RECEIPT TABLE screen will be displayed. The ACTION and TABLEID fields will contain the correct entries.
- Enter your PARS password and user identification code following the USERID caption on the action line of the screen.
- Complete the PAYOR CODE and BILLING DOC ID on the key line of the screen.
- Press ENTER. The RECURRING CASH RECEIPT TABLE for the PAYOR CODE and BILLING DOC ID you entered on the key line of the screen will be displayed.
- Type C for Change Record over the R in the ACTION field on the action line of the screen.
- Use the TAB key to move the cursor to the ARCHIVE FLAG field.
- Type Y for yes over the N appearing in the ARCHIVE FLAG field.

- Press ENTER. The following two messages will be displayed in the message area at the bottom of the screen.
 - 01 - PP01W DVAL TABLE ENTRY NOT FOUND
 - 01 - *LO31 ALL LINES CHANGED

An example of a RECURRING CASH RECEIPT TABLE in which the ARCHIVE FLAG has been set appears below.

SEE EXHIBIT 47

When the RECURRING CASH RECEIPT portion of PARS is processed, this record will be archived and will no longer be displayed as a table screen.

E. Special Situations

1. Annuity Suspended While Partial or Full Annuity Withholding is in Effect -
Occasionally, it may be necessary to suspend an annuity from which deductions are being made to recover an overpayment. Because PARS does not interface with the payment systems, PARS must also be alerted if an annuity is suspended from which partial or full annuity withholding is in force. This is accomplished by changing the HOLD IND field on the RECURRING CASH RECEIPT TABLE (RECR). Take the following actions.
 - Sign on to the PAR System as described in RCM 9.10.50.
 - Type MTI, leave one space, then type the table code name RECR.
 - Press ENTER. A blank RECURRING CASH RECEIPT TABLE screen will be displayed. The ACTION and TABLEID fields will contain the correct entries.
 - Enter your PARS password and user identification code following the USERID caption on the action line of the screen.
 - Complete the PAYOR NUMBER and BILLING DOC ID on the key line of the screen.
 - Press ENTER. The RECURRING CASH RECEIPT TABLE for the PAYOR CODE and BILLING DOC ID you entered on the key line of the screen will be displayed.
 - Type C for Change Record over the R in the ACTION field on the action line of the screen.
 - Use the TAB key to move the cursor to the HOLD IND field.

- Type Y for yes over the N appearing in the HOLD IND field.
- Press ENTER. The following two messages will be displayed in the message area at the bottom of the screen.
 - 01 - PP01W DVAL TABLE ENTRY NOT FOUND
 - 01 - *LO30 ALL LINES CHANGED

NOTE: If the HOLD IND field is not completed timely, any cash receipt document(s) posted in error must be cancelled. Check the ACCOUNTS RECEIVABLE CASH RECEIPT LINE (ARCL) screen to determine if any erroneous cash receipts were posted and to obtain the Cash Receipt Document (C2) Number.

An example of a RECURRING CASH RECEIPT TABLE in which the HOLD IND has been set to Y appears below.

SEE EXHIBIT 48

Once the annuity has been returned to pay status, the HOLD IND must be changed back to N. This is accomplished by the same procedure as outlined above for changing the HOLD IND to Y.

2. RECURRING CASH RECEIPT TABLE Created After Partial or Full Annuity Withholding Has Gone into Effect - As stated earlier, the date entered in the OFFSET BEGIN DT cannot be prior to the calendar date on which the RECR screen is being completed. In the event the RECR screen is not completed until after one or more months of annuity withholding have occurred, take the following actions.

- a. Complete the CASH COLLECTION INPUT TABLE

- Calculate the amount which has been recovered from annuity payments prior to establishment of the RECR screen.
- Complete a CCIT screen as described in RCM 9.10.79.
 - Enter the amount withheld from annuity payments in the TOTAL PAYMENT field.
 - Enter AW for annuity withholding in the TRANS TYPE field.
 - Enter one of the following codes in the ACTION OUT field.
 - 11B Partial Annuity Withholding.
 - 11C Full Annuity Withholding.

- Have the completed CCIT generated cash receipt document approved and scheduled for processing.

b. Complete the RECURRING CASH RECEIPT TABLE

- Determine the total number of months annuity withholding has been in force prior to completion and processing of the RECR screen.
- Complete a RECR screen as described in paragraph B of this section.
 - Enter the first day of the next monthly annuity payment from which full or partial withholding will be applied in the OFFSET BEGIN DT field.
 - Enter the total number of months partial or full withholding will be applied, reduced by the number of months recovery has already been made prior to establishment of the RECR screen, in the ORIG OFFSET MONTHS field.
- The CURRENT BALANCE field, which is filled by the system, will reflect the amount which was recovered and processed through completion of the CCIT screen prior to establishment of the RECR screen.

3. Annuity Withholding and Simultaneous Recovery through Installment Billing - Occasionally, because of the amount of an overpayment, full annuity withholding may be in force. At the same time, the annuitant may have agreed to remit a certain amount each month in order to reduce the overpayment. Because both an INSTALLMENT BILLING AND PAYMENT TABLE (INBT), used to produce monthly billing statements, and a RECURRING CASH RECEIPT TABLE (RECR) cannot exist at the same time, examiners must complete the RECR screen. The CURRENT BALANCE field on the RECR screen will reflect the amount recovered by annuity withholding as well as the cash amount remitted each month. Following completion of the RECR screen, examiners must forward the claim folder to the Overpayment and Recovery Section. Since installment billing notices cannot be generated by PARS in these situations, OPR will control the case and manually trace on installment payments when necessary.

9.10.81 Creating A Cash Receipt Document Using The Write-Off Table (WROT) Screen

The Write-Off Table (WROT) is used to mechanically create a cash receipt document which will transfer open accounts receivable records from PARS to the uncollectible

account. Only claims examiners in the Overpayment Recovery Section (OPR) have access to enter or change records on this table. Accounts receivable records which have not had any collection activity posted to them for 60 days from the delinquency date will automatically default to WROT. In order for records appearing on WROT to actually be transferred to uncollectible, OPR examiners must change the write-off flag and reason code and complete the action out code. Receivables to be transferred to uncollectible which do not appear on WROT can also be added to this table.

When transferring amounts to uncollectible, it is essential that the PAYOR TABLE contains the name of the person responsible for the debt as opposed to RECLAMATION, ESTATE DEVELOPMENT, etc. Paragraph E of this section provides instructions for correcting the payor name if necessary.

A. Accessing the WROT Screen - The WROT screen is accessed as follows.

- Sign on to the PAR System as described in RCM 9.10.50.
- Type MTI, leave one space, then type the table code name WROT.
- Press ENTER.
- A blank WRITE-OFF TABLE screen will appear.

SEE EXHIBIT 49

B. Transferring Existing WROT Records to Uncollectible - To transfer an existing accounts receivable record to uncollectible, make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields beginning with ACTION and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the WROT screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen. The ACTION field will be prefilled with an S, which means Scan Record. Use the TAB key to advance to the next field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four character PARS user identification code and your four character PARS password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.

CAPTION	ENTRY
PAYOR NUMBER:	Enter the prefix and claim number of the railroad employee. Precede serial claim numbers with zeros. The cursor will advance to the identifier position of the PAYOR NUMBER field. <u>DO NOT</u> make any entry in this field. This field was previously titled PAYOR ID.

After completing the PAYOR NUMBER field on the WROT screen, press ENTER. The WRITE-OFF TABLE record for the railroad claim number entered in the PAYOR NUMBER field will be displayed on line 01 of the screen.

SEE EXHIBIT 50

The PAYOR NUMBER, BD ID, TOTAL BILL AMOUNT, LAST DUN DATE, WRITEOFF FLAG and RSN fields will be filled with data contained within PARS.

To transfer the existing record to uncollectible, make the following entries next to or below the captions displayed on the screen.

NOTE: Caution must be exercised when changing existing fields and completing required entries while in the CHANGE mode, as all records displayed on the screen are subject to change.

CAPTION	ENTRY
ACTION:	<p>When the WROT screen for the PAYOR ID you entered above is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.</p> <ul style="list-style-type: none"> • The ACTION field will be prefilled with an R which means Refill Record. • Type C for Change Record over the R. • The cursor will advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	The USERID field will contain your PARS identification code and PARS password. (Your password will not be displayed on the screen.) Use the TAB key to advance to the next field.

CAPTION	ENTRY
PAYOR NUMBER:	<p>Make no entry in this field (previously titled PAYOR ID). Use the TAB key to advance to the next field.</p> <p>NOTE: Line 01 in the data area of the WROT screen will contain the first record for the railroad employee's claim number you entered above. If more than one record for a claim number is shown, use the NEW LINE key to position the cursor on the data line for the Billing Document Identification Number and Total Bill Amount which is to be transferred to uncollectible.</p>
BD ID:	Make no entry in this field. Use the TAB key to advance to the next field.
TOTAL BILL AMOUNT:	Make no entry in this field. Use the TAB key to advance to the next field.
LAST DUN DATE:	Make no entry in this field. Use the TAB key to advance to the next field.
OVER DUE STAT:	Make no entry in this field. Use the TAB key to advance to the next field.
WRITEOFF FLAG:	This field will be prefilled with an N, which means No. Type Y for YES over the N. The cursor will advance to the next field.
WRITEOFF RSN:	<p>This field will be prefilled with an A, which means Uncollectible - OPR. Select a Write-Off Reason Code from the list below which best describes the reason for transfer to uncollectible. Type this code over the A. The cursor will advance to the next field.</p> <p>A Uncollectible - OPR</p> <p>B Uncollectible - BH&A</p> <p>C Uncollectible - Reclamation Abandoned</p> <p>D Uncollectible - Statute of Limitations Expired on Reclamations</p> <p>E \$500 Waiver/Reconsideration Uncollectible</p> <p>F Relief from Recovery</p>

CAPTION	ENTRY
	If the WRITE OFF RSN code remains A, use the TAB key to advance to the next field.
ACT OUT:	<p>Enter one of the following three position codes which best describes the reason for transfer of the accounts receivable to uncollectible.</p> <p>18A Uncollectible - OPR</p> <p>18B Uncollectible - BH&A</p> <p>18C Uncollectible - Reclamation Abandoned</p> <p>18D Uncollectible - Statute of Limitations Expired on Reclamation</p> <p>18E \$500 Waiver/Reconsideration Uncollectible</p> <p>18F Relief from Recovery</p>

An example of a completed WRITE-OFF TABLE in which the record appearing on line 01 in the data area of the screen has been changed for transfer to uncollectible appears below.

SEE EXHIBIT 51

- C. Adding a Record to the WROT Screen - To add a record to the Write-Off Table, make the following entries next to or below the captions displayed on a blank WROT screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	<p>When the WROT screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.</p> <ul style="list-style-type: none"> • The ACTION field will be prefilled with an S, which means Scan Record. • Type A for Add Record over the S. • The cursor will advance to the TABLEID field.

CAPTION	ENTRY
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four character PARS user identification code and your four character PARS password. (Your password will not be displayed on the screen.) The cursor will advance to the next field.
PAYOR NUMBER:	Enter the prefix and railroad claim number which was assigned as the PAYOR NUMBER when the accounts receivable record was established. Precede serial claim numbers with zeros. The cursor will advance to the identifier position. Enter the identifier which was assigned when this record was established. This field was previously titled PAYOR ID. The cursor will advance to the next field.
BD ID:	<u>Always</u> enter B2 in the first two positions of this field. The cursor will advance to the remaining 11 positions. Enter the Billing Document Identification number assigned when the accounts receivable record was established. The cursor will advance to the next field.
TOTAL BILL AMOUNT:	Enter the amount of the overpayment for the accounts receivable record which is being transferred to uncollectible. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> use a dollar sign. Use the TAB key to advance to the next field.
LAST DUN DATE:	Make no entry in this field. Use the TAB key to advance to the next field.
OVER DUE STAT:	Make no entry in this field. Use the TAB key to advance to the next field.
WRITEOFF FLAG:	<u>Always</u> enter a Y for YES in this field. The cursor will advance to the next field.
WRITEOFF RSN:	<p>Enter the one position code from the list below which best describes the reason for transfer of this record to uncollectible. The cursor will advance to the next field.</p> <p>A Uncollectible - OPR</p> <p>B Uncollectible - BH&A</p>

CAPTION	ENTRY
	C Uncollectible - Reclamation Abandoned D Uncollectible - Statute of Limitations Expired on Reclamations E \$500 Waiver/Reconsideration - Uncollectible F Relief from Recovery
ACT OUT:	Enter one of the following three position codes which best describes the reason for transfer of this record to uncollectible. 18A Uncollectible - OPR 18B Uncollectible - BH&A 18C Uncollectible - Reclamation Abandoned 18D Uncollectible - Statute of Limitations Expired on Reclamation 18E \$500 Waiver/Reconsideration - Uncollectible 18F Relief from Recovery

A maximum of 13 records to be transferred to uncollectible can be added on one WROT screen.

An example of a completed WRITE-OFF TABLE adding a record for transfer to uncollectible, appears below.

SEE EXHIBIT 52

- D. Exiting from the WROT Screen - After completing the ACT OUT field, review the entries you have changed or added to the WROT screen to verify these entries are correct. If any errors are detected, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.
1. Establishing the WRITE-OFF TABLE - When all required entries have been completed or changed and all information is correct, press ENTER. Where the ACTION field was completed with an A, and a record was added to this table, the message *L030 ALL LINES ADDED will be displayed in the message area of the screen. Where the ACTION field was completed with a C, and an existing record was changed, the

message *L031 ALL LINES CHANGED will be displayed in the message area of the screen. The display of one of these messages indicates the WRITE-OFF TABLE has been established. Approval and scheduling of the WROT screen are not necessary. Pressing ENTER and having one of the above messages displayed on the screen will establish this table in PARS. A cash receipt document will be mechanically generated to reduce the open accounts receivable balance by the amount displayed under the TOTAL BILL AMOUNT caption and transfer this amount to uncollectible.

2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area at the bottom of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to be taken. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry as indicated. Continue to press ENTER and make corrections until one of the messages described in D1 is displayed in the message area of the screen. It is important that all errors are corrected and all required entries are completed on the WROT screen. PARS will not mechanically process a cash receipt document and transfer an amount to uncollectible as long as errors are present.

The following example shows a completed WRITE-OFF TABLE to which a record was added.

SEE EXHIBIT 53

The following example shows a completed WRITE-OFF TABLE where an existing record was changed.

SEE EXHIBIT 54

- E. Special Situation - When transferring amounts to uncollectible, it is essential that the name of the individual responsible for the debt is contained on the PAYOR TABLE. If the PAYOR NAME field contains an asterisk, reclamation, estate development, or anything other than the payor name, it will be necessary to correct this field prior to creating a cash receipt document through WROT completion. Both a corrected PAYOR TABLE and a modified billing document are required.

1. Correcting the PAYOR TABLE
 - Sign on to the PAR System as described in RCM 9.10.50.
 - Type MTI, leave one space, then type the table code name PAYR.

- Press ENTER. A blank PAYOR TABLE screen will be displayed. The ACTION and TABLEID fields will contain the correct entries.
- Enter your PARS password and user identification code following the USERID caption on the action line of the screen. The cursor will advance to the PAYOR CODE field.
- Enter the PAYOR NUMBER for the record which requires correction in the PAYOR NUMBER field on the key line of the screen.
- Press Enter. The PAYOR TABLE for the PAYOR NUMBER you entered on the key line of the screen will be displayed.
- Type C for Change Record over the R in the ACTION field on the action line of the screen.
- Use the TAB key to move the cursor to the PAYOR NAME field. Type the correct name over the entry which is currently displayed in this field.
- Press ENTER. The following message will be displayed in the message area of the screen.
 - 01 - *L031 ALL LINES CHANGED

2. Creating a Modified Billing Document - Following correction of the PAYOR TABLE as described above, the billing document must be modified.

- When the message "01-*L031 ALL LINES CHANGED" is displayed on the corrected PAYOR TABLE screen, the cursor will be positioned in the ACTION field on the action line of the screen. Type E for Exit in the ACTION field. Press ENTER. The message "V2 ENTER NEXT TASK CODE:" will be displayed on the screen.
- Type DDB. Press ENTER. A blank STARTUP screen will be displayed.
- Complete the STARTUP screen as described in RCM 9.10.58. Enter the Document ID for the billing document which requires modification.
- Press ENTER. A blank BILLING DOCUMENT INPUT SCREEN for the billing document number entered on the STARTUP screen will be displayed.
- Type M for Modify in the ACTION field on the action line of the screen.
- Press ENTER.

- Perform QUICK EDIT as described in RCM 9.10.61.
- Hold the modified Billing Document for approval as described in RCM 9.10.62.
- Approve the modified Billing Document as described in RCM 9.10.63.
- Schedule the modified Billing Document as described in RCM 9.10.64.

After the modified Billing Document has been processed, the WRITE-OFF TABLE can be completed to create a cash receipt document to transfer amounts to uncollectible.

9.10.82 Completing the Installment Billing and Payment Table (INBT)

The Railroad Retirement Board primarily allows installment payment plans with individuals who are indebted to the RRB and who do not have continuing entitlement to an annuity. Occasionally, an annuitant in current pay status may request an installment payment plan rather than partial or full annuity withholding as the method of recovery for a debt. Completion of the INSTALLMENT BILLING AND PAYMENT TABLE in these situations provides for mechanical release of monthly installment billing notices. Establishment of this table is the responsibility of BFO-DRD.

A. Accessing the INBT Screen - To access the INSTALLMENT BILLING AND PAYMENT TABLE (INBT) screen, take the following actions:

- Sign on to the PAR System as described in RCM 9.10.50.
- Type MTI, leave one space, then type the table code name INBT.
- Press ENTER.
- A blank INSTALLMENT BILLING AND PAYMENT TABLE screen will appear.

SEE EXHIBIT 55

B. Completing the INBT Screen - Make the following entries below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When you access the INBT screen, the cursor will be positioned in the ACTION field on the action line of the screen.

	<ul style="list-style-type: none"> The ACTION field will be prefilled with an S which means Scan Record.
	<ul style="list-style-type: none"> Type A for Add Record over the S.
	<ul style="list-style-type: none"> The cursor will advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four-character PARS user identification code and your four-character PARS password. (Your password is not displayed on the screen.) The cursor will advance to the next field.
PAYOR NUMBER:	Enter the PAYOR NUMBER of the debtor for whom you are establishing this installment payment plan. The cursor will advance to the next field.
BILLING DOC ID:	Enter the Billing Document Identification Number that represents the overpayment that is being recovered through an installment payment plan. The cursor will advance to the next field.
EFFECTIVE DATE:	Completion of this field is optional. If there is nothing entered, the system will default to the current date. If this field is completed, it must be in month, day, year sequence; it must be a valid calendar date and must be a current or future date. Precede single digit month and day entries with zeros. If this item is completed, the cursor will advance to the INST AMT field, otherwise use the TAB key to advance the cursor.
	NOTE: The only reason for completing this field when initially establishing this table would be if the installment billing notices are to be released on a future date.
ORIGINAL INST DEBT:	The system will display the original overpayment amount. The cursor will skip over this field.
CURRENT BALANCE:	The system will display the current outstanding amount. The cursor will skip over this field.
INST AMT:	Enter the amount the debtor has agreed to repay each month. You must use a decimal point and complete this entry to two decimal places. <u>DO NOT</u> enter a dollar sign.

INT %:	The system will display the current interest percent. The cursor will skip over this field.		
PEN %:	The system will display the current penalty percent. The cursor will skip over this field.		
ADMIN COST:	The system will display the current administrative costs. The cursor will skip over this field.		
ACT IND:	Make no entry in this field when initially completing this table. The system will default to a Y which means installment bills will automatically be generated. When the CURRENT BALANCE field reaches zero, this flag will change to an N, and installment bills will no longer be generated.		
TEXT:	Type one of the following two position codes depending upon the text you want incorporated into the installment billing notice.		
	•	TA	Use when the overpayment is subject to interest and penalty.
	•	TC	Use when interest and penalty charges do not apply to this overpayment.

The balance of this screen contains space for display of the history of installment billing notices released and monies received against each installment. An installment line is added mechanically to this portion of the screen each time an installment bill is released and each time a cash receipt is received and processed. The cash received is always used to offset the oldest installment bill. An example of a completed INSTALLMENT BILLING AND PAYMENT TABLE appears below.

SEE EXHIBIT 56

- C. Exiting from the INBT Screen - After completing the last required entry on the INBT screen, review the information that you have entered to verify that these entries are correct. If you detect any errors, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.
1. Establishing the INSTALLMENT BILLING AND PAYMENT TABLE - When all required entries have been completed and all information is correct, press ENTER. The message *L030 ALL LINES ADDED will be displayed in the message area of the screen indicating the INSTALLMENT BILLING

AND PAYMENT TABLE has been established. The ORIGINAL INST DEBT, CURRENT BALANCE, INT%, PEN%, ADMIN COST and ACT IND fields will be filled by the system. This table does not require approval or scheduling in order for it to be established.

2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to take. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry as indicated. Continue to press ENTER and make any required corrections until the message *L030 ALL LINES ADDED is displayed in the message area of the screen. It is important that you correct all errors and complete all required entries on the INBT screen. Installment billing notices are not mechanically generated as long as errors are present.

The following example shows a completed INSTALLMENT BILLING AND PAYMENT TABLE.

SEE EXHIBIT 57

A copy of an installment billing notice generated from completion of the INSTALLMENT BILLING AND PAYMENT TABLE appears below.

SEE EXHIBIT 58

D. Special Situations

1. Suspension of Release of Installment Billing Notice - If for some reason the monthly installment billing notice should not be released, take the following actions.
 - Access the INBT screen as described in RCM 9.10.82A.
 - Enter your USERID on the action line of the screen.
 - Enter the PAYOR NUMBER and BILLING DOC ID for the installment billing notice to be suspended on the key line of the screen.
 - Press ENTER. The INBT for the PAYOR NUMBER and BILLING DOC ID entered above will be displayed.
 - Type C for Change over the R for Refill in the ACTION field on the action line of the screen.
 - Use the TAB key to position the cursor in the ACT IND field at the end of the first line in the data area of the screen.

- Type N for No over the Y currently appearing in this field.
- Press ENTER. The message *L031 ALL LINES CHANGED will be displayed in the message area of the screen.

When installment billing notices should again be released, the ACT IND must be changed to Y for yes.

2. Change in the Installment Billing Amount

- a. Accounts Receivable Record is NOT Delinquent or in Default - In the event an individual who is making installment payments requests that the installment amount be increased or decreased, take the following actions.
 - Access the INBT screen as described in RCM 9.10.82A.
 - Enter your USERID on the action line of the screen.
 - Enter the PAYOR NUMBER and BILLING DOC ID for the record that requires a change in the installment bill amount, on the key line of the screen.
 - Press ENTER. The INBT for the PAYOR NUMBER and BILLING DOC ID entered above will be displayed.
 - Type C for Change over the R for Refill in the ACTION field on the action line of the screen.
 - Use the TAB key to position the cursor in the INST AMT field in the middle of the first line in the data area of the screen.
 - Type the new installment bill amount over the figure currently appearing in this field. You must use a decimal point and complete this entry to two decimal places. DO NOT enter a dollar sign. Use the SPACE BAR to erase any portions of the previous amount that may remain after entry of the new installment bill amount.
 - Press ENTER. The message *L031 ALL LINES CHANGED will be displayed in the message area of the screen.
- b. Accounts Receivable Record Is Delinquent or in Default - In the event that an individual who was making installment payments and whose account is delinquent or in default requests a change in the monthly installment amount, take the following actions.
 - Access the INBT screen as described in RCM 9.10.82A.

- Enter your USERID on the action line of the screen.
- Enter the PAYOR NUMBER and BILLING DOC ID for the record that requires a change in the installment bill amount, on the key line of the screen.
- Press ENTER. The INBT for the PAYOR NUMBER and BILLING DOC ID entered above will be displayed.
- Type C for Change over the R for Refill in the ACTION field on the action line of the screen.
- Use the TAB key to position the cursor in the EFFECTIVE DATE field on the key line of the screen. Enter the current date or the date the installment bill at the new amount should be released. Precede single digit months and days with zeros. This date can only be the current or a future date.

NOTE: If no notice of delinquent debt has been produced, (no DN shown on this ARCL record), the first installment bill (IB) for the changed amount will be dated approximately 30 days from the LAST BILL DATE displayed on the ARHT for this record. If a notice of delinquent debt has been produced (DN is displayed on this ARCL record), the first installment bill for the changed amount will be dated with the EFFECTIVE DATE entered in this field.

- Use the TAB key to position the cursor in the INST AMT field in the middle of the first line in the data area of the screen.
- Type the new installment bill amount over the figure currently appearing in this field. You must use a decimal point and complete this entry to two decimal places. DO NOT enter a dollar sign. Use the SPACE BAR to erase any portions of the previous amount that may remain after entry of the new installment bill amount.
- Change the ACT IND to Y for yes if an N for no is currently displayed in this field.
- Press ENTER. The message *L031 ALL LINES CHANGED will be displayed in the message area of the screen.
- A modified Billing Document may also be required to change the WAIVER FLAG if necessary.

9.10.83 Completing the Waiver of Recovery Table (WAIV)

All billing documents which result in the establishment of an open accounts receivable record also establish a record on the WAIVER OF RECOVERY TABLE. For those overpaid annuitants or former annuitants that exercise their due process rights, this table is completed by personnel in the Reconsideration Section, BFO-DRD, or perhaps the Bureau of Hearings and Appeals, depending on the type of request received. When completed, information on this table indicates the status of a particular case in the appeals process. Where the request is subsequently denied, completion of the WAIVER DECISION DATE field determines when interest and penalties will again begin to accrue if applicable.

A. Accessing the WAIV Screen – Access the WAIV screen as follows.

- Sign on to the PAR System in the usual manner.
- Enter “N” in the “ACTION” field, then enter the table code name “WAIV” in the “TABLEID” field.
- Press ENTER.
- A blank WAIVER OF RECOVERY TABLE screen will appear.

B. Securing the Document Requesting Waiver - Since the WAIV table contains the billing document numbers for all established accounts receivable records, scanning the entire WAIV table to arrive at a particular document is avoided by making the following entries on a blank WAIV screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the WAIV screen is accessed, the cursor will be positioned in the ACTION field on the action line of the screen.
	<ul style="list-style-type: none"> • The ACTION field will be prefilled with an S, which signifies Scan Record.
	<ul style="list-style-type: none"> • Type G for Get Record over the S.
	<ul style="list-style-type: none"> • The cursor will advance to the TABLEID field.

TABLE:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	Enter your four-character PARS user identification code and your four-character PARS password. (Your password is not displayed on the screen.) The cursor will advance to the next field.
BILLING DOC ID:	Always enter B2 in the first two positions of this field. The cursor will advance to the remaining 11 positions of this field. Enter the 11-position billing document identification number for the accounts receivable record that has had a request for review, reconsideration, waiver, or appeal filed against it.

After completing the BILLING DOC ID field on line 01 in the data portion of the screen, press ENTER. THE BILLING DOC ID and PAYOR NUMBER for the accounts receivable record you requested is displayed on line 01.

- C. Completing the WAIV Screen - Make the following entries next to or below the captions displayed on the screen. The cursor will place you in the first position of each of the data entry fields and will move through the screen in the following order.

CAPTION	ENTRY
ACTION:	When the WAIV table for the billing document requested in B above is displayed on the screen, the cursor will be positioned in the ACTION field on the action line of the screen.
	<ul style="list-style-type: none"> The ACTION field is prefilled with an R, which means Refill Record.
	<ul style="list-style-type: none"> Type C for Change Record over the R.
	<ul style="list-style-type: none"> The cursor will advance to the TABLEID field.
TABLEID:	The TABLEID field will contain the correct table code name. Use the TAB key to advance to the next field.
USERID:	The USERID field will contain your PARS identification code and PARS password. (Your password is not displayed on the screen.) Use the TAB key to advance to the next field.

BILLING DOC ID:	The BILLING DOC ID field will contain the number of the accounts receivable record for which the annuitant has requested review, reconsideration, waiver, appeal, etc. Use the TAB key to advance to the WAIVER EXPIRATION field. Because the BILLING DOC ID field is a split field, it will be necessary to depress the TAB key twice to advance the cursor.
	NOTE: The cursor will skip over the PAYOR NUMBER field because it is also prefilled.
DELINQUENCY DATE:	If the BILL PRINT FLAG indicator entered on the BILLING DOCUMENT INPUT Screen was an S, this field will be prefilled with a date 30 days from the Document Date. When this field is prefilled, use the TAB key to advance to the WAIVER REQUEST field.
	If the BILL PRINT FLAG indicator entered on the BILLING DOCUMENT INPUT Screen was an N, this field will be blank. Calculate the delinquency date by adding 30 calendar days to the date of the overpayment notice and enter it in this field. The date must be completed in month, day, year sequence. Precede single digit month and day entries with a zero. This date can be a past or a future date. When completed, the cursor will advance to the next field.
WAIVER REQUEST:	For those annuitants that exercise their due process rights, enter a Y in this field. The cursor will advance to the next field. In those cases where the BILL PRINT FLAG indicator on the BILLING DOCUMENT INPUT screen was an S, and the annuitant does not exercise their due process rights, this field will default to an N after the date shown in the WAIVER EXPIRATION field has passed.
	NOTE: Entry of a Y in this field will remove both the dunning count and the last dunning date from the ACCOUNTS RECEIVABLE HEADER TABLE (ARHT). In those situations where a waiver or reconsideration request is legitimately received late and interest, administrative costs and penalty are applicable, the OUTSTANDING BILLING DOCUMENT TABLE (OBDT) must be modified to suspend the assessment of these charges while the decision is being made.

WAIVER DECISION DATE:	When an annuitant exercises their due process rights, make no entry in this field. Use the TAB key to advance to the next field. Only complete this field after a decision has been made on the annuitant's request.	
STAT:	Enter the two position code from the list below which best describes the due process request.	
	R0	OP Readjudication Pending
	R1	RECON Review of the Facts
	R2	RECON Review and Waiver
	R3	DRD Waiver Only
	R4	DCIA Debt Review
	R5	DRD Review/Waiver from RECON
	R6	DRD General Debt Review
	R7	BHA Appeal
	R8	Board Appeal
	R9	Court Appeal
	D*	Reset Collected Due Date
	DA	Readjudication Completed
	DB	Relief From Recovery
	DC	Waiver/Recon Request Withdrawn
	DD	General – Debtor Deceased
	DE	Entered in Error
	DF	DRD Waived in Full
	DG	DRD Waived in Part
	DH	DRD Denial
	DI	Recon Reversed in Full

	DJ	Recon Reversed in Part
	DK	Recon Affirmed
	DL	BHA Waived in Full
	DM	BHA Waived in Part
	DO	BHA Denied
	DP	BHA Dismissed
	DQ	Board Waived in Full
	DR	Board Waived in Part
	DS	Board Denied
	DT	Board Dismissed
	DU	Court Waived in Full
	DV	Court Waived in Part
	DW	Court Denied
	DX	Court Dismissed
	DY	Miscellaneous
	GA	DCIA Review – Affirmed
	GB	DCIA Review – Corrected/Recall
	GC	DCIA Review – Compromised
	GD	DCIA Review – Compromise Declined
	GE	General Debt Review Completed
	The cursor will advance to the next field.	
STATUS CHANGE DATE:	You do not need to make an entry in this field. After you complete the status code field and press enter, the status change date will automatically update with the current date.	

- D. Exiting from the WAIV Screen - After completing the STATUS CHANGE DATE field, review the information you have entered on the WAIV screen to verify that these entries are correct. If you detect any errors, use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and enter the correct information.
1. Establishing the WAIVER OF RECOVERY TABLE - When all required entries have been completed and all information is correct, press "ENTER." The message *L031 ALL LINES CHANGED will be displayed in the message area of the screen indicating the WAIVER OF RECOVERY TABLE has been established. Approval and scheduling of the WAIV screen are not necessary. Pressing ENTER and having the above message displayed on the screen will establish this table in PARS. Completion of this table will prevent interest, penalty and administrative costs from accruing and will prevent the release of further dunning notices until the due process rights request has been disposed of.
 2. Errors Detected - If any errors are detected, or any required entries are not complete, an error or warning message(s) will be displayed in the message area at the bottom of the screen. Refer to Appendix A of this chapter for a description of the problem and corrective action to take. Use the TAB and ARROW keys to move the cursor to the incorrect field(s) or position(s) and complete the required entry as indicated. Continue to press ENTER and make any required corrections until the message *L031 ALL LINES CHANGED is displayed in the message area of the screen. It is important that you correct all errors and complete all required entries on the WAIV screen. Interest, penalty, and administrative cost will continue to accrue and be assessed and dunning notices will continue to be released in non-current entitlement cases as long as errors are present.
- E. Actions to be Taken and Completion of the WAIV Table Following a Decision on a Due Process Request - Once a decision has been reached concerning a due process request from an overpaid annuitant, changes to and completion of the WAIV Table are determined by the type and disposition of the request.
1. Full Waiver - Where waiver of the overpayment was requested and is granted, no further entries are required on the WAIV Table. Complete a cash receipt document (CR) or a cash collection input table (CCIT) to close out the open accounts receivable record.
 2. Waiver Denial or Partial Waiver Granted - Where waiver of the overpayment was requested and is denied or only partially granted, complete the WAIVER DENIAL NOTICE field on the WAIV Table.

- Sign on to the PAR System as described in RCM 9.10.50.
- Type MTI, leave one space, then type the table code name WAIV.
- Press ENTER. A blank WAIVER OF RECOVERY TABLE screen will be displayed.
- Type G for Get Record in the ACTION field on the action line of the screen. The TABLEID field will contain the correct entry.
- Enter your PARS password and user identification code following the USERID caption on the action line of the screen.
- Enter the billing document number for the accounts receivable record which has had waiver denied or only partially granted in the BILLING DOC ID field on line 01 in the data area of the screen.
- Press ENTER. The WAIVER OF RECOVERY TABLE for the accounts receivable record you requested will be displayed on the first line of the data area of the screen.
- Type C for Change Record over the R in the ACTION field on the action line of the screen.
- Use the TAB key to move the cursor to the WAIVER DECISION DATE field.
- Enter the month, day and year of the waiver or partial waiver denial notice. Precede single digit month or day entries with a zero. This date need not be current or in the future. Completion of this field will establish the collection due date 30 days after the date of the waiver denial notice. In non-current entitlement situations, dunning notices will be released and interest, penalty, and administrative cost will begin to accrue based on the completion of this field.
- Use the TAB key to move the cursor to the STATUS CHANGE DATE. Enter the actual month, day and year on which any change is made. Precede single digit month or day entries with a zero.
- Press ENTER. Display of the message *L031 ALL LINES CHANGED at the bottom of the screen indicates the system has accepted the change. In non-current entitlement situations, dunning notices will be released and interest, penalty and administrative cost will accrue and be assessed if payment in full is not received by the payment due date.

- Where partial waiver was granted, complete a cash receipt document (CR) or cash collection input table (CCIT) to decrease the accounts receivable record by the amount that was waived.
3. Review of the Facts and Personal Conference - Rarely will a review of the facts and/or a personal conference alone result in a determination that the entire amount of an overpayment is in error. Should that be the case, however, no further entries on the WAIV screen are required. Where a review of the facts results in a determination that the original decision and notification accurately described the overpayment, complete the WAIVER DENIAL NOTICE field on the WAIV table in the same manner as described for waiver denial in item 2 of this section. Where review of the facts reveals that the amount of the overpayment was incorrectly calculated, in addition to completing the WAIV table as above, the billing document must be modified to reflect the correct overpayment amount.

Entering a date in the WAIVER DENIAL NOTICE field enables the PAR system to establish a new collection due date which in turn drives release of dunning notices and the accrual and assessment of interest, administrative costs and penalty in those situations where it is applicable.

- F. Appeal of an Unfavorable Decision - Should an unfavorable decision be appealed to the Bureau of Hearings and Appeals (BHA), take the following actions. Also, take these actions if an unfavorable decision rendered by BHA is appealed to the Board, or ultimately the court.

- Sign on to the PAR system as described in RCM 9.10.50.
- Type MTI, leave one space, then type the table code name WAIV.
- Press ENTER. A blank WAIVER OF RECOVERY TABLE screen will be displayed.
- Type G for Get Record in the ACTION field on the action line of the screen. The TABLEID field will contain the correct entry.
- Enter your PARS password and user identification code following the USERID caption on the action line of the screen.
- Enter the billing document number for the accounts receivable record where an unfavorable review of the facts or waiver decision is now being appealed in the BILLING DOC ID field on line 01 in the data area of the screen.
- Press ENTER. The WAIVER OF RECOVERY TABLE for the accounts receivable record you requested will be displayed on the first line of the data area of the screen.

- Type C for Change Record over the R in the ACTION field on the action line of the screen.
- Use the TAB key to move the cursor to the WAIVER DENIAL NOTICE field. With the SPACE BAR, erase the date currently appearing in this field. The cursor will advance to the STAT field.
- Enter the two-position waiver status code which best describes the appeal request. The cursor will advance to the STATUS CHANGE DATE field.
- Press ENTER. Display of the message *L031 ALL LINES CHANGED at the bottom of the screen indicates the system has accepted the change. Removal of the date from the WAIVER DENIAL NOTICE field will prevent dunning notices from being released, and will prevent interest, penalty and administrative costs from accruing and being assessed while the request is under consideration.
- If a favorable decision is rendered by BHA, the Board, or the court, no further changes on the WAIVER OF RECOVERY TABLE are required. Process a cash receipt document (CR) on a cash collection input table (CCIT) to close out the accounts receivable record.
- If an unfavorable decision is rendered by BHA, the Board, or the court, the date of the notice advising the annuitant of the unfavorable decision must be entered in the WAIVER DENIAL NOTICE field. Completion of this field and processing of this change will establish a new collection due date which in turn will generate dunning notices and the accrual and assessment of interest, penalty and administrative costs were applicable.

9.10.100 Changing PARS Data

This section of RCM 9.10 deals with how to change data you are entering or that has already been established in the PAR system. This section contains information on:

- How to a change a document;
- What data is or is not changeable; and
- What data entries must be made for the method of change selected.

The following terms are used to describe the various kinds of changes you can make to documents. The terms are linked to the stage of processing a document is in.

1. Correction/Change - You can add, delete or replace incorrect data with correct data in unprocessed documents by making CORRECTIONS/CHANGES. (See RCM 9.10.101, and RCM 9.10.110 - 9.10.130)

2. Cancelling Out of a Document - You can remove a document from the PAR system and return to the STARTUP screen by CANCELLING OUT of the DOCUMENT. (See RCM 9.10.102).
3. Delete - You can remove a document from the PAR system after the document has been entered in the PAR system but before it has been processed by DELETING the document. (See RCM 9.10.122).
4. Modify - You can change some data in the PAR system that was established from a successfully processed document by MODIFYING the original BILLING DOCUMENT or CASH RECEIPT DOCUMENT.

(See RCM 9.10.131 through 9.10.140).
5. Cancel - You can purge almost all traces of a successfully processed document from the PAR system by CANCELLING the document. (See RCM 9.10.141).

Remember if you need to correct something in the PAR system be prompt and accurate. Delays and errors affect more than the information displayed on your terminal. Delaying correction of errors, or inaccurately correcting documents can cause:

- the dates given on manually released overpayment notices to be inaccurate,
- interest, penalty and administrative costs to be charged incorrectly,
- dunning letters to be released incorrectly and with erroneous information,
- additional work to correct errors and handle subsequent complaints,
- delays in collecting the overpayment.

In general, the principles on how make to changes, what changes to make and how to navigate through the system apply to any kind of document. If no difference is specified assume that procedure applies to both billing and cash receipt documents.

9.10.101 Changing Entries Before The Document Screen Is Entered Into The PAR System

Anytime you enter information on a document screen for the first time, you should review it carefully before pressing the ENTER key. If you notice an entry error, use the TAB and ARROW keys to move the cursor to the appropriate position(s) and make the necessary correction(s).

1. type in the entry you wish to make if the field or position is blank,
2. type over an erroneous entry with the correct entry, and/or

3. use the space bar to remove any entries from any fields or positions that should be blank.

Once you press the ENTER key you have officially created part of a document.

9.10.102 Cancelling Out Of The Document Before The Screen Is Entered Into The PAR System

You can CANCEL OUT of a document transaction you have just begun to enter if:

- the DOCUMENT INPUT screen is displayed on your terminal,
- a D is displayed in the MODE field of the document action line, and
- you have never pressed the ENTER key since entering the DOCUMENT INPUT screen.

When you are creating the document, once you access the line screen it is too late to CANCEL OUT.

Situations in which you would want to CANCEL OUT of a document are:

1. You notice in review that the DOCUMENT ID displayed on the DOCUMENT ACTION LINE is incorrect and you need to go back to the STARTUP SCREEN to correct it, or
2. You start entering a document and discover you don't have time to complete it and don't wish to leave a partially completed DOCUMENT INPUT SCREEN in the SUSPENSE FILE.

A. To CANCEL OUT of a document take the following steps:

- Position the cursor in the ACTION field on the document action line of the BILLING DOCUMENT INPUT SCREEN.
- Type X in the action field to CANCEL OUT of the document.
- Press the ENTER key.

B. Results of CANCELLING OUT of a document:

The PAR system returns to the screen viewed immediately before the DOCUMENT INPUT SCREEN was entered.

- The STARTUP screen will be displayed

- The MODE, DOCUMENT ID and USER ID fields will display the data they contained prior to your entering the DOCUMENT INPUT screen that you just CANCELLED OUT of.

You can now either correct your DOCUMENT ID and enter a fresh DOCUMENT INPUT screen, or exit the PAR system.

9.10.103 Using Quick Edit

System edits are mechanical checks on field entries made when processing, to prevent transactions containing bad data from entering the system. The PAR system has the capability of running a document against processing edits on request. This function is called QUICK EDIT.

For instructions on how to use the QUICK EDIT function please refer to RCM 9.10.61 for a billing document or 9.10.75 for a cash receipt document.

9.10.104 PAR System Document Edits

The following is a general list of PAR system edits. It is important to remember that there are limits to what this system can validate both because of its generic design (to be used by all government agencies) and because it is not possible for the system to determine the accuracy of some entries.

- It checks if a billing document or cash receipt document has been previously established with the same DOCUMENT ID. PARS will not allow two documents in the system at the same time with the same ID.
- If you are modifying or cancelling a document, it checks if that document exists in the system.
- It checks that any date entered is valid in the PARS DATE table.
- It checks that all money fields are completed using a decimal point followed by two positions, and with numeric characters only (no dollar signs, cent signs or commas can be entered).
- It verifies that the total amount of a document equals the total line activity of the document.
- It checks that these fields are valid in the CAUS, TYOP, SRCE and ACOT tables:
 - CAUSE CODE
 - TYPE OF OVERPAYMENT CODE
 - SOURCE CODE

- **ACTION OUT CODE**

It cannot validate that the correct code is being used. On a billing document CAUSE, TYPE and SOURCE are required entries. On a cash receipt document ACTION OUT is a required entry.

- It checks that entries made in action flag fields are valid manual entries for the field in question. If these fields are left blank your document will pass system edits because the system will supply default entries for these fields.

9.10.105 Edit Messages

The brief literal portion of the error message is sometimes self-explanatory and no further research is needed to determine the necessary correction. Sometimes the messages are not clear. If you cannot determine what the message means refer to Appendix A of RCM 9.10 for further clarification of what the problem is and how to resolve it.

If the code is not listed in this appendix and you can't determine from the explanation in the edit message what is causing the error:

- Review your document fields for missing, bad or extraneous entries
- If you can't determine what is causing the edit message:
 - Print the screen display by pressing the PRINT key, and
 - Deliver the printout and brief explanation to your section supervisor for review
 - If your section supervisor is not able to determine the problem he/she should contact the PAR system specialist in the Division of Adjudicative Services (in BRB and BSB the supervisor should make this contact through their respective bureau's PAR system specialist).

9.10.110 Making Changes to Docs. Stored in SUSF File

After a document has been entered into the PAR system, but before it has been successfully processed it is stored on the suspense file (SUSF).

The following are guides to correcting and changing documents that reside in the SUSF:

1. Once the DOCUMENT INPUT screen is entered into the suspense file it cannot be accessed while a DOCUMENT LINE screen is in data entry mode (i.e., a D is displayed in the MODE field on the document action line)
2. When the whole document is entered into the suspense file:

- A. The size of the document (how many document lines are attached to it) is set. Special instructions must be followed in order to add document lines (See RCM 9.10.117) or to remove document lines (See RCM 9.10.119). The whole document becomes part of the suspense file for the first time when it is sent to the suspense file for storage with a hold command or when it is run against system edits for the first time (QUICK EDIT).
- B. The document can no longer be CANCELLED OUT. A DELETE command must be used that requires batch processing at the end of the day. (See RCM 9.10.130).
- C. In order to correct or change a document in the SUSF, you must be in the CORRECTION mode (i.e., a C must be displayed in the MODE field on the document action line)

The document will be in the correction mode

- after quick edit is used, or
- when accessed through the SUSF when the document is in a HELD status.
- after C is entered in the MODE field.

If there is an approval on the document or the status displayed is SCHED when you access it through SUSF you will need to remove the approval and change the mode from SCAN to CORRECTION before any changes can be made to the document (See RCM 9.10.113 and 9.10.115).

- D. Most changes can be made to a document in correction mode by typing the information in blank fields, typing over previous erroneous entries in fields and/or using the space bar to erase unwanted entries in fields (as described in 9.10.101) except for the following:
 - adding and deleting document lines (See RCM 9.10.117, and 9.10.119),
 - changing a DOCUMENT ID NUMBER (See RCM 9.10.124 and 9.10.125),
 - changing information in the NAME and ADDRESS fields on a billing document (See RCM 9.10.120),
 - changing the PAYOR NUMBER on the billing document when the PAYR record must also be changed (See RCM 9.10.128-130).

9.10.111 When To Change Or Delete A Document

You will know you need to make changes to or delete a document on SUSF if:

- edit messages other than the standard messages advising that the "document needs approval" appear when you submit your document to QUICK EDIT, (remember to check the document line screen),
- you notice data entry and/or adjudicative errors when you review the document screens, case file, and/or Form T-200 before submitting the document for approval and scheduling (when you are entering data in the PAR system);
- you notice data entry or adjudicative errors when you review the document screens, case file and/or T-200 when you are approving and scheduling a document for processing; or
- the situation changes before a document is processed, such as:
 - a change of address,
 - a change in entitlement status, or
 - checks or EFT payments are returned changing the overpayment amount.

You can ensure that you will uncover any problems that need correction and your transaction will not reject from processing if you verify that:

1. All required fields are completed.
2. Entries are complete and accurately represent folder and/or payment information.
3. Data entered in a field is entered in the correct position within that field. (Always use a tab key to position the cursor at the beginning of a field.)
4. All dollar amount entries are in the proper format.
 - No dollar or cent signs are used.
 - No commas are used.
 - A decimal point is always used after the dollar amount.
 - Two positions after the decimal point are always completed.
 - Except for the decimal point, positions in money fields must be completed only with numbers.

5. The PAYOR NUMBER is correct. This is one of the primary means of identifying and locating an overpayment in the PAR system.
6. Any field that should not have an entry has no data entered. This not only prevents bad data in the field, it allows the system to supply correct entries if the field is completed by inference or default.
7. An alpha entry is not used when a numeric entry is required and vice versa. This confusion most commonly happens with the alpha character O and the numeric 0 (zero).

After making any corrections to a document always QUICK EDIT the document to verify that the correction is successful. Edit messages at the bottom of the screen will not change until the document is re-edited. Do not just press the ENTER key. If you simply press the ENTER key, the system will display an erroneous message that no errors exist.

9.10.113 Removing An Approval

You cannot make a change to a document transaction with an approval on it. You can tell that a document transaction has an approval by scanning the SUSF (see B and C of this section), or if you are viewing the document directly you can tell it has been approved by the display of the following edit messages at the bottom of the DOCUMENT INPUT screen:

- A--*CY41 - APPROVED DOCUMENT

To remove an approval, you must first access the document on the SUSF screen.

A. Accessing the SUSF Screen - To access the SUSF take the following actions:

- Sign on to the PAR system as described in 9.10.50.
- Type MTI, leave one space, then type the table code name SUSF.
- Press the ENTER key.
- A blank SUSF screen will appear.

B. Scanning SUSF to Locate a Particular Record - To locate your record take the following actions:

- After completing the steps in A your cursor will be in the document ACTION field. An S will already be displayed.
- Move the cursor with your TAB key to the USER ID field and type in your USER ID.

- The cursor will now have moved to the first blank line on the SUSF screen. Using the TAB key move the cursor to the DOCUMENT ID TRAN field (TRANSACTION CODE). Type in B2 if you are looking for a billing document, C2 if you are looking for a cash receipt document.
- Using the TAB key, move the cursor to the ORGI (ORGANIZATION) field and type in 2000 (ORSP).
- The cursor is now positioned in the NUMBER field. Type in the ID NUMBER of the document for which you are looking.
- Press the ENTER key.
- The SUSF screen will appear with 15 records displayed. The document you requested will be the first line displayed.

C. Determining if there is an Approval on the Document that Must be Corrected - Look at the fourth column from the left labeled APPRV (APPROVAL).

Although there are five positions in this field, the PAR system uses only one level of approval, which is indicated in the first position in the field.

- If the first position displays a zero, no approval was ever placed on the document transaction.
- If the first position displays a 'Y', there is an approval on the document transaction.
- If there is an 'N' there was an approval, but it has been removed.

D. Removing the Approval - To access the document transaction and remove the approval:

- Move the cursor to the ACTION field on the SUSF screen. Type in S.
- Using the line TAB key, move the cursor back to the line of the SUSF screen containing the DOCUMENT ID of the document you want to correct.
- Press the ENTER key.
- You are now viewing the DOCUMENT INPUT screen of the document in question. The cursor is in the ACTION field of the document action line.
- Type A in that field.
- Using the line TAB key move the cursor to the APPROVAL field on the document action line. Type N in that field.

- Press the ENTER key.
- The following message will now be displayed at the bottom of the DOCUMENT INPUT screen.
 - A--*S051 - APPROVAL 1 REMOVED.

You are now ready for the next step to correct your document, changing from SCAN mode to CORRECTION mode.

9.10.115 Changing From Scan Mode To Correction Mode On Screen

If you enter a DOCUMENT INPUT SCREEN from the SUSF and it has an approval on it, the document will be in SCAN mode when you enter it. After removing the approval, as described in 9.10.113, you will have to change the mode from SCAN (S displayed in the MODE field) to CORRECTION (C displayed in the MODE field).

To accomplish this mode change:

- Type F in the ACTION field.
- Using the field TAB key move the cursor to the MODE field.
- Type C over the S displayed in the field (only the C is visible in this field when your action is complete).
- Press the ENTER key.
- The ACTION field on the document action line is once again blank, but C is now displayed in the MODE field. The following edit messages will be displayed at the bottom of the DOCUMENT INPUT screen:
 - H--*S401 - READY FOR APPROVAL 1
 - H--*F053 - DOCUMENT NOT APPROVED

Your document transaction is now ready for correction.

9.10.116 Moving Through Documents Screens While In Correction Mode

Once you are in correction mode the system will allow you to:

- Move through all the screens in your document transaction in sequence,
- Return to the DOCUMENT INPUT screen from the document line

- Pause and leave your document to check a reference table (PAYR, PDIT, CAUS etc.) and return directly to the document screen on which you were working.

The ability to move through your document and back to your DOCUMENT INPUT screen is helpful whether you are creating a document or modifying it. They are not usable when cancelling a document, because only the DOCUMENT INPUT screen is involved in a cancelling transaction.

A. To Move Through Document Screens in Sequence - take the following steps:

- Position the cursor in the ACTION field on the document action line.
- Type NS in the ACTION field.
- Press the ENTER key.

The first document line screen stored in the system for the document you are viewing will appear.

- If you entered the command on the DOCUMENT INPUT screen and your document transaction included lines for a regular railroad annuity overpayment and a supplemental annuity overpayment, you will be looking at a DOCUMENT LINE screen displaying lines 001 and 002.
- If you entered the command on the DOCUMENT INPUT screen and no DOCUMENT LINE screens exist, or if you entered the command on a DOCUMENT LINE screen and no further lines exist for that document the following message will be displayed at the bottom of your screen:
 - A--*CR19-END OF DOCUMENT
- If you entered the command on your first DOCUMENT LINE screen, and you had accidentally entered your document lines twice, you will be viewing the next line screen in sequence containing those duplicate lines. If, after you press enter and the command action is completed, you do not see the message:
 - A--*CR19-END OF DOCUMENT

you know you are looking at a new portion of your document.

If you press the ENTER key without entering any command in the ACTION field, you will also see the next screen displayed. However, heavy or inconsistent pressure could result in bypassing a screen without being aware of it. Using the NS command guarantees that you are looking at the next screen in sequence, which is especially important when you are correcting errors.

The NS command will also work in the scan mode.

B. To Return to a DOCUMENT INPUT Screen from any DOCUMENT LINE Screen in the Same Document Transaction - take the following steps:

- Position the cursor in the ACTION field of the document action line.
- Type NLO (the third position of the command is numeric, zero) in the ACTION field.
- Press the ENTER key.

The DOCUMENT INPUT screen will now be displayed on your terminal.

This command will also work in the scan mode.

C. To Temporarily Exit from your Document to Check Table Information (PAUSE) - take the following steps:

- Position the cursor in the ACTION field of the document action line.
- Type P (PAUSE) in the ACTION field
- Press the ENTER key.
 - If you entered the document from the SUSF, the SUSF screen you entered the document from will be displayed. Type E in the ACTION field and press the ENTER key to have the message described in the next step displayed. If you entered from the STARTUP screen the message in the next step will be displayed.
 - The message "V2, ENTER NEXT TASK CODE:" will now be displayed on the screen.
- Type MTI, leave one space, then type the four position acronym for the table you want to access (PAYR, PDIT, ACOT, SRCE, CAUS, ARCL etc.)
- Press the ENTER key.
 - A blank screen for the table you requested will be displayed. Follow standard instructions for whatever table actions you need to take. You may access other tables if you need to as long as you don't exit the PAR system.
 - When you have completed all your table actions, position the cursor in the ACTION field of the table action line. Type E in the ACTION field (exit tables).
 - Press the ENTER key.

- The message "V2, ENTER NEXT TASK CODE" will be displayed.
- Type DDB.
- Press the ENTER key.
- The document screen you were viewing before you entered the PAUSE (P) command will again be displayed. The cursor will be positioned in the ACTION field of the document action line. The mode will be the same as when you left the document. This is the only command that will allow you to exit a document and reenter it in data entry mode (D displayed in the MODE field of the document action line).

This last command is very helpful if, due to error messages or indecision, you need to reference a table in the middle of completing or correcting a document.

9.10.117 Adding A Line Or Multiple Lines To A Document In SUSF Correction (IL or ILN Command)

- A. If you need to add one or more lines to your document, and your document does not currently have any document lines (for example, you had to store your document in SUSF before you had time to enter your document line or you prematurely used QUICK EDIT while still viewing the DOCUMENT INPUT screen in data entry mode) take the following actions:
- Position the cursor in the ACTION field on the document action line of the DOCUMENT INPUT SCREEN.
 - Type IL in the ACTION field.
 - If you wish to add more than one line, insert the number of lines to be inserted in the 3rd position of the field (IL2, IL3, etc).
 - Move the cursor to the position in the line beneath the last line displayed on the DOCUMENT INPUT screen.
 - Press the ENTER key.
 - A blank DOCUMENT LINE screen will be displayed. The following message will be shown at the bottom of the screen:

"A--*CU13 - CONTINUING SAME DOCUMENT".
 - Complete all required entries for the new line following standard instructions in RCM 9.10.60. QUICK EDIT and HOLD in SUSF for approval and scheduling if there are no further errors.

- B. If you need to add a line or multiple lines to your document, and your document already has one line:
- Position the cursor in the ACTION field on the document line screen.
 - Type IL in the ACTION field.
 - If you wish to add more than one line, type the number of the lines to be inserted in the 3rd position of the field (IL2, IL3, etc.).
 - Move the cursor to underscore the final position of the last field name of the document line (the ACTION OUT field) which you want the new line to follow.
 - Press the ENTER key.
 - A new DOCUMENT LINE screen with two blank document lines will appear with the message "A--*CU13 - CONTINUING SAME DOCUMENT" displayed at the bottom. (You have not lost the line you previously entered, nor will there be a blank line stored with your document. After you have entered your new document line, QUICK EDITED your document and viewed your document, you will see that the new line has been correctly inserted immediately after the existing line.)
 - Complete all required entries for the new line following standard instructions in RCM 9.10.60. QUICK EDIT and HOLD in SUSF for approval and scheduling if there are no further errors.

9.10.119 Deleting A Line Or Multiple Lines From A Document In SUSF (DL Or DLN Command)

If you need to delete a DOCUMENT LINE(S) from your document (example: you became distracted during document entry, accidentally pressed the ENTER key, then entered the same line a second time; you erroneously attributed part of your overpayment to supplemental annuity when it was all regular railroad annuity that was overpaid) take the following actions:

- Position the cursor in the ACTION field on the document action line of the screen containing the DOCUMENT LINE you want to delete.
 - Press and hold down an alternate shift key (Alt).
 - Press the cursor home key.
 - Release the alternate shift key (Alt).
- Type DL in the ACTION field. If you are deleting 2 lines, enter DL2, etc.

- Using the line TAB key move the cursor to the first line of the DOCUMENT LINE you want to delete. The cursor will now be in the first position of the LINE NUMBER field.
- Press the space bar three times, erasing the LINE NUMBER entry.
- Press the ENTER key. The line is now deleted.
 - The DOCUMENT INPUT screen will now be displayed.
- Type Q in the ACTION field of the document action line.
- Press the ENTER key.
- Scan your document screens to validate that the line is deleted and no further errors exist.
- Handle according to standard procedure regarding scheduling and approval.

9.10.120 Changing Name and Address Fields

Changes to the name and address fields on the billing document (e.g. data entry error detected or change of name or address received before the document is processed) cannot be accomplished by simply typing over what is displayed in these fields on the DOCUMENT INPUT screen. This is because the information is

- Created in PAYR and PDIT table records, and
- stored in PDIT for mailing purposes (The PDIT screen is the only location in the system for entering a second name line for a mailing address).

The correction must then be "pulled through" to your document to:

- Make the information in the system consistent, and
- Make the information available to interactive uncollectible file should the receivable be written off to the uncollectible file.

To Summarize the Basic Steps for Document Name and Address Correction:

- If your action started with viewing the document to be corrected, leave the DOCUMENT INPUT screen using a P (PAUSE) command
- Correct the NAME and ADDRESS fields on the PAYR record using a C (CHANGE) command,
- Move to the PDIT record using the L (LEAF) command,

- Validate new entries displayed on PDIT and if necessary correct the second NAME Line on PDIT with a C (CHANGE) command,
- Return to the DOCUMENT INPUT screen, and
- QUICK EDIT to pull the information to your BILLING DOCUMENT.

See below for step by step instructions:

To change the name and address fields take the following actions.

PAYR SCREEN

- Access the PAYR table.
 - If you are not in the PAR system follow standard instructions in RCM 9.10.50 until you see the message "V2, ENTER NEXT TASK CODE" displayed.
 - If you are viewing the DOCUMENT INPUT screen with the name and/or address fields that need to be corrected, type P in the ACTION field of the document action line (PAUSE command) and press the ENTER key. You will see the message "V2, ENTER NEXT TASK CODE".
- Type MTI, leave one space, then type the table code name PAYR.
- Press the ENTER key. A blank PAYR screen will appear. An "S" will be displayed in the ACTION field and PAYR in the TABLEID field of the table action line.
- Use the field TAB key to advance the cursor to the USERID field.
- Type your eight position USERID (four positions displayed, four positions encrypted in the USERID field).
- The cursor will advance to the PAYOR NUMBER field. Type in the PAYOR NUMBER of the record you need to change.
- Press the ENTER key. The record you need to change will now be displayed.
- The cursor is now positioned in the ACTION field of the table action line. Type C over the R displayed.
- Using the line and field TAB keys move the cursor to the address field(s) that need to be changed. Type the correct entries in the appropriate fields according to the directions in RCM 9.10.56. If the change that you are making is due to the establishment of a representative payee, remember it is the representative payee's name that is entered in the name field on the PAYR record.

- Press the ENTER key. The message "01-*LO31 ALL LINES CHANGED" will be displayed at the bottom of the screen when the change is complete.
- The cursor is positioned in the ACTION field of the table action line. Type L over the C displayed (LEAF command).
- The cursor is now positioned in the TABLEID field. Type in PDIT.
- Press the ENTER key. The PDIT record for your receivable will now be displayed (if there are multiple overpayments for the same PAYOR number, press the enter key until the one with the correct BILLING DOC ID is displayed).

PDIT SCREEN

- The cursor is now positioned in the ACTION field of the table action line.
 - If there are no changes to be made on the second name line of the address (PAYOR'S NAME preceded by 'for' if the representative payee's name was entered on the PAYR record, or erasing the entry in the second line if a representative payee is being removed) scan the name and address to validate that the changes entered on the PAYR record are correctly displayed.
 - If a change is needed on the second PAYOR NAME line, type C in the ACTION field. Use the line TAB key to move the cursor to the second PAYOR NAME line, type in the appropriate date if the second name line is needed for the address or use the space bar to erase the data displayed on this line if it is no longer needed. Press the ENTER key. When the change has been made the message "01-*LO31 ALL LINES CHANGED" will be displayed at the bottom of the screen.
- Type E in the ACTION field of the table action line (to exit the tables portion of the PAR system).
- Press the ENTER key.
- The message "V2 ENTER NEXT TASK CODE" will appear on the screen. Type DDB.
- Press the ENTER key.
 - If this process started with a departure from the DOCUMENT INPUT screen using a P (PAUSE) command, you will now be viewing the DOCUMENT INPUT screen again.
 - If you did not use the P (PAUSE) command to start this process you will be viewing the STARTUP screen.
 - Type C in the MODE field.

- The cursor is now positioned in the TRANSACTION CODE field of the DOCUMENT ID line. Type B2 in this field. Type 2000 in the DIVISION field and the billing document ID NUMBER of the document being corrected in that field.
- Move the cursor using the line TAB key to the USERID field and type your USERID.
- Press the ENTER key. You will now be viewing the DOCUMENT INPUT screen.

BILLING DOCUMENT INPUT SCREEN

- Using the line TAB key move the cursor to the PAYOR NAME and ADDRESS lines. Using the space bar erase the data displayed in these lines.
- Return the cursor to the ACTION field of the document action line. Type Q in that field (QUICK EDIT).
- Press the ENTER key. The PAR system will pull through the new data from the PAYR and PDIT records, and it will now be displayed on the DOCUMENT INPUT screen.

If there are no further corrections necessary the document is ready for approval and scheduling.

9.10.121 Changing The Fund Field Of Unapplied Cash Lines On Unprocessed Mechanically Generated Cash Receipt Documents

The correct entry in the FUND field on an unapplied cash line is 8011. Currently, when the line is created from cash collection input table (CCIT) processing the fund displayed is *PAR. This problem will require a substantial change in contractor software. Until that software collection is made, when you are reviewing such a cash receipt document, you must change the entry in this FUND field of the unapplied cash line from *PAR to 8011.

Take the following steps after you have determined an unapplied cash line exists (the code UA appears in the TRANS TYPE (TRANSACTION TYPE) field in the last line of the CASH RECEIPT DOCUMENT:

- Move the cursor to the FUND field using a TAB key.
- Type 8011 in that field over the *PAR entry displayed.
- If there are no other problems with the CASH RECEIPT DOCUMENT, follow standard directions in RCM 9.10.77 for approval and scheduling.

NOTE: Unapplied cash lines (using the UA TRANSACTION TYPE) should only occur when a recovery is being posted that would require a cash collection (CC) transaction type. Since all check and money order recoveries should be entered into the PAR system through lockbox processing, you will most often see this kind of activity from posting reclamation money when a combined benefit payment is involved.

9.10.122 Deleting An Unprocessed Document Transaction From The Suspense File Or Start-Up Screen

You would want to DELETE a document if:

- In a BILLING DOCUMENT, the BILLING DOCUMENT ID (especially the TRANS CODE and UNIT ID positions) is incorrect.
- In a BILLING DOCUMENT, authorization discovers the overpayment doesn't exist.
- In a BILLING DOCUMENT, the overpayment was caused by an outstanding payment and the payment is returned before the document is processed.
- In a CASH RECEIPT DOCUMENT, authorization determines that the liquidation action is incorrect.
- Something has occurred subsequent to its entry causing it to no longer be necessary.

A. To DELETE an unprocessed document transaction through the PAR system SUSPENSE FILE:

- Access the SUSF screen following directions in RCM 9.10.50.
- Access the record you wish to delete following directions in RCM 9.10.63 (B and C) if you want to delete a billing document, or RCM 9.10.77 (B and C) if you want to delete a cash receipt document.
- Type S in the ACTION field of the table action line.
- Move the cursor to the first position of the first record on the SUSF screen using the tab key.

NOTE: Before moving to the DOCUMENT INPUT SCREEN look at the status and approval fields for the document you are going to delete.

If STATUS is HELD and the first position of the APPRV (approval) field is O or N, you can take your action to DELETE as soon as you enter the DOCUMENT INPUT SCREEN.

If the STATUS is HELD but the first position of the APPRV field is Y you will have to remove the approval before you can DELETE the document.

If the STATUS is SCHED (scheduled) and the first position of the APPRV field is N or O you will have to change the mode from SCAN (S) to correction (C) after you enter the DOCUMENT INPUT SCREEN.

If the STATUS is SCHED and the first position of the APPRV field is Y you will have to first remove the approval and then change the mode from scan to correction.

- Press the ENTER key. You are now viewing the DATA INPUT SCREEN of the document you wish to DELETE.
- Remove the approval from the document if one exists. If this is not necessary move on to the next step. To remove an approval:
 - Type A in the ACTION field of the document action line.
 - Move the cursor to the APPRVL field of the document action line using the line tab key. Type N in that field.
 - Press the ENTER key.
- Change the mode to C if an S appears in the MODE field on the document action line. If this is not necessary move on to the next step. To change to correction mode:
 - Type F in the ACTION field of the document action line.
 - Use the tab key to move the cursor to the MODE field of the document action line. Type C in that field.
 - Press the ENTER key. The MODE field will now display C. You are in correction mode.
- Type DD in the ACTION field of the document action line.
- Move the cursor to the DOCID field of the document action line using a tab key. Erase the TRANSACTION CODE (B2 or C2) by pressing the space bar.
- Press the ENTER key. No approval or scheduling is needed since you are only removing a document transaction from the suspense file and not adding or changing information in PARS.

You will now be viewing the same SUSF screen you left to enter the DOCUMENT INPUT screen. The information displayed is the same as when you entered the DOCUMENT INPUT screen. If you clear the screen by typing N in

the ACTION field of the document action line, press the ENTER key, and then reaccess your document transaction record on SUSF you will see DELETE displayed in the STATUS field for that document on the SUSF screen. You will no longer be able to access that document as it has been deleted from PARS. After production is completed that night the record will be removed from the SUSF screen.

B. DELETING a document from the START-UP screen when there is no approval on it.

- Signon to the PAR system as described in RCM 9.10.50.
- Type DDB on the screen when it displays the message "V2, ENTER NEXT TASK CODE".
- Press the ENTER key. You will now be viewing the START-UP screen.
- Type P in the MODE OF OPERATION field.
- On the DOCUMENT ID line of the START-UP screen type:
 - B2 in the TRAN field if you are DELETING a billing document transaction or C2 if you are DELETING a cash receipt document transaction.
 - 2000 in the DIVISION field, and
 - the DOCUMENT ID NUMBER of the document transaction you are DELETING in the ID NUMBER field.
- Move the cursor to the USER ID field using a tab key and type your USER ID.
- Move the cursor to the SCHEDULING ACTION field using a tab key. Type DD.
- Press the ENTER key.
 - If the document was in HELD or SCHED status in the SUSPENSE FILE with no approval the document is now deleted. The message "A--*CQ8L-DOCUMENT DELETED" will be displayed at the bottom of the START-UP screen.
 - If the document had an approval on it, whether in HELD or SCHED status, the document has not been DELETED. The messages:
 "A--*CY41-APPROVED DOCUMENT" and
 "A--*CY81-APPROVED-ACTION INVALID"

will be displayed at the bottom of the START-UP screen.

- If you successfully DELETED your document, press the CLEAR key to exit the DOCUMENT DATA BASE (DDB), or proceed to make entries for your next document transaction. If you could not DELETE the document because it had an approval on it proceed to C of this section.

C. DELETING a document accessed through the START-UP screen, when there is an APPROVAL on it.

- After taking the steps in B. of this section and determining that the document you wish to DELETE has an approval, type S in the MODE OF OPERATION field on the START-UP screen.
- Press the ENTER key (the other necessary fields, DOCUMENT TRANS CODE, DIVISION, DOCUMENT ID and USER ID, will still be displayed from your first attempt to DELETE).
- You will now be viewing the DOCUMENT INPUT screen for the document transaction you wish to delete. Type A in the ACTION field of the document action line.

- Move the cursor to the APPRVL field of the document action line using the line tab key. Type N.
- Press the ENTER key. The message:

"A--*5051 APPROVAL 1 REMOVED"

will be displayed at the bottom of the DOCUMENT INPUT screen.

- Type F in the ACTION field of the document action line.
- Move the cursor to the MODE field of the document action line using tab key, and type C.
- Press the ENTER key. The messages:

"H--*5401-READY FOR APPROVAL 1" and

"H--*FO53-DOCUMENT NOT APPROVED"

will be displayed at the bottom of the screen along with any other error messages generated by the document transaction you are DELETING.

- Type DD in the ACTION field of the document action line.

- Move the cursor to the DOCID field of the document action line using a tab key. Erase the TRANS CODE (B2 or C2, depending on the document you are DELETING) by pressing the space bar.
- Press the ENTER key. The START-UP screen will now be displayed with the message:

"A--*CQ8L-DOCUMENT DELETED"

You will no longer be able to view the document transaction. If you attempt to do so by typing S in the MODE OF OPERATION field with the appropriate DOCUMENT ID and USER ID DATA and press the ENTER key, the following message will be displayed on the "START-UP" screen:

"A--CX11-BATCH OR DOC HEADER DELETED"

- Continue with your next document transaction or press the CLEAR key to exit the document data base (DDB).

9.10.124 Changing A Billing Document Id On The SUSF

There are two ways you could become aware that a data entry error was made in the billing document ID.

- By scanning the DOCID field in the document action line at the top of either the DOCUMENT INPUT SCREEN or the DOCUMENT LINE SCREEN, or
- By having one of the following error messages displayed on the BILLING DOCUMENT INPUT SCREEN after QUICK EDITING your BILLING DOCUMENT:

"H--PP86E - PDIT TABLE ENTRY NOT FOUND"

"H--PP90E - BD EXISTS IN ARHT TABLE"

NOTE: Edit message PP86E can also be generated because:

- A PDIT record was not established
- A PDIT record was established with the wrong BILLING DOCUMENT ID NUMBER. If so you will need to delete the bad record and add the correct record to the PDIT table, see RCM 9.10.158)
- The PAYOR NUMBER on the BILLING DOCUMENT in question does not match the PAYOR NUMBER on an existing PDIT RECORD.

- If the PAYOR NUMBER on the BILLING DOCUMENT is incorrect or incorrectly positioned in the PAYOR NUMBER field see RCM 9.10.126 for directions to correct it.
- If the PAYOR NUMBER is incorrectly entered on the PAYOR and PDIT records, see RCM 9.10.129 for necessary actions to establish corrected table records.
- If the PAYOR NUMBER was not positioned correctly in the PAYOR NUMBER field on the BILLING DOCUMENT INPUT SCREEN it will not match with a PDIT record. By using the TAB key, verify that the PAYOR NUMBER starts in the first position of the PAYOR NUMBER field and that all positions are entered correctly.

If there is a processed PARS record with the same BILLING DOCUMENT ID as the one you are attempting to establish, the following message will be displayed at the bottom of the PDIT screen when you attempt to add your record:

01-PP90E BD EXISTS IN ARHT TABLE.

If the duplicate does not exist when you add the PDIT record but is established in PARS after you add that record but before you have entered your BILLING DOCUMENT the following message will be displayed at the bottom of the START-UP SCREEN after you have pressed the ENTER key in an attempt to access the BILLING DOCUMENT INPUT screen for the first time:

A--*CD31 - DUPLICATE DOCUMENT ID.

Because you are prewarned in these last two situations, a billing document with a duplicate ID should not be created.

Correcting the DOCUMENT ID on the BILLING DOCUMENT

The DOCUMENT ID cannot be changed on the BILLING DOCUMENT. After you have determined that the DOCUMENT ID is in error and the error was made when it was entered on the START-UP SCREEN when the BILLING DOCUMENT was created and not on the PDIT record you have only two options.

- A. CANCEL OUT of the BILLING DOCUMENT if you have never put the document on HOLD in the suspense file and have never accessed the BILLING DOCUMENT LINE SCREEN.
 - Move the cursor to the ACTION field of the document action line.
 - Type X in the ACTION field.
 - Press the ENTER key.
 - You will now be viewing the START-UP SCREEN.

- All the data you entered before accessing the BILLING DOCUMENT INPUT SCREEN will be displayed. Move the cursor to the DOCUMENT ID line on this screen. Type B2 in the TRAN field if B2 is not displayed there (the START-UP SCREEN will display all your original entries). If B2 was already displayed there or if you have typed B2 in that field move the cursor to the ID NUMBER field of the DOCUMENT ID line.
- Type the correct ID NUMBER.
- Press the ENTER key.
- You will now be viewing the DOCUMENT INPUT SCREEN. Complete the BILLING DOCUMENT INPUT SCREEN and submit for approval and processing following standard instructions in RCM 9.10.63 and 64.

B. DELETE the BILLING DOCUMENT if you have at any time put the document in HOLD status on the SUSPENSE FILE or accessed the DOCUMENT LINE SCREEN. This can be done either of the following two ways:

1. If you accessed the document through the SUSPENSE FILE:
 - you should be viewing the DOCUMENT INPUT SCREEN and the cursor should be in the ACTION field of the document action.
 - TYPE DD in the ACTION field.
 - Move the cursor, using a TAB key, to the DOCID field of the document action line.
 - Using the space bar, erase the TRANSACTION CODE (B2).
 - Press the ENTER key.
 - You will now be viewing the SUSPENSE FILE screen from which you entered the document exactly as you left it. The status displayed for the BILLING DOCUMENT you have just deleted will still say HELD.
 - If you wish to check if your document is scheduled for DELETION take the following steps.
 - The cursor will be in the ACTION field of the table action line. Type S in that field.
 - Move the cursor the SUSF line of the document you just DELETED.
 - Press the enter key.

- You will now be viewing the STARTUP screen.
 - Press the CLEAR key.
 - You will now be viewing the SUSF screen continuing your record again. DELETE should now be displayed in the STATUS field of the SUSPENSE FILE record for your BILLING DOCUMENT and you should no longer be able to access it. The document has been deleted. The SUSPENSE FILE record will be archived the next time nightly production is run.
 - Type E in the ACTION field to exit tables.
 - Follow standard instructions to enter a BILLING DOCUMENT taking care to type the BILLING DOCUMENT ID correctly on the START-UP screen.
2. If you want to DELETE a BILLING DOCUMENT using the START-UP SCREEN, take the following steps:
- Type P in the MODE of OPERATION field.
 - The cursor will have moved to the DOCUMENT ID line. Type B2 in the TRAN field, 2000 in the DIVISION FIELD and the ID NUMBER of the BILLING DOCUMENT you want DELETE in ID NUMBER field.
 - Move the cursor to the USER ID field and type your USER ID.
 - Move the cursor to the SCHEDULING ACTION field and type DD.
 - Press the ENTER key.
 - The following message will now be displayed at the bottom of the START-UP screen:

A--*CQ8P - DOCUMENT DELETED
 - Now complete your START-UP screen and BILLING DOCUMENT screens following standard instructions being careful to correctly enter your new DOCUMENT ID.

9.10.125 Changing A Cash Receipt Document Id On The SUSF

You would need to change your CASH RECEIPT DOCUMENT ID if you made a data entry error in your DOCUMENT ID or if the DOCUMENT ID already exists in PARS.

You would become aware of a data entry error

- by scanning the DOC ID field in the document action line;
- by the display of the following edit messages at the bottom of your screen

01-CPM02 - TRAN CODE/TYPE NOT IN ACED

- If the TRANSACTION CODE entered was other than C2 but exists as a valid code in an accounting reference table (if you enter a TRANSACTION CODE that is not valid in an accounting reference table, your entry will reject when you attempt to add your CCIT record "PP24W ACED TABLE ENTRY NOT FOUND" or when you attempt to enter the CASH RECEIPT DOCUMENT SCREEN from the START-UP SCREEN "A--*CD15 - DOCUMENT TYPE INVALID"). You would know that your CASH RECEIPT DOCUMENT ID is a duplicate of one that exists already in PARS (but not on the SUSPENSE FILE) by the display of the following edit message at the bottom of the CASH RECEIPT INPUT SCREEN after the document is edited:

H--CR07E - DUPLICATE CR DOC.

If there is a SUSPENSE FILE record with the same document ID as the one you are attempting to enter, your action will reject on CCIT (with the following message displayed, H--PPD1E DUPLICATE DOC ID EXISTS) or the START-UP SCREEN (with the following message displayed, A--*CD31 - DUPLICATE DOCUMENT ID) and never get as far as the cash receipt document screen. Then you will have to type over the ID NUMBER, with a new number that will be unique.

Correcting the DOCUMENT ID on the CASH RECEIPT DOCUMENT

The DOCUMENT ID cannot be changed on the CASH RECEIPT DOCUMENT. There are only two options:

1. CANCEL OUT of the CASH RECEIPT DOCUMENT if you have never put the document on HOLD in the suspense file and have never accessed the CASH RECEIPT DOCUMENT LINE SCREEN, or
2. DELETE the CASH RECEIPT DOCUMENT if you have at any time put the document in HOLD status on the SUSPENSE FILE or accessed the DOCUMENT LINE SCREEN.
 - Move the cursor to the ACTION field inside the BILLING DOCUMENT INPUT SCREEN (not the document action line).
 - Type X in the ACTION field.
 - Press the ENTER key.
 - You will now be viewing the START-UP SCREEN.
 - Type D in the MODE of OPERATION field.

- All the data you entered before accessing the CASH RECEIPT DOCUMENT INPUT SCREEN will be displayed. Move the cursor to the DOCUMENT ID line on this screen. Type C2 in the TRAN field if C2 is not displayed there (the START-UP SCREEN will display all your original entries). If C2 was already displayed there or if you have typed C2 in that field move the cursor to the ID NUMBER field of the DOCUMENT ID line.
- Type the correct ID NUMBER.
- Press the ENTER key.
- You will now be viewing the CASH RECEIPT DOCUMENT INPUT SCREEN. Complete the CASH RECEIPT DOCUMENT INPUT SCREEN and submit for approval and processing following standard instructions in RCM 9.10.75-78.
- You will now be viewing the START-UP screen. All the data originally entered on that screen before you accessed your CASH RECEIPT DOCUMENT will be displayed.
- If you are going to manually reenter your CASH RECEIPT DOCUMENT take the following steps.
 - Move the cursor to the DOCUMENT ID line using your TAB key and type over the incorrect fields with the correct entries.
 - Press the ENTER key. You will now be viewing the CASH RECEIPT DOCUMENT INPUT SCREEN again. The correct DOCUMENT ID should now be displayed in the DOC ID field of the document action line. Complete your CASH RECEIPT DOCUMENT following standard directions in RCM 9.10.75 through 9.10.78.
- If you want to reenter your transaction on the cash collection input table, follow standard directions in 9.10.79.

Deleting the CR Document can be done either of the following two ways, depending on how you entered the document:

- A. If you accessed the document through the SUSPENSE FILE you should be viewing the DOCUMENT INPUT SCREEN and the cursor should be in the ACTION field of the document action.
 - TYPE DD in the ACTION field.
 - Move the cursor, using a TAB key, to the DOCID field of the document action line.
 - Using the space bar, erase the C2 TRANSACTION CODE.

- Press the ENTER key.
- You will now be viewing the SUSPENSE FILE screen from which you entered the document exactly as you left it. The status displayed for the CASH RECEIPT DOCUMENT you have just deleted will still say HELD.

If you wish to check if your document is scheduled for deletion:

- The cursor will be in the ACTION field of the table action line. Type S in that field.
- Move the cursor to the SUSF line containing your document transaction.
- Press the enter key.
- You will now be viewing the STARTUP screen.
- Press the CLEAR key.
- You should now be viewing the SUSF screen containing your document transaction.
- DELETE should now be displayed in the STATUS field of the SUSPENSE FILE record for your CASH RECEIPT DOCUMENT and you should no longer be able to access it. The document has been deleted. The SUSPENSE FILE record will be archived the next time nightly production is run.
- Either type N in ACTION field of the table action line and CCIT in the TABLE ID and press the ENTER key,

or

Type E in the ACTION field of the table ACTION line and press the ENTER key.

Your choice depends on whether you reenter your transaction (with a correct DOCUMENT ID) on a CCIT screen or directly on a START-UP SCREEN and CASH RECEIPT DOCUMENT. Most units, unless directed otherwise by supervisor, should reenter their action on a CCIT screen.

- Follow standard directions in 9.10.79 through 9.10.78 if you are reentering your transaction on a START-UP SCREEN, CASH RECEIPT DOCUMENT INPUT SCREEN and CASH RECEIPT LINE SCREEN.

B. If you want to DELETE a CASH RECEIPT DOCUMENT using the START-UP SCREEN take the following steps.

- Type P in the MODE of OPERATION field.
- The cursor will have moved to the DOCUMENT ID line. Type B2 in the TRAN field, 2000 in the DIVISION FIELD and the ID NUMBER of the BILLING DOCUMENT you want to DELETE in ID NUMBER field.
- Move the cursor to the USER ID field and type your USER ID.
- Move the cursor to the SCHEDULING ACTION field and type DD.
- Press the ENTER key.
- The following message will now be displayed at the bottom of the STARTUP screen:

A--*CQ8L - DOCUMENT DELETED

- If you are going to reenter your cash receipt on a CCIT screen (and all units should unless otherwise directed by a supervisor), press the CLEAR key.
- The message "V2 ENTER NEXT TASK CODE" will appear on the screen.
- Type MTI CCIT.
- Press the ENTER key.
- You will now be viewing the CCIT screen. Reenter your transaction, with a correct DOCUMENT ID following directions in RCM 9.10.79.
- If you are going to reenter your CASH RECEIPT DOCUMENT using the START-UP, CASH RECEIPT DOCUMENT INPUT SCREEN and CASH RECEIPT DOCUMENT LINE SCREEN move the cursor to the MODE OF OPERATION field and follow standard directions for completion in RCM 9.10.72 through 9.10.78.

9.10.126 Determining That An Incorrect Payor Number Exists On An Unprocessed Billing Document

The PAYOR NUMBER is the primary key to finding information, in the PAR system, and should be checked very carefully before a document is processed.

You would want to change the PAYOR NUMBER on your unprocessed BILLING DOCUMENT for either of the two following reasons.

- You made a data entry error in the PAYOR NUMBER field on the BILLING DOCUMENT INPUT SCREEN, and that FIELD does not match with a PAYOR NUMBER established in PARS on PAYR and PDIT record.
- You made a data entry error in the PAYOR NUMBER field on the BILLING DOCUMENT INPUT SCREEN, PAYR record and PDIT record.

You would know that there is a problem with the PAYOR NUMBER:

- By visual inspection of the PAYOR NUMBER field on the BILLING DOCUMENT INPUT SCREEN. (This is very important, because if you make the same error in this field on the PAYR table and the PDIT table as well as the BILLING DOCUMENT INPUT SCREEN there is no system edit to tell you that the PAYOR NUMBER is incorrect. The edits tell you that what is displayed in the PAYOR NUMBER field on the BILLING DOCUMENT INPUT SCREEN has not been established in the required PAR system reference tables. This happens because: 1. data entry errors on that screen cause it not to match with previously established records, or 2. the proper reference table records have not been established.), or
- By the display of the following messages at the bottom of the BILLING DOCUMENT INPUT SCREEN:

H--PP86E - PDIT TABLE ENTRY NOT FOUND

H--BD11E - INVALID PAYOR CODE

9.10.127 Correcting The Payor Number Field On The Billing Document Input Screen

- A. If you first notice that there is a problem with the PAYOR NUMBER field on the BILLING DOCUMENT input screen because the edit messages H--INVALID PAYOR CODE and H--PP86E - PDIT TABLE ENTRY NOT FOUND appear at the bottom of the BILLING DOCUMENT INPUT SCREEN after editing take the following basic steps:
- Validate the entry in the PAYOR NUMBER field.
 - Correct the entry in the PAYOR NUMBER field if it is wrong.
 - Edit the document.
 - If the edit messages indicating a problem with the PAYOR NUMBER field are no longer displayed, prepare your document for approval and scheduling following standard instructions.

- If the entry in the PAYOR NUMBER field is correct, or if edit messages indicating a PAYOR NUMBER problem still appear after correcting that field proceed to 9.10.129.

To correct the PAYOR NUMBER, if it is incorrect do the following:

- Move the cursor to the PAYOR NUMBER field.
- Type the correct PAYOR NUMBER over the data displayed in that field taking care that you begin entering data with the first position in the field.

Edit the document by moving the cursor to the ACTION field of the table action line and type Q.

- Press the ENTER key.
- If edit messages H--INVALID PAYOR CODE and H--PP86E-PDIT TABLE ENTRY NOT FOUND are displayed at the bottom of the BILLING DOCUMENT INPUT SCREEN, proceed to D of this section.
- If the above edit messages no longer appear, and there are no other problems, follow instructions in RCM 9.10.63-64 for having the document approved and scheduled.

B. If you have determined by scanning your BILLING DOCUMENT INPUT SCREEN that the PAYOR NUMBER is incorrect take the following basic steps:

- complete your data entry action on the billing document. (Completing all necessary lines and fields will preclude any future need for using a special command to add lines and will prevent unnecessary edit messages from being generated when you edit your document), and
- edit the billing document.

You are editing the document to determine if the bad PAYOR NUMBER detected by sight on the billing document also exists in PAYR and PDIT records.

- If the messages H--BD11E-INVALID PAYOR CODE and H--PP86E-PDIT TABLE ENTRY NOT FOUND are not displayed after editing proceed to 9.10.128.
- If the messages H--BD11E-INVALID PAYOR CODE and H--PP86E-PDIT TABLE ENTRY NOT FOUND are displayed after editing proceed to 9.10.129.

9.10.128 Correcting The Payor Number When No PAYR/PDIT Record Exist

If the PAYOR NUMBER on the BILLING DOCUMENT INPUT SCREEN determined by sight to be incorrect and no edit messages are generated indicating conflict with or lack of PAYR/PDIT records with that same PAYOR NUMBER (i.e., the same incorrect number is present in the PAYR/PDIT records created for this receivable) you will be taking the following basic steps:

- Correct the PAYOR NUMBER field as you did in A of 9.10.127.
- Leave the BILLING DOCUMENT INPUT SCREEN using the pause command.
- Add a correct PAYR record
- Delete the incorrect PDIT record
- Add a correct PDIT record
- Delete the incorrect PAYR record
- Return to the BILLING DOCUMENT INPUT SCREEN
- Re-edit the BILLING DOCUMENT INPUT SCREEN.

To accomplish these steps do the following:

To correct the Payor number field on the BILLING DOCUMENT INPUT SCREEN:

- Move the cursor to the PAYOR NUMBER field.
- Type the correct PAYOR NUMBER (See RCM 9.10.56 for the correct PAYOR NUMBER format).

To use the pause command to leave the input screen and go to the PAYR record:

- Move the cursor to the ACTION field of the document action line and type P in that field.
- Press the ENTER key. The message V2 ENTER NEXT TASK CODE will be displayed.
- Type MTI, press the space bar and type PAYR.
- Press the ENTER key. You are now viewing a blank PAYR record.

To add a correct PAYR record:

- Type S in the ACTION field, move the cursor to the USER ID field and type your USER ID in that field, all on the table action line.
- Move the cursor to the PAYOR NUMBER field and type in the erroneous PAYOR NUMBER you just typed over on the BILLING DOCUMENT INPUT SCREEN.
- Press the ENTER key. The record with the bad PAYOR NUMBER will now be displayed.
- Type A in the ACTION field of the table action line.
- Move the cursor to the PAYOR NUMBER field and type the correct PAYOR NUMBER in that field.
- Press the ENTER key. The screen will now display the message 01-*LO130 ALL LINES ADDED. By accessing the bad record first and then typing over the bad PAYOR NUMBER with the correct one, giving it a new key identifying field, you are able to add this corrected record as a brand new record without changing or entering any fields beside the PAYOR NUMBER field.

To delete the incorrect PDIT record:

- Type L in the ACTION field and PDIT in the TABLE ID field of the table action line.
- Move the cursor to the PAYOR NUMBER field and type in the bad PAYOR NUMBER (you want to access the PDIT record with the bad PAYOR NUMBER).
- Press the ENTER key. You will now be viewing the PDIT record with the bad PAYOR NUMBER.
- Type D in the ACTION field of the table action line (you are deleting this record because you cannot change a key identifying field on a record in PARS, you must delete the bad record and add a new one).
- Press the ENTER key. The message 01--*L032 ALL LINES DELETED should be displayed at the bottom of the screen.
- If the message 01--PPF2E CANNOT DELETE WHEN PDIT EXISTS is displayed, this PAYOR NUMBER is being used for another receivable. Take no further steps to delete it.

To add a correct PDIT record:

- Keep all the data you deleted displayed on the PDIT screen. Type A in the ACTION field of the table action line.
- Using a TAB key move the cursor to the PAYOR NUMBER field.

- Type in the correct PAYOR NUMBER. You will not have to type in any other information if all the information entered into the record you deleted, outside of the PAYOR NUMBER, is correct.
- Press the ENTER key. The message 01-*L030 ALL LINES ADDED will be displayed at the bottom of the screen.

(So far you have corrected the PAYOR NUMBER on the BILLING DOCUMENT INPUT SCREEN added a PAYR record with the correct PAYOR NUMBER, deleted the PDIT record with the incorrect PAYOR NUMBER, and added a PDIT record with the correct PAYOR NUMBER. Before returning to the billing document you will have to delete the PAYR record with the incorrect PAYOR NUMBER. This could not be done the first time you accessed the PAYR table because you cannot delete a PAYR record when a PDIT record exists and you cannot add a PDIT record if the PAYOR NUMBER is not first established on the PAYR table. So, you will now have to return to the PAYR table.

To delete the incorrect PAYR record:

- Type L in the ACTION field and PAYR in the TABLE ID field of the table action line.
- Move the cursor to the PAYOR NUMBER field and type in the bad PAYOR NUMBER.
- Press the ENTER key. The PAYR record with the bad PAYOR NUMBER will now be displayed.
- Type D in the ACTION field of the table action line.
- Press the ENTER key. The message 01-*L032 ALL LINES DELETED will be displayed. You can now return to your billing document.

To return to the BILLING DOCUMENT INPUT SCREEN:

- Type E in the ACTION field of the table action line (exit tables).
- Press the ENTER key.
- The screen will now display the message V2 ENTER NEXT TASK CODE. Type DDB.
- Press the ENTER key.
- The BILLING DOCUMENT INPUT SCREEN that you originally left using the pause (p) command will now be displayed, without having to enter any identifying information.

To re-edit the INPUT SCREEN

- Type Q in the ACTION field of the document action line to make sure all actions have been correctly taken.
- Follow standard directions to hold the document in the suspense file for approval and scheduling.

9.10.129 Correcting PDIT/PAYR Records When Billing Document Field Is Correct

If the PAYOR NUMBER field is correct or has been corrected but edit messages are displayed showing that an invalid PAYOR NUMBER has been used and a PDIT record cannot be found with that PAYOR NUMBER you must take the following basic steps:

- Leave the BILLING DOCUMENT INPUT SCREEN using the pause command.
- Scan the PDIT table to attempt to locate the bad record.
- If it is not located:
 - Add the correct PAYR record.
 - Add the correct PDIT record.
- If it is located:
 - Add a correct PAYR record
 - Delete the bad PDIT record
 - Add the correct PAYR record
- Return to the BILLING DOCUMENT INPUT SCREEN.

To accomplish these steps do the following:

To leave the BILLING DOCUMENT INPUT SCREEN:

- To see if there is a record using the prefix and claim number of your receivable and the BILLING DOCUMENT ID you are using for the receivable in question, you must leave the BILLING DOCUMENT INPUT SCREEN to check PDIT.
 - Type P in the ACTION field of the document action line.
 - Press the ENTER key.

- If you entered the document through the START-UP screen you will see the message V2 ENTER NEXT TASK CODE. Type MTI, space with the space bar, then type PDIT.
- If you entered the document through the SUSPENSE FILE screen from which you accessed your billing document, type N in the ACTION field and PDIT in the TABLE ID field of the table action line.
- Press the ENTER key.

To scan the PDIT Table:

- You are now viewing a blank PDIT screen. Type S in the ACTION field, and your USERID in the USERID field of the table action line.
- Type the prefix and claim number (entering zeroes between the prefix and the first position of the claim number, if it is less than 9 positions) in the PAYOR NUMBER field (do not enter anything in the last position of the field).
- Press the ENTER key.
- You are now viewing the first record in the PDIT table that matches the data you entered in the PAYOR NUMBER field, if such a record exists, or the closest number subsequent to the number you entered if that number doesn't exist on a record. Determine if the number displayed is the same as the number you entered. (If it isn't you will have to add a PAYR and a PDIT table record for your overpayment following standard directions in RCM 9.10.56 and 9.10.57.) If the first ten positions of the PAYOR NUMBER are the same as you entered previously proceed with these directions.
- Look at the BILLING DOCUMENT ID field. If that ID is not the same as for your receivable, press the ENTER key. The screen will fill with the next record in sequence. Scan the records in PDIT until you locate one with the same BILLING DOCUMENT ID or until you have seen all the records in PDIT in which the first ten positions of the PAYOR NUMBER matches the prefix and claim number of the overpayment.
- If you cannot match the prefix, claim number, and BILLING DOCUMENT ID, you do not have to take any further steps to locate the bad PDIT/PAYR records that may have been entered. Add PAYR and PDIT table records to the PAR system following standard directions in RCM 9.10.56 and 9.10.57 (remember the PAYR record must be added before the PDIT record).
- you do match on the first ten positions of the PAYOR NUMBER and the BILLING DOCUMENT ID you have located the bad PDIT record. All the information on the record should be correct except for the last position of the PAYOR NUMBER, just

as it should be on the PAYR record. The necessary steps you will have to take in their correct sequence are:

- Add a PAYR record with the correct PAYOR NUMBER.
- Delete the PDIT record with the incorrect PAYOR NUMBER.
- Add the PDIT record with the correct PAYOR NUMBER.
- Delete the PAYR record with the incorrect PAYOR NUMBER.
- Return to the billing document to reedit it and put it on hold status in the SUSPENSE FILE for approval and scheduling.

To add a correct PAYR Record:

- Type L (leaf command) in the ACTION field and PAYR in the TABLE ID field of the document action line.
- Press the ENTER key. You are viewing the PAYR record with the incorrect PAYOR NUMBER.
- Type A in the ACTION field of the table action line.
- Move the cursor to the PAYOR NUMBER field using a TAB key. Using the arrow key (arrow pointing right) move the cursor to the last position of the field. Type in the correct alpha or numeric character.
- Press the ENTER key.
- The message 01-*030 ALL LINES ADDED will be displayed.

To delete the incorrect PDIT record:

- Type L in the ACTION field and PDIT in the TABLEID field of the document action line.
- Move the cursor to the PAYOR NUMBER field using a tab key. Move the cursor to the last position of the field and type in the incorrect character (you want to leaf back to the PDIT record with the bad PAYOR NUMBER).
- Press the ENTER key.
- You will now have the PDIT record with the bad PAYOR NUMBER displayed.
- Type D (delete) in the ACTION field of the table action line.

- Press the ENTER key. The message 01-*L032 ALL LINES DELETED will appear at the bottom of the screen. If the message 01-PPF2E CANNOT DELETE WHEN PDIT EXISTS is displayed, this PAYOR NUMBER is being used for another receivable. Take no further steps to try and delete it.

To add a correct PDIT record:

- Type A in the ACTION field of the table action line.
- Move the cursor to the PAYOR NUMBER field using a tab key. Move the cursor to the final position of the field using the arrow key (arrow points right)I. Type the correct character in that position.
- Press the ENTER key. The message 01-*L030 ALL LINES ADDED will be displayed at the bottom of the screen.

To delete the incorrect PAYR record:

- Type L (leaf) in the ACTION field and PAYR in the TABLEID field of the table action line.
- Press the ENTER key. The PAYR record with the correct PAYOR NUMBER will now be displayed on your screen.
- Type D in the ACTION field of the table action line.
- Move the cursor to the PAYOR NUMBER with a tab key. Move the cursor to the final position of the field and type in the erroneous final character.
- Press the ENTER Key. The message 01-L032 ALL LINES DELETED will now be displayed on the screen. You have now added a PAYOR and a PDIT table record and deleted a PAYOR and PDIT table record using only table commands and entering data only in the final position of the PAYOR NUMBER field.

To re-edit the billing document:

- Type E in the ACTION field of the table action line.
- Press the ENTER key. The message V2 ENTER NEXT TASK CODE will be displayed.
- Type DDB
- Press the ENTER key. The document you left to access the PAYR and PDIT tables is now displayed. Quick edit the document to verify that there is no further problem. Then place it on hold status in the SUSPENSE FILE for approval and scheduling following standard instructions.

9.10.130 Changing A Payor Number On A Cash Receipt Document

You would need to change the PAYOR NUMBER on your unprocessed CASH RECEIPT DOCUMENT if you made a data entry error in the PAYOR NUMBER field on the CCIT record that created the CASH RECEIPT DOCUMENT or in direct entry of that field on the CASH RECEIPT DOCUMENT LINE SCREEN. When you are manually completing a CASH RECEIPT DOCUMENT LINE SCREEN, follow directions in RCM 9.10.74 to leave the VND/PRV field blank; this will result in the system filling this field with the PAYOR NUMBER associated with the BILLING DOCUMENT ID entered in the REFERENCE NUMBER field. This guarantees you will not have an erroneous entry in this field, unless the error is initiated on CCIT.

You will know that the PAYOR NUMBER in the VND/PROV field is incorrect if the following message is displayed on the bottom of the CASH RECEIPT DOCUMENT LINE SCREEN:

- CR32E-VEND CODE NOT = AR ENTRY.

To correct an erroneous PAYOR NUMBER in the VND/PRV field on a CASH RECEIPT DOCUMENT LINE SCREEN you will basically have to take the following three steps:

- validate the entries in the REF TC and REF NUMBER fields,
- erase the entry in the VND/PRV field, and
- QUICK EDIT the CASH RECEIPT DOCUMENT to mechanically complete the VND/PRV field with the PAYOR NUMBER from the billing document referred to in the REF TC and REF NUMBER fields.

To accomplish those steps do the following:

To validate the entries in the REF TC AND REF NUMBER fields:

- Compare the entries in REF TC and REF NUMBER with the BILLING DOCUMENT ID of the overpayment to which you wish to post a cash receipt.
 - If the data in these two fields is incorrect, take action as described in RCM 9.10.125. Then, proceed with the remaining necessary steps to correct the VND/PRV field.
 - If the data in these two fields is correct proceed with the remaining necessary steps to correct the VND/PRV field.

To erase the VND/PRV field:

- Move the cursor to the VND/PRV field using the tab key. Press the space bar once for each completed position in this field, erasing its contents.

To Edit:

- Move the cursor to the ACTION field of the document action line. Type Q in that field.
- Press the ENTER key. The message CR32E-VEND CODE NOT = AR ENTRY will no longer be displayed at the bottom of the screen. The VND/PRV field will now be completed with the PAYOR NUMBER from the referenced billing document.

9.10.131 Modifying A Receivable After It Has Been Processed In PARS

- A receivable can be changed after it is established in the PAR system by entering a modified billing document transaction in PARS with the same BILLING DOCUMENT ID as the receivable with the data you wish to change.
- To change any offset posted to a receivable you must MODIFY the CASH RECEIPT DOCUMENT on which the offset was posted.
- The following information requires BOTH a TABLE Change and a BILLING DOCUMENT MODIFICATION:

PAYR NAME 1st LINE	PAYR
PAYR NAME 2nd LINE	PDIT
The address to be displayed on installment billing and dunning notices.	PAYR

- The contents of the following fields listed in the right hand column can be modified by changing table data OR by a BILLING DOCUMENT MODIFICATION. If there are no other changes needed for the receivable make your change on the TABLE involved rather than with a BILLING DOCUMENT MODIFICATION. If one of these fields needs an immediate change, make the change on the TABLE involved even if a BILLING DOCUMENT MODIFICATION is necessary.

FIELD	TABLE
DUNNING FLAG	OBDT
BILL PRINT FLAG	OBDT

WAIV FLAG	OBDT
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DATA	TABLE
Indicator of a request for waiver or reconsideration of overpayment	WAIV
Expiration date for waiver or reconsideration of overpayment request	WAIV
Date waiver or reconsideration of overpayment denial was released	WAIV
The type of text to be used on installment bills	INBT
Installment billing effective date	INBT
The amount of an installment bill agreement	INBT
The indicator that an installment billing agreement is active	INBT
The code indicating where a receivable has been referred for recovery or additional development	AREF
Date that the referral code is effective	AREF
Amount of full or partial withholding	RECR
The code indicating if the recovery is partial or full withholding	RECR
The code indicating if recovery by partial or full withholding is currently in force	RECR

E. The following changes could be made by MODIFYING the original BILLING DOCUMENT:

- Reduce the amount of the receivable to remove any erroneous amount;
- Reduce the amount of the receivable because an outstanding check or electronic fund transfer (EFT) payment has been returned, even if it reduces the receivable to zero;

- Change contents of PAYOR NAME field stored in PARS (ARHT);
- Change the DUNNING FLAG;
- Change the BILL PRINT FLAG;
- Change the WAIV flag
- Add PENALTY, ADMINISTRATIVE COST or INTEREST lines to a BILLING DOCUMENT;
- Change the collection due date;
- Correct the amount of PENALTY ADMINISTRATIVE COST or INTEREST lines on a BILLING DOCUMENT;
- Correct CAUSE, SOURCE and TYPE CODES
- Within limitations, modify a line amount to zero and add it back for the same transaction with different entries in the non-modifiable fields.
- If a BILLING DOCUMENT must be removed from PARS and the action cannot be taken in the same month the document was established you must MODIFY the amount to zero. If a BILLING DOCUMENT transaction can be processed within the same month as the original BILLING DOCUMENT entered, CANCEL the BILLING DOCUMENT (See RCM 9.10.142).

F. Miscellaneous Information on Document Modifications.

Do not attempt to MODIFY a document while there is a document transaction with the same ID NUMBER on the suspense file (SUSF). A DOCUMENT ID on the SUSF must be unique. If you complete a START-UP screen to begin the process of MODIFYING a document, and the DOCUMENT ID entered exists on SUSF, the following edit message will be generated

"A--*CD31 - DUPLICATE DOCUMENT ID" and the system will not allow you to enter the DOCUMENT INPUT SCREEN.

You can only modify to decrease the open balance amount on a BILLING DOCUMENT LINE.

If you need to decrease a BILLING DOCUMENT open balance after a cash receipt document has been posted; (the original overpayment was larger than the current balance), you will have to modify the amount of the cash receipt document to zero first to increase the open balance of the overpayment to the amount of the necessary modification. The excess amount, depending on the type of action it was, will have to be refunded to the PAYOR, returned to

Treasury, or no further action taken if the cash receipt action had been a write-off to uncollectible. See RCM 6.6 for appropriate actions to take.

MODIFICATION is done on the same BILLING DOCUMENT screens used for initial data entry

- BILLING DOCUMENT INPUT SCREEN
- BILLING DOCUMENT LINE SCREEN

In general, you only need to enter the data you are changing.

Never manually enter more data than you absolutely have to on a document MODIFICATION. When you QUICK EDIT the document the system will fill in the missing document data from information stored in ARHT and ARLT. Let the system do the work for you and avoid the risk of making a mistake.

9.10.132 Basic Data Input Instructions For A Billing Document Modification (No change in amount)

To Modify a Billing Document:

1. Access the billing document input screen for the document to be modified.
2. Type M (Modify) in the Action field.
3. Move the cursor to the field(s) you wish to change and type in the new data.
4. Access the document line screen if charges are needed there.
5. Quick Edit and Hold the document for approval and scheduling.

PREPARATION

- Know the ID NUMBER of the BILLING DOCUMENT you are MODIFYING.
- Know the numbers of the BILLING DOCUMENT LINES you want to change. (Check ARLT and ARCL - secure prints if necessary).
- Know the amount by which you want to increase or decrease any lines.
- Know what codes you will need to enter, if any.

SIGNON

- Sign on to the PAR system as directed in RCM 9.10.50.

- When the message "V2, ENTER NEXT TASK CODE" is displayed, type DDB to access the STARTUP screen.
- Press the ENTER key. The STARTUP screen will now be displayed.

STARTUP SCREEN

- Type D in the MODE of OPERATION field.
- Complete the DOCUMENT ID line of the STARTUP screen.
 - Type B2 in the TRANS field.
 - Type 2000 in the DIVISION field.
 - Type the DOCUMENT ID NUMBER of the BILLING DOCUMENT you are modifying in the NUMBER field.
- Move the cursor to the USERID field using a TAB key. Type your USERID in this field.
- Press the ENTER key. The BILLING DOCUMENT INPUT SCREEN will now be displayed.

BILLING DOCUMENT INPUT SCREEN

- Move the cursor to the ACTION field of the DOCUMENT INPUT SCREEN (not the ACTION field of the document action line) using a tab key and type M (MODIFY).
- Move the cursor to the field you want to change, if it is modifiable. See RCM 9.10.133 for a list of fields that may and may not be changed directly with a billing document MODIFICATION. Type in the new data.
 - If the only fields you are changing are displayed on the DOCUMENT INPUT SCREEN, you do not have to access the DOCUMENT LINE SCREEN (e.g., your change involves DUNNING FLAG, BILL PRINT FLAG). The only exception to this is the TEXT TYPE field (See RCM 9.10.137).
 - If your MODIFICATION involves increasing or decreasing a receivable amount see RCM 9.10.134.
 - If your MODIFICATION involves a PAYOR NAME/ADDRESS see RCM 9.10.138.
 - If your modification involves adding PENALTY, ADMINISTRATIVE COST or INTEREST lines to the BILLING DOCUMENT see RCM 9.10.135.
- Type in the correct entry. RCM 9.10.133 lists options for MODIFIABLE fields.

BILLING DOCUMENT LINE SCREEN

- If you need to change a field located on a BILLING DOCUMENT LINE SCREEN, after you have completed all necessary entries on the BILLING DOCUMENT INPUT SCREEN:
 - Press the ENTER key. The BILLING DOCUMENT LINE SCREEN will be displayed
 - The cursor will be in the first position of the LINE NO field. Type in the line number of the BILLING DOCUMENT LINE with the data you wish to change.
 - Move the cursor directly to the field you want to change (e.g., the TYPE CODE field) and type in the desired data.
 - If there are more BILLING DOCUMENT LINES in which you need to enter change data move the cursor to the LINE NO field on the second empty BILLING DOCUMENT and type in the line number for the next BILLING DOCUMENT LINE that requires changes. Move the cursor to the field you will be changing using a tab key. Type in the change data. If you need another blank line, press the ENTER key and two more blank BILLING DOCUMENT LINES will appear on your screen. Remember, when MODIFYING data in PARS using a BILLING DOCUMENT, you only have to modify fields relevant to the specific change. You do not have to have any BILLING DOCUMENT LINES on your MODIFICATION transaction if you do not have to change a field on a line. You do not have to have an entry for each line existing on a PARS receivable, only on the lines that need correction.

QUICK EDIT

- When you have completed your entries QUICK EDIT your document as directed in RCM 9.10.108.

HOLD FOR APPROVAL AND SCHEDULING

- After successfully editing your document place it on HOLD in the suspense file (type H in the ACTION field of the document action line and press the ENTER key) to await approval and scheduling, just as you would an initial document.

9.10.133 Billing Document Fields And Modification

The following is a list of BILLING DOCUMENT fields. The narrative to the right of the field states if the field can be directly MODIFIED or used in MODIFYING a BILLING DOCUMENT, and what the possible entries are for the field.

Field Name	Narrative
DOC DATE	NOT MODIFIABLE
ACCTG PERIOD	NOT MODIFIABLE
TRANS TYPE	NOT MODIFIABLE
BUDGET FY	NOT MODIFIABLE
ACTION	Always complete with M when MODIFYING a document.
TOTAL	<p>This field contains the combined amount of all the lines you are entering in your document transaction. This does <u>not</u> represent the total amount of the receivable after the transaction is processed unless the transaction will establish the receivable in PARS.</p> <ol style="list-style-type: none"> 1. Add together all increased line amounts from your transaction. If you are only establishing or increasing a receivable amount, enter this amount in the TOTAL field. 2. Add together all decreased line amounts. If you are only decreasing the receivable amount, enter this amount in the TOTAL field. 3. If you have both line increase and decreases in your transaction, determining which is greater the combined increase or combined decreases. Subtract the smaller amount from the larger amount and enter the difference in the TOTAL field. 4. If your increases equal your decreases enter 0.00 in the TOTAL field.
COMMENTS	<p>No edits exist on this field and there are no limits to changes except for the 12 position size of the field. Whatever is entered in this field will completely replace whatever existed in the COMMENTS field in the accounts receivable header table (ARHT) before the modification. You cannot truly erase the contents of this field if it is erroneous and you have no information you want entered. However, simply type a single asterisk in this field when modifying the BILLING DOCUMENT and you will get the desired effect.</p>

BILL PRINT FLAG	<p>MODIFIABLE FIELD</p> <p>The following are BILL PRINT FLAGS currently used in PARS.</p> <p>Y = Command to print a bill. This is used by ORSP only in the installment bill process and is usually system generated.</p> <p>P = Y command has been processed, a bill has been released and necessary dates generated in PARS.</p> <p>S = Command to generate system dates as though a bill has been generated but no PARS bill is issued.</p> <p>U = S command has been processed, dates have been generated, no bill was released.</p> <p>N = Command not to issue a bill or generate system dates. Used by ORSP on initial BILLING DOCUMENTS.</p> <p>A BILL PRINT FLAG of Y can be entered no matter what BILL PRINT FLAG already exists in PARS. BILL PRINT FLAGS of P and U can never be manually entered in PARS, only system generated after Y and S flags are processed. An existing BILL PRINT FLAG can never be modified to an N. A BILL PRINT FLAG can be MODIFIED to S only if the existing BILL PRINT FLAG is N. The most frequent reason for changing this field is release of the overpayment letter sometime after establishment of the overpayment in PARS. <u>This field can also be directly changed with a CHANGE command on the OBDT.</u></p>
COLLECTION DUE DATE	<p>MODIFIABLE FIELD</p> <p>This is a six position field. Two positions are allotted and must be completed for the following: month, day, year. Example: 10 01 91.</p> <p>The COLLECTION DUE DATE is calculated to be 30 days after the release of the overpayment letter or waiver/reconsideration/ hearings and appeal denial letter. In PARS this is calculated from the BILL PRINT DATE in ARHT or WAIV DENIAL DATE field in WAIV.</p> <p>This date is used to determine when initial PENALTY is</p>

	<p>charged and when the first DUNNING notice is released. When recurring administrative costs are implemented in PARS, this date will determine when the initial assessment occurs. If you need to MODIFY this field because there was a delay in the release of an initial overpayment letter, remember to correct the WAIVER EXPIRATION DATE in the WAIV table (should be the same as the COLLECTION DUE DATE).</p> <p>Do not use a BILLING DOCUMENT MODIFICATION to correct the COLLECTION DUE DATE if a BILL PRINT FLAG of N exists in ARHT/OBDT, a COLLECTION DUE DATE does not currently exist in PARS and the overpayment letter is now being released. Change the BILL PRINT FLAG to S when the letter is released. When that is processed it will mechanically set the COLLECTION DUE DATE and WAIVER EXPIRATION DATE at 30 days after processing.</p> <p>Do not change the COLLECTION DUE DATE with a BILLING DOCUMENT MODIFICATION if it needs to be changed because a waiver, reconsideration or hearings and appeal DENIAL DATE needs to be entered or corrected. Changing/entering the denial date in the WAIV table will automatically reset the COLLECTION DUE DATE to thirty days after the denial date.</p>
DUNNING FLAG	<p>MODIFIABLE FIELD</p> <p>This is a one position field. There are two possible entries:</p> <p>Y = Yes Dunn</p> <p>N = No, don't dunn (or stop dunning).</p> <p>If the wrong flag was initially entered, either flag can be entered at any time. <u>If this is the only field you need to change (nothing else is being modified), change it on OBDT.</u> If you are changing the BILL PRINT FLAG from N to S, remember to change the DUNNING FLAG from N to Y at the same time.</p>
WAIVER FLAG	<p>MODIFIABLE FIELD</p> <p>This field has two positions, the acceptable flags for this field can be either one or two positions.</p> <p>This field allows for control of exactly what charges are</p>

	<p>assessed. This field in PARS for ORSP (displayed on ARHT or OBDT) is most commonly blank (assess all charges) or filled with a A (don't assess any charges). Other acceptable flags are:</p> <p>I - waive interest charges</p> <p>H - waive administrative costs</p> <p>P - waiver penalty charges</p> <p>IH - waiver interest and administrative costs</p> <p>IP - waive interest and penalties</p> <p>HP - waive administrative costs and penalties</p> <p>There are no restrictions on changes. You can modify the field to any acceptable flag. If you want to change the contents of the field from an absolute value to spaces (assess all charges) enter an asterisk (*) in this field when doing your BILLING DOCUMENT MODIFICATION. This is because a blank field on the DOCUMENT INPUT or LINE SCREEN in a BILLING DOCUMENT MODIFICATION is interpreted by the system as no change wanted (i.e., you only complete the fields you want to change). The asterisk is interpreted by the system as a request to fill this field with spaces. <u>If this is the only change you need to make, change this field on OBDT.</u></p>
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TEXT TYPE	<p>MODIFIABLE FIELD</p> <p>This is a two position field.</p> <p>Possible entries:</p> <p>TA - No charges will be assessed, conversion</p> <p>TB - No charges assessed and will not be referred out if payments default. Instead, administrative offset will be initiated.</p> <p>TC - Charges will be assessed if installment payments are delinquent or default.</p> <p><u>This code should be entered on the INBT record when you</u></p>
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	<p>are establishing the installment billing record. <u>If you insert the wrong code, it is also easier to change on the INBT record.</u> Should you want to change or enter text on a BILLING DOCUMENT MODIFICATION, the code you choose must be entered in the TEXT TYPE field both on the BILLING DOCUMENT INPUT SCREEN and the BILLING DOCUMENT LINE SCREEN. Current TEXT TYPE is displayed both on the ARHT and INBT screens for the receivable.</p>
PAYOR NUMBER	<p>NOT MODIFIABLE FIELD</p> <p>This is a key identifier in PARS. If it is wrong you must CANCEL the BILLING DOCUMENT (if the CANCELLATION can be processed in the same month the receivable was established in PARS) or MODIFY the amount to ZERO, then reenter a new BILLING DOCUMENT with the correct PAYOR NUMBER.</p>
PAYOR NAME	<p>MODIFIABLE FIELD</p> <p>Before processing a name change by a BILLING DOCUMENT MODIFICATION, the change must first be made on the PAYOR. The PDIT must also be changed if the name change involves the second line of the PAYOR NAME. (See RCM 9.10.138). After that is done, pull the change through the system by processing a BILLING DOCUMENT MODIFICATION. The only entry needed to make the MODIFICATION is the M in the action field of the BILLING DOCUMENT INPUT SCREEN. Do not enter anything in the PAYOR NAME field; the information will be pulled through from the PAYOR record. PAYOR NAME is also displayed on PAYR, PDIT, ARCH and ARHT record. The BILLING DOCUMENT MODIFICATION will correct the display on the ARHT screen.</p>
PAYOR ADDRESS	<p>MODIFIABLE FIELD</p> <p>Before processing an address change on a BILLING DOCUMENT MODIFICATION, the change must first be made on the PAYOR record for the receivable (see RCM 9.10.138). After that is done, pull the changes through the system by processing BILLING DOCUMENT MODIFICATION. The only entry you must make is M in the ACTION field of the BILLING DOCUMENT INPUT SCREEN (not the document action line). Do not enter anything in any of the address fields; the data will be pulled</p>

	through from the PAYOR record. The PAYOR ADDRESS is displayed on the ARCH, PDIT and ARHT screens. The BILLING DOCUMENT MODIFICATION changes the display on ARHT screen.
CAUSE OF OVERPAYMENT	<p>MODIFIABLE FIELD</p> <p>This is a three position field. All three positions must be completed. Any existing CAUSE of OVERPAYMENT CODE can be changed to any CAUSE OF OVERPAYMENT CODE that is valid in the system. The PARS CAUS TABLE contains a complete list of CAUSE OF OVERPAYMENT CODES. Be careful not to use any CAUSE CODE designated as belonging to SUBD or DBD on the CAUS table. The current CAUSE OF OVERPAYMENT CODE for the receivable is displayed on the ARHT or ARCH screen.</p>
LINE NO.	NONMODIFIABLE FIELD
BFY (BUDGET FISCAL YEAR)	NONMODIFIABLE FIELD
FUND	NONMODIFIABLE FIELD
TRANSType (TRANSACTION TYPE)	NONMODIFIABLE FIELD
ORG/SUB ORGANIZATION CODE/ SUBORGANIZATION CODE	NONMODIFIABLE FIELDS
BFYS (BUDGET FISCAL YEARS)	NONMODIFIABLE FIELD
FUND	NONMODIFIABLE FIELD
BOC (BUDGET OBJECT CODE)	NONMODIFIABLE FIELD
AMOUNT	<p>MODIFIABLE FIELD</p> <p>The amount of a receivable can be increased or decreased. This field on the BILLING DOCUMENT LINE SCREEN is completed with the amount you want to increase or decrease that specific line by. See RCM 9.10.134 for</p>

	specific instructions on modifying amounts. Line amount totals can be secured from the ARLT table record for the receivable by subtracting the DOC LINE CLOSED AMT field from the DOC LINE ART field.
I/D (INCREASE/DECREASE INDICTOR)	This is not a field to be modified; however, it is an instruction related to an AMOUNT MODIFICATION. If there is an entry in the BILLING DOCUMENT LINE AMOUNT field this field must be completed with an I (increase this line of the receivable by the amount entered in the AMOUNT field) or a D (decrease this line of the receivable by the amount entered in the AMOUNT.) See RCM 9.10.134 for directions on modifying an amount.
SOURCE (SOURCE CODE)	MODIFIABLE FIELD This is a four position field. All four positions must be completed. Any existing SOURCE CODE can be modified to any SOURCE CODE valid in PARS. The PARS SRCE table contains a complete list of all SOURCE CODES valid in PARS. Be careful not to use any SOURCE CODE designated as belonging to SUBD or DBD on the SRCE table. The current SOURCE CODE for a receivable can be viewed on the ARCH or ARLT table.
TYPE OF OVERPAYMENT	MODIFIABLE FIELD This is a three position field. All three positions must be completed with any existing TYPE OF OVERPAYMENT CODE valid in PARS. The PARS TYOP table contains a complete list of all TYPE OF OVERPAYMENT CODE valid in PARS. Be careful not to use any TYPE CODE designated as belonging to SUBD or BDB. The current TYPE OF OVERPAYMENT CODE for a receivable can be viewed on ARCH or ARCT table.
ACTION OUT	This field is completed if you are DECREASING the amount of the receivable with your BILLING DOCUMENT MODIFICATION. The codes you would use are ACTION OUT codes with a first position of 8 or 9 (correction codes) and a final position of A and ACTION OUT Code 88T. (B's are used for CASH RECEIPT DOCUMENT MODIFICATIONS). Use 12A if you are reducing a receivable because the

annuity check has been returned or 12C if our EFT payment has been returned (green sheets in file). These codes are displayed in the ACOT table in PARS.
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9.10.134 Modification To Increase/Decrease Amounts

You may want to increase the amount of your receivable because:

- an erroneously low amount was entered when it was established, or
- an additional overpayment was discovered after the receivable was established but before the overpayment letter was released on the original amount.

You may want to decrease the overpayment because:

- An erroneously high amount was entered when it was established,
- a treasury check or EFT payment was returned reducing part or all of the overpayment,
- an error exists in an identifying field (DOCUMENT ID or PAYOR NUMBER, see RCM 9.10.140 for more information on this type of case) on the BILLING DOCUMENT and you want to remove it by modifying the document to zero, or
- the overpayment is no longer valid and you want to remove it by modifying the amount to zero.

Unless you can remove a BILLING DOCUMENT in the same month it is posted, you must remove it by MODIFYING the amount to zero. CANCEL a BILLING DOCUMENT only if it can be removed in the same month it was established.

Take the following steps to MODIFY the amount of a BILLING DOCUMENT:

- Sign on the PAR system as described in RCM 9.10.50.
- Secure a STARTUP screen by typing DDB after signon has been successfully completed.
 - Enter D in the MODE OF OPERATION field.
 - Enter B2 under TRANS,
 - Enter 2000 under DIVISION,
 - Enter the 11 position billing document number requiring modification under ID NUMBER.

- Enter your four character PAR identification code and your four character PAR password in the USER ID field.
- Press ENTER. A BILLING DOCUMENT INPUT SCREEN will be displayed.
- Move the cursor to the ACTION field within the BILLING DOCUMENT INPUT SCREEN (not the ACTION field on the document action line) using a tab key and type M.
- Move the cursor to the TOTAL field using a tab key and enter the total amount of the change that will be requested on all the lines entered with this BILLING DOCUMENT MODIFICATION. This field must always be numeric and be completed with a decimal point and two positions after the decimal point. Never enter commas, dollar signs or cent signs.
 - Add together all the increase amounts (i.e., all the amounts for lines for which I will be used as the INCREASE/DECREASE INDICATOR). If you only will have lines with increases in this MODIFICATION this is the amount you enter.
 - Add together all the decrease amounts (i.e., all the amounts for lines for which D will be used as the INCREASE/DECREASE INDICATOR). If you will only have lines with decreases in this MODIFICATION, this will be the amount you will enter.
 - If you will have both increases to lines and decreases to lines in this MODIFICATION, ascertain the total amount of the increases, then the total amount of the decreases. Subtract the smaller amount from the larger amount. Enter the remainder in this field. If the amount of the increases is equal to the amount of the decreases enter 0.00 in this field.
- Press the ENTER key. A BILLING DOCUMENT LINE SCREEN will be displayed.
- Type the line number of the BILLING DOCUMENT LINE you wish to MODIFY in the LINE NO. field.
- Move the cursor using the tab key to the AMOUNT field. Type the amount by which you wish to increase or decrease the line of the BILLING DOCUMENT indicated in the LINE NO. field.

Always enter the amount using a decimal point with two numeric positions completed after the decimal. Never enter commas, dollar signs or cent signs.

- Move the cursor to the I/D field using the tab key. Type I if you are increasing the BILLING DOCUMENT LINE or D if you are decreasing it.

- Move the cursor to the ACTION OUT field using a tab key. Type in the appropriate action out code (see RCM 9.10.132) if you are decreasing the receivable. If you are increasing the receivable do not complete this field.
- Following completion of the ACTION OUT field perform the QUICK EDIT process as described in RCM 9.10.61. It is essential to correct any errors which may be detected. The PAR system will not process a modification in which an error is present.
- Just as creating a billing document requires approval and scheduling, so does modification. Procedures for these functions can be found in RCM 9.10.63 and 64.

9.10.135 Modification To Add Lines

BILLING DOCUMENT LINES are added to a receivable after it has been established in PARS:

- If the overpayment was erroneously established without the supplemental annuity portion;
- If the overpayment was originally established in PARS for regular annuity only and an additional supplemental annuity overpayment is discovered before the overpayment letter is released; or
- If OPR receives payment for a receivable that includes charges not assessed by PARS (for example, from cases referred to the Department of Justice for collection).

A regular annuity overpayment LINE cannot be added to a BILLING DOCUMENT by MODIFICATION. This is because special accounting entries must be established to deal with the fund split of the entry on that line. Those entries can only be established in PARS when a BILLING DOCUMENT is initially processed, not by a document MODIFICATION.

Do not manually create BILLING DOCUMENT LINES for interest, penalty or administrative cost when a receivable should have been assessed charges but was not. This would occur if the WAIVER FLAG was erroneously coded A instead of being left blank. If the COLLECTION DUE DATE and the WAIVER EXPIRATION DATE are correct you need only change the WAIVER FLAG and PARS will calculate the charges due back to the correct date and create the BILLING DOCUMENT LINES for the charges in the next production run. If the dates are not correct, correct the WAIVER EXPIRATION DATE in the WAIV table (See RCM 9.10.167) before MODIFYING the BILLING DOCUMENT to correct the COLLECTION DUE DATE and WAIVER FLAG. If only the WAIVER FLAG needs to be changed, change it on the OBDT table (See RCM 9.10.163).

To create a LINE by BILLING DOCUMENT MODIFICATION:

SIGNON

- Sign on the PAR system as described in RCM 9.10.50.
- Type DDB on the screen displaying the message "V2 ENTER NEXT TASK CODE."

Access the STARTUP SCREEN

- Press the ENTER key. The STARTUP screen will now be displayed.
- Type D in the MODE of OPERATION FIELD
- Complete the DOCUMENT ID line.
 - Type B2 in the TRANS field (transaction code).
 - Type 2000 in the DIVISION field.
 - Type the ID number of the BILLING DOCUMENT you wish to add the LINE to in the ID number field.
- Move the cursor to the USER ID field using a tab key. Type your eight position USER ID.
- Press the ENTER key. The BILLING DOCUMENT INPUT screen will now be displayed.

BILLING DOCUMENT INPUT SCREEN

- Move the cursor to the ACTION field within the BILLING DOCUMENT INPUT SCREEN (not the ACTION field on the document action line) and type M.
- Move the cursor to the TOTAL field and type in the total amount you are adding to the established billing document (if the only action you are taking in your MODIFICATION is adding LINE 002, the contents of this field will be the same as the AMOUNT field on LINE 002).
- Press the ENTER key. A BILLING DOCUMENT LINE SCREEN will now be displayed.

Modify the BILLING DOCUMENT LINE SCREEN

The table below shows the field to be completed and the proper entries to be made on the BILLING DOCUMENT LINE SCREEN for the modifications shown below. Each field is shown in the order it is accessed as entries are made. Move the cursor to the first position of each field before making entries:

A. Creating a LINE for a supplemental annuity overpayment

- B. Creating an interest LINE
- C. Creating an administrative cost LINE
- D. Creating a penalty LINE

SEE EXHIBIT 63

QUICK EDIT

Quick edit the document transaction as described in RCM 9.10.108.

APPROVAL AND SCHEDULING

Hold the transaction for approval and scheduling as described in RCM 9.10.63-64.

9.10.136 Modification to Remove Lines from a Billing Document

You would want to remove a line from a BILLING DOCUMENT if:

- an error was made in adjudication and a portion (regular annuity or supplemental annuity) of the overpayment is erroneous,
- interest, administrative cost and/or penalty was charged erroneously,
- checks or EFT payments may have been returned, totally eliminating the overpayment, in a month other than the month the overpayment was established (i.e., you want to remove all your overpayment LINES).

In order to remove a LINE from a BILLING DOCUMENT (overpayment) you have to MODIFY the AMOUNT displayed on the ARLT screen in the DOC LINE AMOUNT field for the specific LINE of the receivable involved. If a CASH RECEIPT DOCUMENT has been processed and an amount now appears in the DOC LINE COLLECTED AMT, DOC LINE CLOSED AMT and/or DOC LINE WRITTEN OFF AMT fields on ARLT the BILLING DOCUMENT LINE cannot be removed. However, if all CASH RECEIPT LINES referencing the BILLING DOCUMENT LINE are removed first, you will be able to remove the BILLING DOCUMENT LINE (see RCM 9.10.140 for directions on removing a CASH RECEIPT DOCUMENT LINE).

Once you process a MODIFICATION to decrease a LINE by the full amount that LINE will completely disappear from ARLT. If you MODIFY the full established amount off all the LINES of any BILLING DOCUMENT, the ARCH, ARHT, ARLT, PDIT and OBDT records for that receivable will completely disappear.

If an overpayment is being completely removed and charges have been assessed, remove the charge LINES when you remove the regular and/or supplemental annuity overpayments.

DATA ENTRY FOR REMOVING BILLING DOCUMENT LINES

SIGNON

- Sign on the PAR system as described in RCM 9.10.50.
- Type DDB on the screen displaying the message "V2 ENTER NEXT TASK CODE."

STARTUP SCREEN

- Press the ENTER key. The STARTUP screen will now be displayed.
- Type D in the MODE of OPERATION FIELD
- Complete the DOCUMENT ID line.
 - Type B2 in the TRANS field (transaction code).
 - Type 2000 in the DIVISION field.
 - Type the ID number of the BILLING DOCUMENT you wish to add the LINE to in the ID number field.
- Move the cursor to the USER ID field using a tab key. Type your eight position USER ID.
- Press the ENTER key. The BILLING DOCUMENT INPUT screen will now be displayed.

BILLING DOCUMENT INPUT SCREEN

- Move the cursor to the ACTION field within the document fields (not the ACTION field on the document action line) using the type M.
- Move the cursor to the TOTAL field and type in the total amount you are removing from the established billing document.
- Press the ENTER key. A BILLING DOCUMENT LINE SCREEN will now be displayed.

BILLING DOCUMENT LINE SCREEN

- Type the LINE NUMBER of the BILLING DOCUMENT LINE you are removing in the LINE NO field of the first blank document line displayed (the cursor will already be in the correct position)

- Move the cursor to the AMOUNT field using a tab key and type the amount of the BILLING DOCUMENT LINE (DOC LINE AMT from ARLT) you are removing this BILLING DOCUMENT MODIFICATION.
- Move the cursor to the I/D field using a tab key, and type D (decrease).
- Move the cursor to the ACTION OUT field using a tab key and enter the correct three position ACTION OUT CODE that describes why you are removing part or all the BILLING DOCUMENT.

QUICK EDIT

- Quick edit the document transaction as described in RCM 9.10.108.

APPROVAL AND SCHEDULING

- Hold the transaction for approval and scheduling as described in RCM 9.10.63-64.

9.10.137 Modification To Add Text Type

This field is only entered by examiners in the overpayment recovery section (OPR) of the division of compliance (DOC).

Text type is to be established or changed only by entering the proper code on INBT (see RCM 9.10.82 for initial entry or 9.10.162 for corrections).

9.10.138 Changing Payor Name And/Or Address After The Billing Document Is Processing

Just as with an unprocessed BILLING DOCUMENT, correcting a PAYOR NAME and/or PAYOR ADDRESS after the BILLING DOCUMENT is processed requires two separate actions:

- correcting the PAYR and PDIT (if necessary) record because the name and address is taken from that data when installment bills or dunning notices are released and it is accessed there for some reports; and
- MODIFYING the BILLING DOCUMENT for the overpayment to establish the new PAYOR NAME (except for the second line) and/or address in PARS.

DATA ENTRY IN SEQUENCE FOR CHANGING NAME AND ADDRESS

Signon

- Sign on to the PAR system as directed in RCM 9.10.50.

- When the message "V2, ENTER NEXT TASK CODE" is displayed type MTI, press the space bar once, then type PAYR.
- Press the ENTER key. A blank PAYR screen will now be displayed.

PAYR SCREEN

- The cursor will be positioned in the ACTION field of the table action line. An S (SCAN) will be displayed in that field and PAYR will be displayed in the TABLE ID field. Move the cursor to the USERID field using a tab key and type your PARS USERID.
- The cursor will now be positioned in the PAYOR NUMBER field. Type the complete eleven position PAYOR NUMBER for the receivable involved.
- Press the ENTER key. The PAYR record for your receivable will now be displayed.
- The cursor will again be positioned in the ACTION field of the table action line. Type C (CHANGE).
- Move the cursor to the field (or fields, sequentially,) requiring change:
 - PAYOR NAME (first line)
 - PAYOR ADDRESS LINE 1
 - PAYOR ADDRESS LINE 2
 - PAYOR ADDRESS LINE 3 (city, state and/or zip code fields).

Type in the correct data. If the new information typed in the field is shorter than the previous entry and extra characters are displayed, erase them by pressing the space bar once for each character that needs to be removed. See RCM 9.10.56 for complete address instructions. See RCM 10.2 Appendix B for correct state abbreviations to use.

- Check your entries and make sure the address is correct and displayed as it should be for mailing purposes. If it is correct, press the ENTER key.
- The message "01-*LO31 ALL LINES CHANGED" will be displayed. If there are changes to be made on PDIT (the 2nd PAYOR NAME line has to be added, changed or removed) access the PDIT screen by doing the following:
 - Type L (leaf) in the ACTION field of the table action line.
 - Type PDIT in the TABLEID field.

- Press the ENTER key. Proceed to the following section on the PDIT screen for further instructions.

If there are no further changes needed in the PAYOR NAME, exit PAYR by doing the following.

- Type E in the ACTION field of the action line.
- Press the ENTER key.
- Proceed to section after the following section for directions on accessing the STARTUP SCREEN to enter the BILLING DOCUMENT MODIFICATION.

PDIT SCREEN

After leaving to the PDIT SCREEN from the PAYR SCREEN, you will be viewing the PDIT record with the same PAYOR NUMBER as the screen you just left.

If there are multiple billing documents associated with a PAYOR NUMBR, the first one in sequence will be displayed. Press the ENTER key and refill the screen until the record with the correct BILLING DOCUMENT ID is shown, then take the following steps.

- Type C in the ACTION field of the document action line.
- Move the cursor to the second PAYOR NAME LINE using a tab key (the first PAYOR NAME LINE and the ADDRESS LINES will reflect the changes just made on the PAYR record).
 - Type in the second PAYOR NAME line if you are adding or changing it (remove any extra letters displayed by pressing the space bar, if you are changing the name line)
 - Press the space bar once for each letter displayed if you are removing the second name line.

The name and address should now appear as you would want it on a mailing envelope.

- Press the ENTER key. The message "01-*LO31 ALL LINES CHANGED" will be displayed.
 - Type E in the ACTION field of the table action line.
 - Press the ENTER key. The message "V2 ENTER NEXT TASK CODE" will appear.
- Accessing and completing the STARTUP SCREEN
- Type DDB.

- Press the ENTER key. The STARTUP SCREEN will be displayed.
- Type D in the MODE OF OPERATION field.
- Move the cursor to the DOCUMENT ID LINE.
 - Type B2 in the TRANS field.
 - Type 2000 in the DIVISION field.
 - Type the eleven position ID NUMBER of the BILLING DOCUMENT you are MODIFYING.
- Move the cursor to the USERID field and type your USERID
- Press the ENTER key. The BILLING DOCUMENT INPUT SCREEN will be displayed.

BILLING DOCUMENT INPUT SCREEN

- Move the cursor to the ACTION field within the BILLING DOCUMENT portion of the screen (not the ACTION field on the document ACTION line) using a tab key. Type M. This is the only entry you need to make to pull the PAYOR NAME/ADDRESS changes through the system you just made on PAYR/PDIT.
- Make any other changes, if any other changes are needed.
- Home the cursor back to the ACTION field of the document action line.

QUICK EDIT

- Perform Quick edit as described in RCM 9.10.61.

APPROVAL AND SCHEDULING

- Follow directions for approval and scheduling in RCM 9.10.63 and 64.

RESULTS

- After the document transaction has been processed the corrected address can be viewed on ARHT. Remember ARHT can only display the first PAYOR NAME LINE

9.10.139 Removing And Reentering A Nonmodifiable Field

In the PAR system there are two reasons why fields can't be modified - either they are key identifying fields (PAYOR NUMBER or DOCUMENT ID, see RCM 9.10.140) or the fields are used for budgeting/accounting purposes and generate accounting, budgeting or general ledger data by the document transaction. Within certain limitations, to correct

budgeting/accounting fields, you can remove the entire DOCUMENT LINE (with the wrong data) and recreate the line with the correct data.

Restriction for Use

- To reduce the line to zero, no transactions can be posted against it. All LINES of CASH RECEIPT DOCUMENTS referring to the BILLING DOCUMENT LINE you wish to MODIFY to ZERO must themselves be modified to zero first (see RCM 9.10.146 for direction to MODIFY a CASH RECEIPT LINE to zero).
- The fields to be changed must be LINE fields (they appear on the BILLING DOCUMENT LINE SCREEN and are viewable on the ARLT (accounts receivable line table) after processing.
- You cannot remove a line 001 and restore it to change the FUND field from 8012 to *PAR. This is because a fund split (*PAR funds are divided in PARS into social security and non social security components) can only be established during initial document processing and not from a document MODIFICATION.
- If you use this method to correct a TRANSTYPE field from NA to RA (reactivated uncollectible) the MODIFICATION will not remove the receivable from the uncollectible file. Therefore, to correct this situation you would have to MODIFY the BILLING DOCUMENT with the bad TRANSTYPE to zero and enter a new BILLING DOCUMENT with the RA TRANSTYPE.

DATA ENTRY INSTRUCTIONS

Signon

- Sign on to the PAR system as described in RCM 9.10.50.
- When the message "V2 ENTER NEXT TASK CODE" appears type DDB.
- Press the ENTER key. A blank STARTUP screen will appear.

STARTUP SCREEN

- Type D in MODE OF OPERATION field.
- Complete the DOCUMENT ID line.
 - Type B2 in the TRANS field.
 - Type 2000 in the DIVISION field.
 - Type the ID NUMBER of the DOCUMENT your are going to MODIFY in the ID NUMBER field.

- Move the cursor to the USERID field using a tab key, and type your USERID.
- Press the ENTER key. A blank BILLING DOCUMENT INPUT SCREEN will now be displayed.

BILLING DOCUMENT INPUT SCREEN

- Move the cursor to the ACTION field within the BILLING DOCUMENT INPUT SCREEN (not the one on the document action line), using a tab key, and type M.
- Move the cursor to the TOTAL field using a tab key and type 0.00.
- Press the ENTER key. A blank BILLING DOCUMENT LINE SCREEN will appear.

BILLING DOCUMENT LINE SCREEN

- Type the LINE NUMBER of the DOCUMENT LINE on which you wish to change the DATA in the LINE NO field.
- Move the cursor to the AMOUNT field using a tab key and type the full amount of the DOCUMENT LINE you are going to remove and recreate. This amount is displayed in the DOC LINE AMOUNT field on the ARLT.
- Move the cursor to the I/D field using a tab key, and type D (decrease).
- Move the cursor to the ACTION OUT field and type the appropriate BD correction ACTION OUT CODE.
- Again type the LINE NUMBER of the DOCUMENT LINE you are changing in the LINE NO field of the second blank document line displayed (the cursor will have moved there after you completed the entry in the ACTION OUT field). This is because, in this particular type of transaction, you are deleting and reentering the same DOCUMENT LINE. See RCM 9.10.135 for specific field entries to add lines.
- Move the cursor to the FUND field and type the correct fund for the DOCUMENT LINE you are reestablishing. Since you are reestablishing this LINE all fields have to be completed on the line as you would for an initial billing document.
- Move the cursor to the TRAN TYPE field and type the correct TRANSACTION TYPE for the BILLING DOCUMENT LINE you are reestablishing (a print of the ARLT screen for that LINE is helpful when you are doing this).
- In the ORG/SUB field type 2000 if you are reestablishing line 001 or 002 or 1600 if you are reestablishing a charge line. Press the field tab key and type the two position unit identification code entered with the original document (displayed on the ARLT screen).

- Type the correct code in the REV SRCE/SUB field if you are reestablishing a charge line.
- Use the line tab key to move the cursor to the BOC/SUB field and type 4220 if you are reestablishing line 001 or 002.
- Use the line tab key to move the cursor to the AMOUNT field. Type the amount of the LINE (same amount that was entered in the AMOUNT field in the first line completed on the screen).
- Use the field tab key to move the cursor to the I/D field and type I.
- Use the line tab to move the cursor to the SOURCE field and type the correct four position source code for the overpayment (displayed on the ARLT screen as previously established).
- Type the correct three position type of overpayment code in the TYPE OF OVERPAYMENT field (displayed on ARLT screen as previously established).

QUICK EDIT

- Perform QUICK EDIT as described in RCM 9.10.61. The following message will be displayed at the bottom of the BILLING DOCUMENT LINE SCREEN "02-BD01W-NEW LINE ADDED TO AR".

APPROVAL AND SCHEDULING

- Follow directions for approval and scheduling in RCM 9.10.63 and 64.

RESULTS

After the document transaction is processed, the LINE will be displayed in ARLT with the correct information. An activity line will be displayed on ARCL with an ACTIVITY CODE of BA and a transaction amount of 0.00.

9.10.140 Correcting Payor Number And Billing Document ID After Processing

There is no way to change a PAYOR NUMBER and/or BILLING DOCUMENT ID on a BILLING DOCUMENT after it had been processed. These are primary identifiers for overpayments in PARS.

Do not take any corrective action if a BILLING DOCUMENT ID is incorrect unless the TRANS CODE is not B2 but it should be. It would be counter productive to remove a processed billing document from the PAR system and attempt to restore the information on a new BILLING DOCUMENT just to correct the unit identification, examiner number

or initials, serial calendar date, last digit of the year and/or counter on a BILLING DOCUMENT ID.

If the PAYOR NUMBER is incorrect, action must be taken to close out the BILLING DOCUMENT and establish one under the correct PAYOR NUMBER. This field is the only link to the DEBTOR and claim folder and, as such, it must be correct.

If there is a COLLECTION DUE DATE present on ARHT and OBDT records for the BILLING DOCUMENT that will be closed, and the current date is equal to or greater than that date, send the case to the overpayment recovery section (OPR) for corrective action.

Check if an RECR, INBT and/or AREF record exists on the PAYOR NUMBER/BILLING DOCUMENT ID you are closing out. Print a copy of the table records that exist for the BILLING DOCUMENT you are closing. After your new BILLING DOCUMENT is established create new records for the new BILLING DOCUMENT.

The following are the main steps you will take in closing out a receivable with a bad PAYOR NUMBER and reopening a new BILLING DOCUMENT with a correct PAYOR NUMBER.

1. Take prints of ARHT ARLT and ARCL screens for the BILLING DOCUMENT
 - If any exist also take prints of RECR, INBT and AREF records.
2. PAYR
 - Enter new PAYOR NUMBER in COMMENTS field of the bad PAYOR record.
 - Create a new PAYR record
3. PDIT
 - If cash receipts have been posted to the receivable with the bad PAYOR NUMBER, change the old PDIT record to display the new PAYOR NUMBER and BILLING DOCUMENT ID at the bottom of the screen.
 - Enter a new PDIT record using the new PAYOR NUMBER/BILLING DOCUMENT ID NUMBER, displaying the old PAYOR NUMBER/BILLING DOCUMENT ID at the bottom of the screen.
4. DOCUMENT PROCESSING
 - MODIFY the amount of the bad BILLING DOCUMENT to zero, or cancel it if it meets criteria
 - Establish a new BILLING DOCUMENT for the overpayment

5. After Establishment of the New BILLING DOCUMENT

- Modify the new BILLING DOCUMENT to add any necessary interest, administrative cost or penalty lines.
- Establish any necessary records in the following tables:
 - RECR
 - INBT
 - AREF
- Enter WAIVER EXPIRATION DATE in the WAIV table record consistent with the COLLECTION DUE DATE, if any.
- Take any necessary action with the overpayment.

Detailed instructions on how to do steps 1-5 follow:

Removing a BILLING DOCUMENT with a bad PAYOR NUMBER and reestablishing the receivable when no cash receipt documents exist. This includes cases where all cash receipt documents posted have been completely removed by CANCELLATION or MODIFICATION.

- Print copies of the ARHT, ARLT and ARCL records for the BILLING DOCUMENT you are going to remove. You will use these to:
 - document the folder on the change from the bad PAYOR NUMBER/TRANS CODE to the correct one (staple a note to the prints showing the new PAYOR NUMBER/BILLING DOCUMENT ID for the overpayment);
 - extract information for the new BILLING DOCUMENT you will establish for the overpayment.
- If a receivable is delinquent, it is past the collection due date, this corrective action should be taken by OPR.

PAYR Record

- Establish a new record with a correct PAYOR NUMBER if that field is incorrect.
 - Access a blank PAYR record following directions in RCM 9.10.56.
 - Type S in the ACTION field of the table action line.
 - Move the cursor to the USER ID field using a tab key and type your USER ID.

- The cursor will have moved to the PAYOR NUMBER field. Type in the incorrect PAYOR NUMBER.
- Press the ENTER key. The PAYR record that was established with the incorrect PAYOR NUMBER will be displayed.
 - Type C in the ACTION field of the table action line.
 - Move the cursor to the COMMENTS field and type "NOW (PAYOR NUMBER.)"
 - For example: NOW
 - Press the ENTER key.
- Type A in the ACTION field of the table action line.
- Move the cursor to the PAYOR NUMBER FIELD and type the correct PAYOR NUMBER.
- Move the cursor to the COMMENTS field and type "PREV" followed by the incorrect PAYOR NUMBER
- Make any other changes to the record if any are needed.
- Press the ENTER key and the record will be added under the correct PAYOR NUMBER. The message "*L030 ALL LINES ADDED" will be displayed at the bottom of the screen.
- Type L in the ACTION field of the table action line.
- Type PDIT in the TABLE ID field.
- Move the cursor to the PAYOR NUMBER field and type over the necessary characters displayed to restore the incorrect PAYOR NUMBER.
- Press the ENTER key.

PDIT RECORD

- If you corrected the PAYOR NUMBER and accessed PDIT from the PAYR table following the previous instructions you will be viewing the PDIT record for the bad PAYOR NUMBER.
 - Type A in the ACTION field of the table action line.
 - Move the cursor to the PAYOR NUMBER field and type the correct PAYOR NUMBER.

- Type in the new BILLING DOCUMENT ID for the overpayment.
- Check the rest of the fields on PDIT, make any corrections necessary.
- Move the cursor, using the line tab key, to OTHER PAYOR NAME #1 field:
 - Type the word "previous" followed by the BILLING DOCUMENT NUMBER previously used for the receivable.
 - Press the field tab key to move the cursor to the #2 field across from the PAYOR NAME #1 field and type the incorrect PAYOR NUMBER previously used for the overpayment
- Press the ENTER key. The message "L030 ALL LINES ADDED" will be displayed.
- Type E in the ACTION field of the table action line.

Transition to Document Modification

- Press the ENTER key. The message "V2 ENTER NEXT TASK CODE" will be displayed.
- Type DDB.
- Press the ENTER key. You are now viewing the STARTUP screen.

BILLING DOCUMENT TRANSACTIONS

There are two BILLING DOCUMENT TRANSACTIONS you will have to enter now:

1. One to remove the BILLING DOCUMENT with the bad PAYOR NUMBER, and
2. One to establish the overpayment in PARS with the correct PAYOR NUMBER.
 1. Remove the BILLING DOCUMENT with the bad PAYOR NUMBER
 - Type D in the MODE of OPERATION field.
 - In the DOCUMENT ID line:
 - type B2 in the Tran field.
 - type 2000 in the DIVISION field.
 - type the ID number of the document you are going to remove in the ID NUMBER field.

- Move the cursor to the USERID field using a tab key and type your USERID.
- Press the ENTER key. A blank BILLING DOCUMENT INPUT SCREEN will be displayed.

BILLING DOCUMENT INPUT SCREEN

- Move the cursor using a tab key to the ACTION field within the document screen (not the one on the document action line) and type M.
- Move the cursor to the TOTAL field and enter the amount displayed in the TOTAL AMT field from the ARHT screen for the BILLING DOCUMENT you are removing.
- Press the ENTER key. You will now be viewing a blank BILLING DOCUMENT LINE SCREEN.

BILLING DOCUMENT LINE SCREEN

Take the following steps for each open line of the BILLING DOCUMENT you are removing. Refer to the screen prints taken from the accounts receivable line table (ARLT) you took before starting.

- Type the line number of the BILLING DOCUMENT LINE to be removed in the LINE NO field
- Move the cursor to the AMOUNT field using a tab key and enter the amount shown on the ARLT printout in the DOC LINE AMT field for the document line you are closing.
- Move the cursor to I/D field using a tab key and type D.
- Move the cursor to the ACTION OUT field using a tab key and type 24A.

Repeat the above process for every line of the BILLING DOCUMENT you are removing including INTEREST, ADMINISTRATIVE COST and PENALTY.

- QUICK EDIT the document according to instructions in RCM 9.10.61.
- Type H in the ACTION field of the document action line to hold it in the suspense file for approval and scheduling.

- Press the ENTER key. You will now be viewing STARTUP screen displaying information from the document transaction you've just completed.
2. Establish the overpayment with the new PAYOR NUMBER/BILLING DOCUMENT ID.
- Type D in the MODE of OPERATION field.
 - In the DOCUMENT ID line:
 - Type B2 in the TRANS field.
 - Type 2000 in the DIVISION field.
 - Type the new BILLING DOCUMENT ID NUMBER in the ID NUMBER field.
 - Your USERID should still be displayed in the USERID field from the previous transaction. Press the ENTER key. A blank BILLING DOCUMENT INPUT SCREEN will be displayed.

BILLING DOCUMENT INPUT SCREEN

The following directions assume everything, except the PAYOR NUMBER, was correct on the previous billing document. If something else was wrong, substitute the correct information when the directions tell you to enter information from the previous BILLING DOCUMENT. Refer to the ARHT and ARLT printout from the document you MODIFIED to zero.

- Type the transaction code displayed on the ARLT printout in the TRANS TYPE field.
- Move the cursor to the ACTION field within the document and type E.
- Type the amount displayed in the BILLED AMT field on your ARHT printout in the TOTAL field. If there were interest, administrative cost or penalty lines on the BILLING DOCUMENT you are restoring you will have to MODIFY the BILLING DOCUMENT after it is processed (see RCM 9.10.135). Charge lines cannot be entered on an initial BILLING DOCUMENT.
- Move the cursor to the BILL PRINT FLAG field and type N. Type in the later of the COLLECTION DUE DATE or LAST DUN DATE displayed on the ARHT printout in the DUE DATE field. If nothing is displayed in that field in the printout leave it blank on the screen.
- Move the cursor to the DUNNING FLAG field.

- If there is an N displayed in the DUNNING FLAG field of the ARHT printout, type N in this field,
- If there is a Y in the DUNNING FLAG field on ARHT but 2 notices have already been released (DUNNING COUNT field on the ARHT printout) type N in this field to prevent further notices from being released.
- If there is a Y in the DUNNING FLAG field on ARHT; less than 2 notices have been released; the WAIVER FLAG field is blank on the printout, and interest, administrative cost and/or penalty amounts have been charged, type N in this field. You will change this to a Y if you modify your new BILLING DOCUMENT to add interest, penalty and/or administrative cost lines.
- If there is a Y in the DUNNING FLAG field, less than 2 notices have been released and the WAIVER FLAG field is blank, type Y in this field.
- If the WAIVER FLAG field on the ARHT printout is blank leave the WAIVER FLAG field on the BILLING DOCUMENT blank; if it is completed, type the code displayed in the field on the ARHT printout in the WAIVER FLAG field.
- Type the newly established correct PAYOR NUMBER in the PAYOR NUMBER field.
- Type the cause of overpayment from the ARHT printout in the CAUSE OF OVERPAY field.
- Press the ENTER key. A blank BILLING DOCUMENT LINE SCREEN will appear.

BILLING DOCUMENT LINE SCREEN

You will have to recreate any regular annuity overpayment (line 001) or supplemental annuity overpayment (line 002) associated with the billing document you removed. Use the ARLT printouts. Remember any interest, administrative cost and/or penalty lines must be added by modification after this document is processed (see RCM 9.10.135). They cannot be added on an initial billing document transaction.

- Type the line number of the first line of your restored billing document in the LINE NO field.
- Move the cursor to the FUND field using a tab key and type the correct fund for the overpayment line.
 - *PAR for line 001
 - 8012 for line 002
- Move the cursor to the ORG/SUB field using a tab key,

- Type 2000
- Press the field tab key
- Type your two position unit ID.
- Move the cursor to the BOC/SUB field using a tab key and type 4220.
- Move the cursor to the AMOUNT field and type the amount from the DOC LINE AMT field from the ARLT printout for the line number you entered in the LINE NO field.
- Move the cursor to the SOURCE field and type the source code on ARLT for the line you are restoring.
- Move the cursor to the TYPE OF OVERPAYMENT field and type the type of overpayment code displayed on ARLT for the line you are restoring.
- If the overpayment has both lines 001 and 002 complete the second line on the BILLING DOCUMENT LINE SCREEN, again following the preceding instructions.
- QUICK EDIT the document you just completed following the standard directions in RCM 9.10.61.
- Put the document on HOLD in the suspense file and submit it for approval and scheduling as described in RCM 9.10.63 and 64.

After Your Document Transactions Process

A. Results

1. Old Billing Document

- ARHT record no longer exists
- ARLT record no longer exists
- OBDT record no longer exists
- PDIT record no longer exists
- ARCH record no longer exists
- WROT record, if any, will not exist after the programs for that table are seen for the first time after the document is removed. This does not disappear instantaneously with document processing.
- AREF record if any, will still exist on that table but the CURRENT BALANCE field will be blank. When the archive flag is changed to Y

(manually) the record will be archived the next time the referral programs are run.

- INBT record, if any, will still exist on that table until it is archived. The CURRENT BALANCE field will display zeros.
- RECR record, if any, will still exist until the record is archived.
- WAIV table record no longer exists.
- PAYR table record still exists and the COMMENTS field contains the new PAYOR NUMBER.

2. The New BILLING DOCUMENT

- ARHT record exists.
- ARLT record exists for lines 001 and/or 002. The BILLING DOCUMENT will now have to be modified to add interest, administrative cost or penalty lines if any existed on the document you removed (see RCM 9.10.135 for procedure on adding lines).
- WAIV record exists. The record must be changed to add the correct waiver expiration date and any other field data from the record that was removed.
- OBDT record now exists.
- PDIT record exists that displays the old PAYOR NUMBER/BILLING DOCUMENT ID at the bottom of the screen.
- ARCH record exists that displays the old PAYOR NUMBER/BILLING DOCUMENT
- If the date that was entered in the COLLECTION DUE DATE field is less than the current date by 60 days or more it should have been selected for a WROT record. If there are less than 60 days between the current date and the collection due date or if there is no collection due date (current entitlement, reclamation or on-going development case) there will be no record created on WROT.
- ARCL record now exists that shows the receivable established on the new PAYOR NUMBER/BILLING DOCUMENT ID.
- There will be no referral record created on AREF because no dunning count will exist when this record is created. If a referral record is needed you will have to manually establish it.

- There will be no INBT record mechanically created. If one is needed created on following standard procedure in RCM 9.10.82.
- There will be no RECR record mechanically created. If one is needed follow standard instructions in RCM 9.10.80.

Removing a BILLING DOCUMENT with a bad PAYOR NUMBER and reestablishing the receivable when cash receipt documents have been posted to it

Only the open portion of a BILLING DOCUMENT can be decreased by MODIFICATION. A BILLING DOCUMENT cannot be cancelled if it has cash receipts referred to it. In order to MODIFY the entire amount of a BILLING DOCUMENT to zero, or cancel it, all cash receipt documents referring to that BILLING DOCUMENT must be MODIFIED to zero or cancelled. Then those cash receipt documents would have to be reposted to the new BILLING DOCUMENT. Since this could be a considerable amount of work, especially if there has been an active recurring cash receipt or installment bill situation, with a risk of error in reposting, you will only be moving the open balance of the receivable to the new PAYOR NUMBER/BILLING DOCUMENT ID. The PDIT and ARCH records of the new BILLING DOCUMENT will display the old PAYOR NUMBER/BILLING DOCUMENT ID used for the overpayment at the bottom of those screens.

Data entry Instructions

Follow the previous directions except for the following additions.

PDIT

- When you access the old PDIT record:
 - Type C in the ACTION field of the table action line,
 - Move the cursor, using the line tab key to the OTHER PAYOR NAME #1 field
 - Type "NOW" followed by the new BILLING DOCUMENT ID you will be using for the overpayment.
 - Move the cursor to #2 field across from the OTHER PAYOR NAME #1 field using a tab key and type the new PAYOR NUMBER.
 - Press the ENTER key. The message "01-*L031 ALL LINES CHANGED" will be displayed at the bottom of the screen.

- Now you can follow the direction for adding the new PDIT record given in the preceding section. What you just entered will now be displayed on the ARCH record for the old BILLING DOCUMENT just as entered on the PDIT record.

BILLING DOCUMENT LINE SCREEN for the document transaction to close out the BILLING DOCUMENT with the incorrect PAYOR NUMBER

- In the AMOUNT field for each line you are closing refer to the ARLT print you took for the particular line. Subtract the DOC LINE CLOSED AMT (Combines the amounts in the DOC LINE COLLECTED AMT and DOC LINE WRITE OFF AMT FIELDS) from the DOC LINE AMT. Type the remainder in this field.

Otherwise follow the directions in the preceding section. The amount you close out on the old BILLING DOCUMENT will be the amount you establish on the new BILLING DOCUMENT.

RESULTS

The only change in results is that since you are not closing out this entire amount of the BILLING DOCUMENT, only the open amount only the ABLT record will disappear after processing.

9.10.141 Cancelling A Billing Document

CANCELLATION is a method of removing an overpayment from the PAR system completely. A BILLING DOCUMENT can only be CANCELLED if the transaction will be processed within the same month that the BILLING DOCUMENT was established (DOCUMENT DATE on the ARHT record). If the CANCELLATION cannot be processed within the same month the BILLING DOCUMENT was established you must remove it by MODIFYING the amount to zero. (see RCM 9.10.134.) You cannot cancel a BILLING DOCUMENT if a cash receipt has been posted to it (unless you first cancel or modify the CASH RECEIPT DOCUMENT(S) to zero amount.)

Take the following steps to CANCEL a BILLING DOCUMENT.

SIGNON

- Sign on to the PAR system as described in RCM 9.10.50.
- Type DDB on the screen when it displays the message "V2 ENTER NEXT TASK CODE".
- Press the ENTER key. The STARTUP screen will now be displayed.

STARTUP SCREEN

- Type D in the MODE OF OPERATION field.

- Complete the DOCUMENT ID line.
 - Type B2 in the TRANS field (TRANSACTION CODE).
 - Type 2000 in the DIVISION field.
 - Type the ID number of the BILLING DOCUMENT you wish to CANCEL in the ID NUMBER field.
- Move the cursor to the USER ID field using a tab key. Type your eight position USER ID.
- Press the ENTER key. A blank BILLING DOCUMENT INPUT screen will now be displayed.

BILLING DOCUMENT INPUT SCREEN

- Move the cursor to the ACTION field within the document screen (not the ACTION field on the document action line at the tip of the screen) using a tab key, and type X. No further entries are needed. Do not access the BILLING DOCUMENT LINE.

QUICK EDIT

- Quick edit the document transaction as described in 9.10.61.

APPROVAL AND SCHEDULING

- Hold the transaction for approval and scheduling as described in RCM 9.10.63 - 64.

RESULTS

After cancellation is processed all table records for the receivable will be deleted from the system including the case history line table (ARCL) record, except for those in the following list.

- The RECR record, if any, will not be removed until the N in the ARCHIVE FLAG field is manually changed to a Y.
 - Access the RECR record.
 - Type C in the ACTION field of the table action line.
 - Type your USERID in the USERID field.
 - Move the cursor, using a tab key, to the ARCHIVE FLAG field and type Y (yes, archive) over the N displayed.

- Press the ENTER key. The message "01-*L031 ALL LINES CHANGED" will be displayed.

The next time BFO archives records from RECR it will be removed. The CURRENT BALANCE and INT % fields will display the legend "NOT NUMERIC".

- The AREF record if any, will still be present. The CURRENT BALANCE field will now be blank. The ARCHIVE flag will still be N. This record can only be removed by archiving. You will have to manually change the flag to Y.
 - Access the AREF record.
 - Type C in the ACTION field of the table action line.
 - Type your USERID in the USERID field.
 - Move the cursor, using a tab key, to the ARCHIVE FLAG field and type Y over the N displayed.
 - Press the ENTER key. The message "01-*L031 ALL LINES CHANGED" will be displayed.

The record will be archived the next time that program is run for AREF.

- The INBT record, if any, will not be removed until general archiving/clearance programs are run. Once these are instituted they will be run annually. There is no ARCHIVE FLAG field on the INBT table.
- The WROT record, if any, will disappear the next time programming is run for that table. The entire table is emptied for processing, then documents meeting criteria are selected to refill it. A cancelled document would not be selected when the table is refilled.
- The vendor cross reference table (VXRF) should still have the billing document listed after cancellation. This table lists all documents associated to a specific PAYOR NUMBER. If, after entering S in the ACTION field of the table action line and your USERID in the USERID field you enter a PAYOR NUMBER the in the appropriate field and press enter the TRANS CODE, TRANSACTION DATE and DOCUMENT ID of all referenced documents should be displayed, including cancelled documents.

9.10.142 Modifying A Cash Receipt Document After It Has Been Processed In PARS

A. Type of CASH RECEIPT DOCUMENT THAT CANNOT BE MODIFIED

A processed CASH RECEIPT DOCUMENT that was generated by the write-off table (WROT) can never be MODIFIED or CANCELLED.

All receivable amounts written-off on WROT are entered into ORSP's uncollectable file. If that receivable amount must be reestablished on the PAR system, a new BILLING DOCUMENT with an RA TRANS TYPE must be entered to remove the amount from the uncollectable file. A CASH RECEIPT MODIFICATION or CANCELLATION would restore the balance on the PAR system but would not remove the amount from the uncollectable file.

B. Table Changes that can Impact CASH RECEIPT DOCUMENTS

CASH RECEIPT DOCUMENT data cannot be corrected by a change to a table record after the document has been processed (unlike some established BILLING DOCUMENT fields which can be changed by a table action).

If you entered table data to generate a CASH RECEIPT DOCUMENT, that data can be corrected on the table before the table records are processed to create cash receipt documents.

- For a CCIT record, processing is after 4:30, Monday through Friday.
- For a WROT record, processing is after 4:30, Monday through Friday.
- For RECR records, processing is usually the first business day of the month.

Changes to tables are accomplished by:

- Accessing the necessary table and record,
- Typing "C" in the action field of the table action line,
- Moving the cursor to the USER ID field and typing your USER ID,
- Moving the cursor to the field(s) that must be changed and typing over the contents of the field with the correct data (erasing extraneous characters with the space bar), and
- pressing the ENTER key.

Remember a change to the RECR table changes future CASH RECEIPT DOCUMENTS created, not documents already generated. See RCM 9.10.177, 9.10.182 and 9.10.184 for more specific information on changes to these tables.

C. Changes that can be made with a CASH RECEIPT DOCUMENT MODIFICATION

Make the following kinds of changes by processing a CASH RECEIPT DOCUMENT transaction to MODIFY an already processed CASH RECEIPT DOCUMENT.

- REDUCE the amount of the CASH RECEIPT posted due to data entry error, insufficient funds (bad check) etc.
- Increase the amount of the CASH RECEIPT posted, when the original amount posted was erroneously low.
- Apply unapplied cash to lines that have been increased or newly created on the BILLING DOCUMENT (for example: money is posted from the Department of Justice that is greater than the amount of the receivable thus creating an unapplied cash line on the cash receipt document.
- Remove unapplied cash lines after the cash has been dispersed.
- Within limitations, modify a line amount to zero and add it back with different entries in the non-modifiable fields.

D. Miscellaneous Information on CASH RECEIPT DOCUMENT MODIFICATIONS

- Do not attempt to MODIFY a CASH RECEIPT DOCUMENT while there is a document transaction with the same ID NUMBER on the suspense file (SUSF). You will not be able to enter it. A DOCUMENT ID on the SUSF must be unique. If you complete a START-UP screen to begin the process of MODIFYING a CASH RECEIPT DOCUMENT and the DOCUMENT ID you attempted to enter already exists on SUSF, the following edit message will be generated:

"A - *C031 - DUPLICATE DOCUMENT ID" and the system will not allow you to enter the CASH RECEIPT DOCUMENT INPUT SCREEN.

- When MODIFYING a CASH RECEIPT DOCUMENT to remove an UNAPPLIED CASH LINE that was created because more was remitted for the social security portion of outstanding payments, do not take the action until you are completing paperwork to transfer the funds (as a control).
- If you are going to completely remove a CASH RECEIPT DOCUMENT you must do it by MODIFYING the amount to zero and entering the appropriate action out code. Do not cancel a CASH RECEIPT DOCUMENT.
- You can obtain the CASH RECEIPT DOCUMENT NUMBERS referenced to a particular PAYOR NUMBER by scanning VXRF, the vendor (PAYOR) cross reference table. That table displays all documents referenced to the PAYOR NUMBER you enter in the KEY field.
- You can obtain the CASH RECEIPT DOCUMENT NUMBERS referenced to a particular BILLING DOCUMENT (overpayment) by scanning.
 - ARCL (accounts receivable case history line table), or

- DXRF (document cross reference table)

ARCL will give you the most complete information displaying how much of the CASH RECEIPT DOCUMENT was posted to each existing line of the BILLING DOCUMENT and identifying the number of CASH RECEIPT LINES involved. Unapplied cash lines are not currently displayed on ARCL.

DXRF will display all CASH RECEIPT DOCUMENTS referenced to the BILLING DOCUMENT ID entered in the key TRANS CODE and TRANS NUMBER fields.

- Specific information needed from a previously processed CASH RECEIPT DOCUMENT can be secured from the CASH RECEIPT HEADER TABLE (CRHT) or the CASH RECEIPT LINE TABLE (CRLT). Helpful fields on CRHT are:
 - DEPOSIT NUMBER
 - DOC DATE (the date the transaction was processed, later modifications do not impact this date).
 - AMOUNT (total CASH RECEIPT DOCUMENT AMOUNT)
- Never manually enter more information than you have to on a document MODIFICATION. When you QUICK EDIT the document the system will bring up the missing document data from information stored in CRHT and CRLT from the original document. Let the system do the work for you and avoid the risk of making a mistake.
- Helpful fields on CRLT are:
 - the LINE NUMBER of each CASH RECEIPT LINE created;
 - the FUND the CASH RECEIPT LINE was applied to;
 - the amount of the CASH RECEIPT LINE;
 - the billing document TRANS CODE, ID NUMBER and LINE to which the amount of that CASH RECEIPT LINE was posted; and
 - the ACTION OUT CODE that identifies the type of liquidation that took place.

9.10.143 Cash Receipt Document Fields And Modification

The following is a list of CASH RECEIPT DOCUMENT fields used by ORSP. The narrative to the right of the field states if the field can be directly MODIFIED or must be completed when MODIFYING A CASH RECEIPT DOCUMENT. Directly MODIFIABLE

means an entry in the field on the MODIFICATION transaction will change the same field on the original transaction. Fields designated as NOT MODIFIABLE should never be completed on a CASH RECEIPT MODIFICATION.

FROM THE START-UP SCREEN

TRANSACTION CODE (C2)	NOT A MODIFIABLE FIELD (CASH RECEIPT DOCUMENT must be cancelled or MODIFIED to zero and a new CASH RECEIPT DOCUMENT entered)
DOCUMENT ID NUMBER	NOT A MODIFIABLE FIELD (there is no error in DOC ID format which would justify CANCELLING a CASH RECEIPT DOCUMENT or MODIFYING it to zero to correct)

CASH RECEIPT INPUT SCREEN FIELDS

Field Name	Narrative
DIVISION CODE	NOT A MODIFIABLE FIELD (CASH RECEIPT DOCUMENT must be CANCELLED or MODIFIED to zero and a new CASH RECEIPT DOCUMENT entered).
DOC DATE	NOT A MODIFIABLE FIELD
ACCOUNTING PERIOD	NOT A MODIFIABLE FIELD (never changed)
ACTION	Always complete this with an M when MODIFYING CASH RECEIPT DOCUMENTS already established in PARS.
BUDGET FY	NOT A MODIFIABLE FIELD (never changed by ORSP)
FUND	This field is only addressed on the line level. See the narrative for this field for the CASH RECEIPT LINE SCREEN.
TRANS TYPE	This field is not completed on the CASH RECEIPT INPUT SCREEN. See narrative for that field under CASH RECEIPT LINE SCREEN.
DEP NUMBER	NOT A MODIFIABLE FIELD.

DOCUMENT TOTAL	<p>This field contains the combined amount of all the line amount activities on your CASH RECEIPT MODIFICATION. This is <u>not</u> the total CASH RECEIPT amount after MODIFICATION.</p> <ol style="list-style-type: none"> 1. Add together all increase line amounts on your transaction. If all your line amount changes are increases, enter this amount in the DOCUMENT TOTAL field. 2. Add together all decrease line amounts on your transaction. If all your line amount changes are decreases, enter this amount in the DOCUMENT TOTAL field. 3. If you have both line increases and decreases in your MODIFICATION transaction, determine which amount is larger, the combined increases or the combined decreases. Subtract the smaller amount from the larger amount and enter the difference in the DOCUMENT TOTAL field. 4. If the increase line amounts on your MODIFICATION transaction equal the decrease amounts, enter 0.00 in the DOCUMENT TOTAL field. 5. If your MODIFICATION did not involve an amount (example: MODIFYING the ACTION OUT CODE), you would leave this field blank. Currently, however, you would not MODIFY a CASH RECEIPT DOCUMENT to correct an ACTION OUT CODE.
ACCOMPLISHED DATE	NOT A MODIFIABLE FIELD (never changed)

CASH RECEIPT DOCUMENT LINE SCREEN FIELDS

Field Name	Narrative
LINE NUMBER	FILLED with the LINE NUMBER of the CASH RECEIPT DOCUMENT LINE you need to change, in sequence.
REF TC	NOT A DIRECTLY MODIFIABLE FIELD. This field can be changed, however, by doing a complete line decrease to zero and adding it back on the same transaction with different reference information (see RCM 9.10.145).

REF NUMBER	NOT A DIRECTLY MODIFIABLE FIELD. This can be changed, however, by doing a complete line decrease to zero and adding it back on the same transaction with different reference information (see RCM 9.10.145).
REF LINE	NOT A DIRECTLY MODIFIABLE FIELD. This can be changed, however, by doing a complete line decrease to zero and adding it back on the same transaction with different reference information (see RCM 9.10.145).
BFY	NOT A DIRECTLY MODIFIABLE FIELD. The contents of this field should never be entered manually. The blank field is completed by default from the ARLT record identified by the REFERENCE TRANSACTION CODE (TC), REFERENCE BILLING DOCUMENT NUMBER (REF NUMBER) and REFERENCE BILLING DOCUMENT LINE fields. Any change needed in this field would have to be done on a BILLING DOCUMENT MODIFICATION. A CASH RECEIPT DOCUMENT TRANSACTION with an entry in this field that doesn't match ARLT will reject from QUICK EDIT and processing.
FUND	NOT A DIRECTLY MODIFIABLE FIELD. The contents of this field should never be entered manually. The blank field is completed by default from the ARLT record identified by the REFERENCE TRANSACTION CODE (TC), REFERENCE BILLING DOCUMENT NUMBER (REF NUMBER) and REFERENCE BILLING DOCUMENT LINE fields. Any change needed in this field would have to be done on a BILLING DOCUMENT MODIFICATION. A CASH RECEIPT DOCUMENT TRANSACTION with an entry in this field that doesn't match ARLT will reject from QUICK EDIT and processing.
TRANS TYPE	NOT A DIRECTLY MODIFIABLE FIELD. This can be changed, however, by doing a complete line decrease to zero and adding it back on the same transaction with different reference information (see RCM 9.10.145).
BUDGET ORG/SUB	NOT A DIRECTLY MODIFIABLE FIELD. The contents of this field should never be entered manually. The blank field is completed by default from the ARLT record identified by the REFERENCE TRANSACTION CODE (TC), REFERENCE BILLING DOCUMENT NUMBER (REF NUMBER) and REFERENCE BILLING DOCUMENT LINE fields. Any change needed in this field

	would have to be done on a BILLING DOCUMENT MODIFICATION. A CASH RECEIPT DOCUMENT TRANSACTION with an entry in this field that doesn't match ARLT will reject from QUICK EDIT and processing.
REV SRCE/SUB	NOT A DIRECTLY MODIFIABLE FIELD. The contents of this field should never be entered manually. The blank field is completed by default from the ARLT record identified by the REFERENCE TRANSACTION CODE (TC), REFERENCE BILLING DOCUMENT NUMBER (REF NUMBER) and REFERENCE BILLING DOCUMENT LINE fields. Any change needed in this field would have to be done on a BILLING DOCUMENT MODIFICATION. A CASH RECEIPT DOCUMENT TRANSACTION with an entry in this field that doesn't match ARLT will reject from QUICK EDIT and processing.
BOC/SUB	NOT A DIRECTLY MODIFIABLE FIELD. The contents of this field should never be entered manually. The blank field is completed by default from the ARLT record identified by the REFERENCE TRANSACTION CODE (TC), REFERENCE BILLING DOCUMENT NUMBER (REF NUMBER) and REFERENCE BILLING DOCUMENT LINE fields. Any change needed in this field would have to be done on a BILLING DOCUMENT MODIFICATION. A CASH RECEIPT DOCUMENT TRANSACTION with an entry in this field that doesn't match ARLT will reject from QUICK EDIT and processing.
VND/PRV (PAYOR NUMBER)	NOT A DIRECTLY MODIFIABLE FIELD. The contents of this field should never be entered manually. The blank field is completed by default from the ARLT record identified by the REFERENCE TRANSACTION CODE (TC), REFERENCE BILLING DOCUMENT NUMBER (REF NUMBER) and REFERENCE BILLING DOCUMENT LINE fields. Any change needed in this field would have to be done on a BILLING DOCUMENT MODIFICATION. A CASH RECEIPT DOCUMENT TRANSACTION with an entry in this field that doesn't match ARLT will reject from QUICK EDIT and processing.
AMOUNT	If you are changing the amount of a previously established CASH RECEIPT DOCUMENT line, enter the amount of the increase or decrease to the original line amount.
I/D	If you are increasing the line amount enter I. If you are

	decreasing the line amount enter D. This field must always be completed when MODIFYING a CASH RECEIPT line.
P/F	This field is only used by OPR on certain CASH RECEIPTS generated by WROT. It is a modifiable field and should never be completed without first consulting with the supervisor of OPR.
ACTION OUT	<p>This field must be completed with a correction ACTION OUT CODE any time you decrease the amount of a line, except for an unapplied cash line (CASH RECEIPT DOCUMENT LINE with UA in the TRANSACTION TYPE field). CASH RECEIPT DOCUMENT correction codes are:</p> <p>87B Insufficient Funds/Bad Check</p> <p>88B Erroneous Entry</p> <p>89B Miscalculation</p> <p>90B Adjudicative Error</p> <p>If you are increasing the line amount and you are keeping the same code (for example, with an administrative offset, it is still an annuity offset, you just have more annuity than you previously thought) you do not need to enter the ACTION OUT CODE. The system will bring up the code from the original document line if you leave the field blank.</p>

9.10.144 Basic Data Entry Instructions For Modifying A Cash Receipt Document

A. PREPARATION

Secure all the information you need for your MODIFICATION before you start accessing and completing the CASH RECEIPT DOCUMENT INPUT screens.

- Know the ID NUMBER of the CASH RECEIPT document you are MODIFYING.
- Know the numbers of the CASH RECEIPT lines you want to change.
- Know the reference field entries if you need to enter any.

- Know the amount by which you want to increase or decrease any lines.
- Know what action out code you will enter, if any.

B. START-UP Screen

- Type D in the MODE OF OPERATION field.
- Complete the DOCUMENT ID line.
 - Type C2 in the TRAN field.
 - Type 2000 in the DIVISION FIELD.
 - Type the ID NUMBER of the CASH RECEIPT document you wish to change in the ID NUMBER field.
- Type your USER ID in the USER ID field.
- Press the ENTER key. The CASH RECEIPT DOCUMENT INPUT screen will be displayed.

C. CASH RECEIPT DOCUMENT INPUT SCREEN

- Type M in the ACTION field within the document screen (not on the document action line).
- Complete the DOCUMENT TOTAL field as described in RCM 9.10.142.
- Press the ENTER key. The CASH RECEIPT LINE screen will be displayed.

D. CASH RECEIPT DOCUMENT LINE SCREEN(S)

- Type the LINE NUMBER in the LINE NO field of the first CASH RECEIPT DOCUMENT LINE you have to correct, and proceed with each successive line until your corrective action is complete.
 - If you are completely DELETING and then reestablishing a line to correct fields that are not directly MODIFIABLE your transaction will have two lines with the same number (see RCM 9.10.145).
- If the
 - REF TC field,
 - REF NUMBER field,
 - REF LINE field, or

- TRAN TYPE field

do not have to be changed, leave these fields blank. PARS will complete these fields with information from the original CASH RECEIPT document when you QUICK EDIT. If these fields are incorrect on the original document see directions in RCM 9.10.146.

- If the data in the
 - BFY field,
 - FUND field,
 - BUDGET ORG/SUB field,
 - REV SRCE/SUB field (if a change line is involved),
 - BOC/SUB field, or

on the original CASH RECEIPT DOCUMENT are incorrect, the BILLING DOCUMENT referred to must be corrected. Never manually complete these fields on a CASH RECEIPT MODIFICATION.

- Type the amount of any increase or decrease to the original CASH RECEIPT DOCUMENT LINE in the AMOUNT field (not the new correct line amount, the increase or decrease to the old amount that will result in a correct line amount).
- If you are increasing the amount of the line type I, if you are decreasing the amount type D, in the I/D field.
- If you are decreasing the line amount enter the appropriate CASH RECEIPT correction action out code in the ACTION OUT field (see ACTION OUT CODES listed in 9.10.143 or refer to the action out table (ACOT) on PARS). If you are increasing the existing amount leave this field blank (system will bring up the existing action out code for this line). If you are establishing a new line enter the action out code appropriate for your liquidation activity.

E. QUICK EDIT your document MODIFICATION.

F. Have your transaction approved and scheduled for processing following standard instructions.

9.10.145 Insufficient Funds (Bad Checks)

When PSG is notified (receives debit voucher) that a check posted to an ORSP receivable had insufficient funds and could not be negotiated, take the following steps in PARS.

A. Determine the cash receipt ID Number

- Access the ARCL table and scan it for the record that contains the CASH RECEIPT activity when the bad check was posted.
- Use the prefix and claim number supplied on the debit voucher for the first ten positions of the PAYOR NUMBER.
- Press the ENTER key and check for
 - PAYOR NAME
 - CASH RECEIPT activity for the entry on the debit voucher
 - the amount of the cash activity to match the amount of the debit voucher
 - If you find a match based on PAYOR NUMBER and date, check CRHT and CRLT for the CASH RECEIPT DOCUMENT listed. It might have an unapplied cash line. If there is an unapplied cash line the total amount on CRHT will match the amount of the debit voucher.
 - If you can't find cash receipt activity for the date indicated on the debit voucher on ARCL, access the vendor (PAYOR NUMBER) cross reference screen (VXRF). Type in the first 10 positions of the PAYOR NUMBER in the VENDOR field. Press the ENTER key and all document activity related to the PAYOR NUMBER. If there is no CASH RECEIPT ID displayed with the first screen, press the ENTER key to view the next screen in succession until you locate the CASH RECEIPT DOCUMENT (if it is here and not on ARCL, everything went into unapplied cash). If unapplied cash is involved, the folder will have to be secured to see what further steps are needed after PARS actions are taken (reverse an SSA transfer, prevent vouchering the return of a nonexistent overreimbursement, etc.).

B. SECURE CASH RECEIPT LINE INFORMATION FROM CRLT

- Take a print of the complete CRLT record for the CASH RECEIPT DOCUMENT.

C. MODIFY THE CASH RECEIPT AMOUNT TO ZERO ON THE PAR SYSTEM

STARTUP SCREEN

- Type D in the MODE OF OPERATION field.
 - Type C2 in the TRAN field
 - Type 2000 in the DIVISION field.
 - Type the ID NUMBER of the CASH RECEIPT DOCUMENT you are going to MODIFY in the ID NUMBER field.
- Type your USER ID in the USER ID field.
- Press the ENTER key. The CASH RECEIPT DOCUMENT INPUT screen will be displayed.

CASH RECEIPT DOCUMENT INPUT SCREEN

- Type M in the ACTION field in the input screen.
- Type the total amount of the cash receipt document you are modifying to zero in the DOCUMENT TOTAL field.
- Press the ENTER key. You will now be viewing the CASH RECEIPT LINE input screen.

CASH RECEIPT DOCUMENT LINE SCREEN(S)

Complete the four necessary fields for each line of the CASH RECEIPT DOCUMENT you are MODIFYING to ZERO. (Refer to the printout you took of the CRLT record).

- Type the LINE NUMBER of the first CASH RECEIPT DOCUMENT line in the LINE NO field.
- Type in the amount of that line in the AMOUNT field.
- Type D in the I/D field.
- Type 87B in the ACTION OUT field.
- Repeat the above steps for each CASH RECEIPT DOCUMENT line created for the bad check.
- QUICK EDIT your transaction.
- Follow standard procedure to get your document transaction approved and scheduled for processing.

9.10.146 Simple Modification To Decrease (Includes Modifying The Amount To Zero) Or Increase The Amount Of A Cash Receipt Document Line

START-UP SCREEN

- Type D in MODE of OPERATION field.
- Complete the DOCUMENT ID line.
 - Type C2 in the TRAN field.
 - Type 2000 in the DIVISION field.
 - Type the ID NUMBER of the CASH RECEIPT document you are going to modify in the ID NUMBER field.
- Type your USER ID in the USER ID field.
- Press the ENTER key. You are now viewing the CASH RECEIPT DOCUMENT INPUT SCREEN.

CASH RECEIPT DOCUMENT INPUT SCREEN

- Type M in the ACTION field within the input screen (not the ACTION field of the document action line at the top of the screen).
- Type in the total amount of the document activity in the DOCUMENT TOTAL field. If you are only decreasing line amount this field will be the total of your line amounts. See RCM 9.10.142 for complete instructions for this field if your action is more complex.
- Press the ENTER key. You will now be viewing the CASH RECEIPT DOCUMENT LINE INPUT screen.

CASH RECEIPT DOCUMENT LINE INPUT SCREEN

- Type in the line number of the CASH RECEIPT DOCUMENT LINE you are decreasing or increasing in the LINE NO field.
- Type in the amount you want to DECREASE or INCREASE in the AMOUNT field.
- Type D if you are DECREASING the line amount or I if you are INCREASING the line in the I/D field.
- Type the appropriate cash receipt action out code in the ACTION OUT field.

- Repeat these instructions if you are correcting the amount on more than one line.

QUICK EDIT

- QUICK EDIT your document transaction.

APPROVAL and SCHEDULING

- Follow standard instructions to get your document approved and scheduled for processing.

9.10.147 Removing and Reentering Non-modifiable Fields

While the PAR system cannot allow direct modification of certain fields, it is able to close a document line (completely reverse it out of accounting tables) and re-enter it on the same transaction. The type of error this is useful to correct is when the wrong reference number has been entered on a line (for example, a cash refund has been applied to an employee's overpayment instead of the spouse's overpayment or has been placed in unapplied cash because a document reference wasn't entered.

- A. Secure a print of the CRLT record for the CASH RECEIPT DOCUMENT (when you are done keep it as a folder record).
- B. Access the START-UP screen following standard instructions and complete it.
 - Type D in the MODE of OPERATION field.
 - Complete the DOCUMENT ID line.
 - Type C2 in the TRAN field.
 - Type 2000 in the DIVISION field.
 - Type the ID NUMBER of the CASH RECEIPT DOCUMENT you are MODIFYING in the ID NUMBER field.
 - Press the ENTER key. The CASH RECEIPT DOCUMENT input screen will be displayed.
- C. Complete both necessary entries on the CASH RECEIPT DOCUMENT INPUT screen.
 - Type M in the ACTION field inside the input screen (not on the document action line).
 - Type 0.00 in the DOCUMENT TOTAL field.

- Press the ENTER key. The CASH RECEIPT LINE Input screen will now be displayed.
- D. Complete two line actions for each CASH RECEIPT DOCUMENT line for which you have to correct a document reference or transaction type field. The first action will reduce the existing line to zero. The second action will recreate the CASH RECEIPT DOCUMENT LINE.
- Type the line number of the DOCUMENT LINE you are changing in the LINE NO field.
 - Type the AMOUNT of the line you are correcting in the AMOUNT field.
 - Type 'D' in the I/D field.
 - Type 88B in the ACTION OUT field.
 - The next line entry is to simultaneously reestablish the cash receipt line you are removing with your first line action (see RCM 9.10.74 for detailed instructions for completing a CASH RECEIPT DOCUMENT LINE). Type the same line number in the LINE NO field of the second CASH RECEIPT DOCUMENT LINE displayed on your screen (you want to reestablish the line with the same LINE NUMBER).
 - Type B2 in the REF TC (reference transaction code) field.
 - Type the correct BILLING DOCUMENT ID NUMBER in the REF NUMBER field (the correct receivable to which the liquidation activity should be posted.)
 - Type the correct BILLING DOCUMENT LINE NUMBER to which the amount should be posted:
 - 999 Penalty
 - 998 Administrative Cost
 - 997 Interest
 - 001 Regular RRA Overpayment
 - 002 Supplemental Annuity Overpayment
 in the REF LINE field.
 - Type the correct CASH RECEIPT TRANSACTION type for the CASH RECEIPT LINE in the TRAN TYPE field.

- For reference lines 001 or 002 this is:
 - AW if the recovery is from annuity,
 - CC if the recovery is cash,
 - WO if the recovery is from a write-off action, and
 - UA for Unapplied Cash, if the cash or credits cannot be applied to an overpayment.
- For charge lines 997, 998, or 999 this is
 - IP if interest, administrative cost or penalty is being liquidated with manually entered cash receipt (no matter what the source of the offset is).
- Type the amount of the line in the AMOUNT field.
- Type I in the I/D field.
- Type the correct action out code in the ACTION OUT field.
- Repeat the above instructions for each line you have to correct.
- QUICK EDIT your modification transaction.
- Follow standard procedures for approving and scheduling your document.

9.10.148 Unapplied Cash Lines

When cash refunds or credits are posted to PARS and there is no open balance

- No receivable exists;
- A receivable exists but there is no open balance; or
- A receivable exists with an open balance, but the amount posted exceeds the balance

The excess amount which cannot be applied to an overpayment is recorded in a CASH RECEIPT DOCUMENT LINE with a TRANSACTION TYPE of UA, unapplied cash. These unapplied cash lines must be removed when the action is taken to repay, transfer or correctly apply the money or credits reflected in that line.

Unapplied cash lines are most commonly created when:

- the cash or credit received is for outstanding payments that include a social security benefit (the overpayment on PARS is only the railroad annuity),
- duplicate reimbursements are received,
- the open balance on PARS is incorrect due to an erroneous posting, or
- the annuitant refunds more than the outstanding debt.

A. If the unapplied cash line represents

- social security reimbursement, or
- overreimbursement of an overpayment

MODIFY the unapplied CASH RECEIPT DOCUMENT line to zero (see directions in RCM 9.10.147 section D):

- When the SF-1081 is sent to BFO on a social security reimbursement;
- When advice of credit reversal is received either through the Treasury Receivable Accounting and Collection System (TRACS) or by SF-1081 from Treasury after notifying Treasury to reverse credit for overreimbursement of outstanding payment(s) not under direct deposit; or
- When paying out an overreimbursement from a PAYOR (annuity withheld and cash refund received) and the award clears vouchering.

B. If the unapplied cash line represents money/credits that should be applied but couldn't because:

- erroneous cash receipt(s) have caused the receivable balance to be lower than it should; or
- The billing document for the receivable needs to be MODIFIED because the overpayment amount was entered incorrectly or an additional charge line needs to be added.

Take your corrective action first. This includes:

- MODIFYING cash receipt documents to correct amounts,
- MODIFYING the amount of a cash receipt document to zero if the transactions are duplicate postings, or
- MODIFYING the BILLING DOCUMENT to correct the amount and/or add interest, administrative cost or penalty lines.

When you have completed your corrective action, follow directions in RCM 9.10.146 to close out the unapplied cash line and reestablish it with the proper reference information and TRANSACTION TYPE (in other words correctly applying it).

- C. If there is nothing on the CASH RECEIPT DOCUMENT but an unapplied cash line and this amount will never be unapplied to an RRB overpayment you can CANCEL the CASH RECEIPT DOCUMENT instead of MODIFYING each line to zero. (See RCM 9.10.149C.)
- D. Before you remove an unapplied cash line, print a copy of it and file it in the folder. An unapplied cash line disappears from CRLT as soon as the modification to zero is processed. There is no record of an unapplied cash line on ARCL. Only the amount of a CASH RECEIPT DOCUMENT applied to a receivable is displayed on the ARCL record. The total amount of a CASH RECEIPT document can be found on CRHT (key is the CASH RECEIPT DOCUMENT ID) or on VXRf (key is PAYOR NUMBER) if the PAYOR NUMBER was entered on the CASH RECEIPT DOCUMENT.
- E. If you cannot determine what action to take with an unapplied cash line, send the folder on a G-26 route slip to the RRA Calculations Unit of Policy & Systems (RAC). In the comment section write: UNAPPLIED CASH.

9.10.149 Cancelling A Cash Receipt Document

- A. Never cancel a CASH RECEIPT DOCUMENT which has one or more lines posting an offset to a receivable.

These activities must be tracked by action out code and the ACTION OUT field cannot be completed on a CANCELLATION.

- B. If you have a CASH RECEIPT DOCUMENT that is:

- totally composed of unapplied cash, and
- you will not be applying it to a receivable (see RCM 9.10.147(B))

you can cancel it. Since unapplied cash lines are not recorded on ARCL there is no purpose to entering an action out code that will not be stored.

- C. Directions for CANCELLING a CASH RECEIPT DOCUMENT having only an unapplied cash line that will not be referenced to a railroad receivable.

START-UP SCREEN

- Type D in the MODE of OPERATION field.
- Complete the DOCUMENT ID LINE.

- Type C2 in the TRAN field.
- Type 2000 in the DIVISION field.
- Type the ID NUMBER of the document you are going to CANCEL in the ID NUMBER field.
- Type your USER ID in the USER ID field.
- Press the ENTER key. You will now be viewing the CASH RECEIPT INPUT screen.

CASH RECEIPT INPUT SCREEN

- Type X in the ACTION field within the CASH RECEIPT INPUT SCREEN (NOT the ACTION field in the document action line at the top of the screen).

QUICK EDIT

QUICK EDIT the document following standard instructions.

APPROVAL AND SCHEDULING

Follow standard instructions to APPROVE and SCHEDULE your transaction for processing.

9.10.150 Types Of PAR System Tables

There are three types of tables in the PAR System

- Reference tables containing data that validates data entries or drives processing (see RCM 9.10.151);
- System generated and maintained tables which are not interactive and cannot be directly changed. However, data displayed can be indirectly changed by:
 - Processing document modifications, or
 - Making changes or additions to other table records (see RCM 9.10.152); and
- Interactive tables that take data input using change and in certain cases deletion commands. See RCM 9.10.153 through 9.10.172 for instructions to change or delete records in these tables.

9.10.151 General Information On Table Changes

- Key fields on interactive tables can never be changed. These fields are clearly labeled at the top of the screen for the particular table involved. (See RCM 9.10.156, 9.10.157 and 9.10.158 for directions on adding new records and removing bad ones.) If you attempt to change a key field the message

"*L014 CHANGED RECORD DIFFERENT"

will be displayed at the bottom of the screen.

- PAR system table changes are done on-line with no approvals or night processing needed to change table data.
 - Additional processing might be needed to get the end product you desire. For example, when you add a record to the Cash Collection Input Table (CCIT) you have created that record when you press the ENTER key, but the desired result - a correctly calculated and completed CASH RECEIPT DOCUMENT - is created in that night's production.
 - Anyone with the proper security clearance can change what is entered before processing which can be as soon as that night (CCIT) or as long as a month (RECR). In the case of AREF changes, if someone changes the DESTINATION CODE you entered before it can be processed, the code you entered will never be displayed on ARCL - only the last code entered before nightly processing.
 - The only way table activity can be lost, since it is directly entered on-line, is if corrupted data requires a roll back of the data base. In that case the table records would be in the position of the previous nights back-up (would not reflect table additions, deletions, changes done that day).

9.10.152 PAR System Reference Tables

Only the PAR system administrator in BFO can change or delete information in PAR system reference tables.

PAR system reference tables include:

- ACOT, the table that stores all ACTION OUT CODES used in PARS;
- ARDT, the table that stores all DESTINATION CODES and DESTINATION CODE controls on charges and overridable error messages;
- AREP, the table that stores criteria for mechanical selection of receivables for the accounts receivable referral table (AREF) and criteria/codes needed for the automatic write-off process;

- AROP, the table that contains criteria for the mechanical assessment of charges and selection of receivables for the write-off table (not automatic write-off);
- AR02, the table that contains some default and special use TRANSACTION TYPES;
- ARTX, the table that stores the installment billing and reminder notice texts ORSP needs;
- CAUSE, the table that stores all CAUSE OF OVERPAYMENT CODES used in the PAR system;
- SRCE, the table that stores all SOURCE OF OVERPAYMENT CODES used in the PAR system;
- TYOP, the table that stores all TYPE OF OVERPAYMENT CODES used in the PAR system; and
- WORC, the table that stores all the write-off table reason codes used in the PAR system.

These tables are not affected by clearing or archiving in PARS.

9.10.153 Generated/System Maintained Tables

System generated and maintained tables take no direct table ACTION commands other than inquiry commands (scan (S), get (G) refill (R), or leaf (L)). Information is entered and changed generally through processing, DOCUMENT MODIFICATION or natural aging in the PAR system. In special situations the PAR system administrator can change field data using technical tables and programs. There are also changes to certain mechanically maintained tables that result from other table processing.

The following are PAR system generated/maintained tables, descriptions of their contents, and information on how field data or table records are added, changed or removed from them.

9.10.154 Case History Header Table (ARCH)

- ARCH contains all the information displayed in PDIT plus the original overpayment amount and associated codes established in PARS after the BILLING DOCUMENT is processed.
 - Changes to NAME and ADDRESS fields in PAYR and PDIT records are reflected ARCH.
 - Changes to other PDIT fields will change the contents for those fields in ARCH.

- BILLING DOCUMENT MODIFICATIONS of the original overpayment amount or CAUSE, TYPE or SOURCE CODES will change the contents of those fields on ARCH.
- CANCELLATION or MODIFICATION of the complete amount of a BILLING DOCUMENT will delete an ARCH record.
- ARCH records of closed receivables are removed from PARS when archiving/clearance programs are run. These are archived on tape to be stored on microfilm and paper.

9.10.155 Case History Line Table (ARCL)

- ARCL is established after a BILLING DOCUMENT is processed. The only changes to ARCL (outside of special corrections by the PAR system administrator) are additions to the table records.
- BILLING DOCUMENT MODIFICATIONS result in a line of activity for each document line changed, added or removed. This includes mechanical processing for assessing interest, administrative cost or penalty.
- Processing a CASH RECEIPT DOCUMENT or CASH RECEIPT DOCUMENT MODIFICATION will generate a line of activity for each line on the CASH RECEIPT DOCUMENT referenced to the BILLING DOCUMENT the ARCL record is tracking. Any line(s) with UA as the TRANSACTION TYPE (unapplied cash) are not recorded on ARCL.
- Generation of any bill, original or installment, or processing a BILL PRINT FLAG of S (suppressed bill) even though it does not create a paper bill, will result in a line of activity.
- ARCL records are deleted if a BILLING DOCUMENT is CANCELLED, but are retained if the amount of the BILLING DOCUMENT is MODIFIED to zero.
- ARCL records of closed receivables, which meet the criteria will be removed from the system when archiving/clearance programs are run, and will be archived (retained) on tape to be stored on microfilm.
- RCM 9.10.10 contains detailed information on ARCL fields.

9.10.156 Accounts Receivable Header Inquiry Table (ARHT)

- ARHT contains a summary of activity on individual BILLING DOCUMENTS and is created when the BILLING DOCUMENT is initially processed.
- TRANSCODE and DOCUMENT NUMBER and PAYOR NUMBER fields cannot be changed by any system activity.

- PAYOR NAME and ADDRESS fields will be changed when a BILLING DOCUMENT MODIFICATION is processed after changes have been made to the PAYOR table name and address fields. Without a BILLING DOCUMENT MODIFICATION these fields will not change. The second PAYOR NAME line displayed on PDIT and ARCH is not displayed on ARHT.
- The contents of the BILL PRINT FLAG field on ARHT can be changed by
 - BILLING DOCUMENT MODIFICATION,
 - Changing the BILL PRINT FLAG field on OBDT, or
 - Entering an INBT record.
 - Mechanically after an S or a Y flag is processed.
- The contents of the DUNNING FLAG field can be changed by
 - BILLING DOCUMENT MODIFICATION, or
 - Changing the DUNNING FLAG field on OBDT.
- The contents of the DUNNING COUNT field is changed each time a reminder notice is generated. The contents of this field is erased
 - When an INBT record is entered or reset, and
 - When an "Y" is entered in the WAIV REQUEST field on the WAIV table.
- The contents of the WRITE-OFF FLAG field will change
 - To "P" when it is selected for the write-off table mechanically, and
 - to "Y" if the receivable is written off.
- The contents of the WRITE-OFF REASON CODE field will change to display the reason code if a receivable is written-off.
- The DOCUMENT CLOSING DATE field is filled when an overpayment is completely liquidated with the date of the transaction that closes it.
- The contents of the LAST BILL DATE field is changed (updated) anytime a regular or installment bill is generated with the date of that activity.
- The contents of the COLLECTION DUE DATE field changes:
 - each time the LAST BILL DATE field changes with a date 30 days later than the LAST BILL DATE,

- by BILLING DOCUMENT MODIFICATION, or
- when the date is entered or changed in the WAIVER DENIAL NOTICE field on the WAIV table (COLLECTION DUE DATE is 30 days after the WAIVER DENIAL NOTICE).
- The BILL PRINT DATE field is filled when the first bill is operated for a receivable and doesn't change after that.
- The INTEREST APPLY DATE field is filled/changed whenever interest is mechanically assessed in PARS. BILLING DOCUMENT MODIFICATIONS to add, increase or partially decrease interest will not change the INTEREST APPLY DATE (effective February, 1992). A BILLING DOCUMENT MODIFICATION to completely remove all interest assessed will erase the INTEREST APPLY DATE (effective February, 1992).
- HAN APPLY DATE field is filled/changed whenever administrative costs are mechanically assessed in PARS. BILLING DOCUMENT MODIFICATIONS to add, increase or partially decrease administrative costs will not change the HAN APPLY DATE (effective February, 1992). A BILLING DOCUMENT MODIFICATION to completely remove all administrative costs assessed will erase the HAN APPLY DATE (effective February, 1992).
- The contents of the LAST DUN DATE field change each time a reminder notice is generated reflecting the date generated. This field is erased when:
 - an INBT record is established or reset, or
 - when a "Y" is entered in the WAIVER REQUEST field on the WAIV table.
- The WRITE-OFF DATE field is filled when a write-off CASH RECEIPT transaction (generated from the write-off table) is processed, with the date of the transaction.
- The contents of the WAIVER FLAG field changes
 - when the field is changed on a BILLING DOCUMENT MODIFICATION, or
 - when that field is changed on OBDT.
- The contents of the O/P CAUSE field can only be changed by BILLING DOCUMENT MODIFICATION.
- The contents of the BILLED AMOUNT field (original overpayment) FIELD can only be changed by BILLING DOCUMENT MODIFICATION.
- The contents of the INTEREST AMOUNT field can be filled or changed by

- MANUAL BILLING DOCUMENT MODIFICATION, or
- mechanical assessment of interest.
- The contents of the HANDLING (ADMINISTRATIVE COST) field can be filled or changed by
 - manual BILLING DOCUMENT MODIFICATION, or
 - mechanical assessment of ADMINISTRATIVE COSTS
- The contents of the PENALTY AMOUNT field can be filled or changed by
 - manual BILLING DOCUMENT MODIFICATION, or
 - mechanical assessment of PENALTY.
- The contents of the TOTAL AMOUNT field will change when the BILLED AMOUNT and/or INTEREST AMOUNT AND/OR HANDLING AMOUNT AND/OR PENALTY AMOUNT fields change due to
 - BILLING DOCUMENT MODIFICATION, or
 - mechanical assessment of changes.
- The PENALTY APPLY DATE field is filled/changed whenever a penalty amount is mechanically assessed in PARS, BILLING DOCUMENT MODIFICATIONS to add, increase or partially decrease the penalty amount will not change the PENALTY APPLY DATE (effective February, 1992). A BILLING DOCUMENT MODIFICATION to completely remove all penalty assessed will also erase the PENALTY APPLY DATE (effective February, 1992).
- the WRITE-OFF AMOUNT field is filled or changed (updated) each time an amount is written-off through the write-off table.
- The COLLECTED DOCUMENT AMOUNT field is filled/changed (updated) everytime a CASH RECEIPT DOCUMENT LINE is processed, either initially or through MODIFICATION, that is referenced to the BILLING DOCUMENT identified in the TRANS CODE and NUMBER fields on the ARHT record; excluding CASH RECEIPT transactions generated through the write-off table.
- The contents of the DOCUMENT CLOSED AMOUNT field reflects the total amounts in the WRITE-OFF AMOUNT field and the COLLECTED AMOUNT field. Therefore, it changes
 - when a write-off CASH RECEIPT created by the write-off table is processed, and

- when an initial CASH RECEIPT or CASH RECEIPT MODIFICATION is processed.

WRITE OFF AMOUNT, COLLECTED AMOUNT and DOCUMENT CLOSED AMOUNT fields are not impacted by BILLING DOCUMENT MODIFICATION to increase or decrease line amounts unless the decrease removes the open balance of the overpayment.

- When clearing/archiving programs are run, closed ARHT records that meet archiving/clearance criteria will be deleted (not retained on tape.)
- When the full amount of a billing document is MODIFIED to zero or cancelled the ARHT record for that receivable is automatically deleted.

9.10.157 Accounts Receivable Line Inquiry Table (ARLT)

- ARLT contains records with summary information on individual BILLING DOCUMENT lines (regular railroad overpayments, supplemental annuity overpayment and individual charge lines).
 - Information in the table can only be changed by BILLING DOCUMENT MODIFICATION except for the DOC LINE COLLECTED AMOUNT, DOC LINE CLOSED AMOUNT and DOC LINE WRITE-OFF AMOUNT fields.
 - The DOC LINE COLLECTED AMOUNT field is filled or updated whenever a CASH RECEIPT DOCUMENT (initial or modification) is processed which is referenced to this document line.
 - The DOC LINE WRITE-OFF AMOUNT field is filled or updated whenever a CASH RECEIPT DOCUMENT is created through the WRITE-OFF table and processed which is referenced to this document line.
 - The DOC LINE CLOSED AMOUNT field is filled or updated whenever there is any registered activity in the DOC LINE COLLECTED AMOUNT or DOC LINE WRITE-OFF AMOUNT fields (this field is a total of the amounts in those fields).
- When archiving/clearance programs are run all ARLT closed records that meet criteria will be deleted from the system (not stored).
- When the full amount of a billing document line is MODIFIED to zero that line is deleted from PARS.

9.10.158 Billing Document Fund Split Table (BDFS)

- BDFS stores the percentage split of social security and nonsocial security funds with a *PAR FUND overpayment.

- No changes or deletions can be made directly or indirectly to records in this table.
- Records in this table for closed receivables which meet clearance/archiving criteria are deleted when those programs are run.

9.10.159 Cash Receipt Header Inquiry Table (CRHT)

- CRHT stores data from the CASH RECEIPT INPUT screen from each CASH RECEIPT DOCUMENT that is processed.
- Only a CASH RECEIPT DOCUMENT MODIFICATION can change data on this screen. The only field that can be changed is AMOUNT field.
- Completely modifying the CASH RECEIPT DOCUMENT AMOUNT to zero will delete the record from the CRHT table.
- Cancelling a CASH RECEIPT DOCUMENT will delete the CRHT record.
- When the archiving/clearance programs are run any CRHT record referenced to a closed BILLING DOCUMENT that meets criteria will be deleted from the PAR system, unless the CASH RECEIPT DOCUMENT contains one or more unapplied cash lines (any cash receipt lines with empty BILLING DOCUMENT reference fields).

9.10.160 Cash Receipt Line Inquiry Table (CRLT)

- CRLT contains data from the CASH RECEIPT LINE SCREEN(S) of each CASH RECEIPT DOCUMENT processed.
- Data on a CRLT record can only be changed by a CASH RECEIPT DOCUMENT MODIFICATION.
- MODIFYING a line amount to zero will delete the CRLT record for that CASH RECEIPT DOCUMENT LINE.
- CANCELLING a CASH RECEIPT DOCUMENT will delete all CRLT record for that document.
- When archiving/clearance programs are run, all CRLT records referencing closed receivables that meet criteria will be deleted.
- CRLT records not referenced to a BILLING DOCUMENT (unapplied cash) are not affected by archiving/clearance programs. CRLT records belonging to the same CASH RECEIPT DOCUMENT as the unreferenced lines are also not affected by archiving/clearance programs.

9.10.161 Suspense File (SUSF)

- SUSF contains records of unprocessed documents.
 - Record changes are only made through document activities (examples: holding for review, scheduling for process, applying or removing approvals). The system registers the last person accessing the document.
 - A record is removed from SUSF by deleting the document identified.
 - Records of successfully processed documents are archived (removed) from SUSF daily at the end of the production run.

9.10.165 Accessing Table Records

There are three different navigational commands which can be used to access table records.

- S (scan)
- G (get)
- L (leaf)

SCAN Table Command

If you are already viewing the table you need to access:

- Type S in the ACTION field of the table action line.
- Enter your USER ID if it isn't already displayed.
- Complete as many of the TABLE KEYS (see RCM 9.10.176 -184 for information on KEY FIELDS for specific tables) as you are able to or need to. You do not have to complete all table keys when using the SCAN command; the PAR system will bring up the first record stored matching the key field(s) you have completed. Be careful and check all identifying data on the record displayed before you make any changes. Remember there can be more than one person on a claim number and there may be more than one overpayment existing for a PAYOR.
- Press the ENTER key. If you only entered the first 10 positions of the PAYOR NUMBER and the first record displayed matches those 10 positions but is not the record you want, press the ENTER key again. There is already an R command in the ACTION field to refill the screen. Repeat this until you find your record or you've determined a table record doesn't exist.
- Proceed to make your change/delete action, if you locate your record.

- When you first access a table S is automatically entered in the ACTION field.

GET Table Command

This command must be used when you need to change or delete a record on the WROT table or when changing record data on the WAIV or OBDT tables (if your action requires a C or a D in the table ACTION field this applies). These tables display multiple records on a single screen unless a GET command is used when accessing information. When the GET command is used only the record requested is displayed. Additional records would be put unnecessarily at risk if a SCAN command is used. To use the G (get) command after accessing your table:

- Type G in the ACTION field of the table action line.
- Type your USER ID, if it isn't displayed, in the appropriate field.
- Fully complete all key fields for the table you are accessing. The get command will not work if all KEY fields are not completed.
- Press the ENTER key. If your record exists in the table it will now be the only one displayed on the screen. If a record with the exact same key fields as you entered does not exist in the table the message

"01---*L004 LINE NOT FOUND"

will be displayed at the bottom of the screen.

- Proceed to take your CHANGE/DELETE action.

LEAF Command

When tables have the same key, the system allows you to move from one table to another and stay on a record belonging to the same BILLING DOCUMENT or CASH RECEIPT DOCUMENT if the table records share at least one key field. This saves time and data entry when using the table portion of PARS. Also, if you have verified that the initial record you are accessing is correct, the leaf command removes risk of data entry error in accessing the next table record. When the new table record is displayed the key fields will already be filled. If no record exists for your key field entries the following messages will be displayed at the bottom of the screen:

"01--*L008 END OF FILE"

"01-*L004 LINE NOT FOUND"

If you must establish a record you will already have your key fields accurately completed when you take your add (A) action, if the record from which you are leafing has identical KEY FIELDS as the table to which you are leafing.

To leaf (L) from one table record to another:

- Type L in the ACTION field of the table action line.
- Type the four position acronym of the TABLE you wish to access in the TABLE ID field of the table action line.
- Press the ENTER key.
- Proceed with your CHANGE/DELETE action if your record exists.

9.10.166 The Change Command

For interactive tables use the change table (C) command to:

- Add a field entry to an existing table record,
- Change a field entry to an existing table, and/or
- erase a field entry.

After you have accessed the correct table record:

- Type C in the ACTION field of the table action line.
- Move the cursor, using the tab key, to the necessary field.
 - The cursor will move only to fields in which an entry can be made.
- Take your corrective action.
 - Type the correct entry in any empty field you need to fill.
 - Type over the existing entry in any field you need to change, removing excess data by depressing the space bar.
 - Erase any data where the field should be empty or you want a default entry to be displayed, using the space bar.
- Press the ENTER key. The record now exists in PARS exactly as it is displayed. Table changes are real time on-line changes. The PAR system will not obey a C command entered in tables listed in 9.10.151 and 9.10.152.

9.10.167 Deleting Table Records

There are five interactive PARS tables which will accept a DELETE (D) command for a record, three of them only under certain conditions.

- CCIT, the cash collection input table, contains records which will be processed into CASH RECEIPT DOCUMENTS. Any record contained in this table can be deleted; there are no qualifications. Before deleting a record from this table, check to make sure that the action should not be taken. CCIT records are deleted from this table mechanically when successfully used to create a CASH RECEIPT DOCUMENT.
- INBT, the installment billing table, contains records of installment billing activity. Records can be DELETED from this table if no bill has yet been released. Once a bill is released these records can only be removed from the system when the archiving/clearance programs are run.
- PAYR, The PAYOR information table, stores records containing the first PAYOR NAME line and the PAYOR address and validates the existence of the PAYOR NUMBER in the system. Records in this table can be deleted if there are not existing PDIT records that reference the PAYOR numbers established on them. PAYOR records are not impacted by archiving/clearance programs and are not deleted when a BILLING DOCUMENT is cancelled or completely modified to zero.
- PDIT, the payor debtor information table, stores records containing identifying information on ORSP overpayments. Records in this table can be DELETED if an ARHT record does not exist with the BILLING DOCUMENT NUMBER established on the PDIT record. PDIT records will be deleted by clearing/archiving programs if the BILLING DOCUMENTS identified on them meet criteria. They will also be mechanically deleted if the BILLING DOCUMENT is CANCELLED or MODIFIED to zero.
- WROT, the write-off table, contains records mechanically selected or manually entered for write-off. These records can be DELETED without qualification. These records are mechanically deleted from the table when a CASH RECEIPT DOCUMENT is created from the WRITE-OFF table record. Cancellation of the BILLING DOCUMENT, complete MODIFICATION to zero or complete liquidation of the debt will remove the record from this table.

To DELETE a table record do the following after accessing the correct table record (remember to use the GET command for WROT)

- Type "D" in the ACTION field of the table action line.
- Press the ENTER key.

If the command is successful the message "01-*L032 ALL LINES DELETED" will be displayed at the bottom of the screen.

If you discover you did not want to delete the record before you leave the screen, all data is still displayed,

- Type an A in the action field of the table action line, and

- Press the ENTER key.

The record(s) will be added back to the table.

If you are DELETING the record due to an error in one of the key fields:

- After successfully deleting the record with the bad data in a key field, keep the record displayed on screen.
- Move the cursor to the field(s) with the bad data and type in the correct information.
- Press the ENTER key. This prevents having to fully complete the record again and removes the risk of erroneously completing a field that was entered correctly the first time.

9.10.168 The Importance Of The Final Position On A Table Edit Message

A table edit message, like a document edit message is composed of an identifying alpha-numeric code and a short informative description. If the final position of the code is a W the message is a warning. If the action you are taking is correct, disregard the warning. If no error message exist, your command has been accepted and processed. If you do not want the record to process as it is you will have to use a CHANGE command to correct the necessary fields or a DELETE command to remove the record until the problem can be resolved.

Examples:

- An examiner is entering an initial BILLING DOCUMENT and a CCIT record for a recovery from accrual at the same time. When the CCIT record is entered the edit message "01-PP29W AMT RECEIVED OUTSTANDING BALANCE" is displayed at the bottom of the CCIT screen. The reason for the message is that the BILLING DOCUMENT has just been entered and is not yet processed. The record has been added to CCIT and can be left as is.
- A CCIT record is entered to post recovery from accrual on a receivable that was established some time ago. After the ENTER key is pressed to add the record the edit message "01-PP29W AMT RECEIVED is OUTSTANDING BALANCE is displayed. Since this BILLING DOCUMENT is established, you know there is something wrong with the entry because it is larger then the existing overpayment. The record has been added to CCIT as the message is only a warning. DELETE the record from CCIT to prevent if from creating a bad CASH RECEIPT DOCUMENT. Determine what your correct action should be (in this case if a CASH REFUND has already been received, pay out the accrual).

If the last position of the edit message code is an E, it is an error message. The system will take no action on the command you entered. If you don't correct the error situation it

will be as if you hadn't entered anything. If the problem is simply data entry error, move the cursor to the necessary field and type over the bad entry with the correct one using the space bar to erase extraneous data. The original command will still be in the ACTION FIELD. Just press the ENTER key and see if your correction has been successful.

9.10.175 Interactive Tables

Interactive tables are those tables on the PAR system which allow any user with the proper clearance to make on-line changes to the information stored directly on the screens for those records. This makes changes to this information quick and easy (see general directions in RCM 9.10.166 and 167). This also means great care must be taken in making changes to these tables.

Sections 9.10.176 through 9.10.184 will contain:

- CHANGE/DELETION information for each interactive PARS table,
- A sample screen showing which fields on each particular table are eligible for change, and
- References to complete change instructions existing in other sections of RCM 9.10.

9.10.176 Changing Information On Or Deleting Records From The AREF Table

- Records on the accounts receivable referral table can be added either mechanically by meeting system criteria, or manually, only by the overpayment recovery section.
- Once added a record cannot be deleted by using a DELETE command. The system will only change the ARCHIVE FLAG to a "Y" and permit the record to be removed if the balance equals zero. Once the ARCHIVE FLAG is set to "Y" the record will be removed when regular monthly archiving programs are run.
- Always change the REFERRAL STATUS CODE to "R" when making an entry in the DESTINATION CODE field.
- Always use the space bar to erase any data in the REFERRAL DATE and REFERRED AMOUNT fields when changing the contents of the DESTINATION CODE field. This allows the system to bring up the current date and current open balance amount as default entries.
- When an action is successfully completed to change the contents of the DESTINATION CODE field the system will fill the COLLECTED AMOUNT field with zeroes and the LAST PAYMENT field with spaces. These two codes along with

REFERRAL DATE and referred amount are to contain information since the DESTINATION CODE was entered.

- When a record no longer qualifies for the referral table (an installment billing agreement is established or reset, etc.)
 - Enter C in the ACTION field of the table action line.
 - Move the cursor to the second line if there are fields filled (not ARCHIVE FLAG) and erase the contents of those fields. If there are no entries there proceed to instructions for the REFERRAL STATUS field.
 - Press the ENTER key.
 - Move the cursor to the REFERRAL STATUS field and type S.
 - Press the ENTER key.

SAMPLE AREF SCREEN

WITH KEY AND CHANGE FIELDS INDICATED

SEE EXHIBIT 64

- Fields in the above sample filled with alpha characters display one character per available positions in that field.
- Fields which display "K" in the above sample are key fields and cannot be changed after the record has been added to the PAR system. An attempt to change will result in the following message after pressing the ENTER key "L014 CHANGED RECORD DIFFERENT", and the change will not be made. A new record must be added with all fields correctly completed. Follow the direction in the last dotted item of RCM 9.10.64 to make changes to the bad AREF record to be left on PARS.
- Fields displaying "C" in the sample can be accessed for change.
- If the contents of a field is blank in the above sample, the field:
 - cannot be accessed for change,
 - is inferred from another table and must be changed by a different action if incorrect, and/or
 - is not used by ORSP.

9.10.177 Changing Information On Or Deleting Records From The CCIT Table

- Records on this cash collection input table can be entered either manually or mechanically from the LOCKBOX process.
- Any record on this table can be DELETED.
- All CCIT records which successfully produce CASH RECEIPT DOCUMENTS in nightly production will be deleted from CCIT automatically.
- Records with an entry in the REFERENCE BILL DOC ID field that does not exist in ARHT will be retained in CCIT.
- All CCIT fields which are not key fields can be corrected following general CHANGE procedure (see RCM 9.10.154).
- If you added a record to CCIT with a bad entry in the REFERENCE BILL DOC ID field it is necessary to DELETE the bad record from CCIT when you add the corrected record; otherwise it will continue to be retained on CCIT (the system does this to accommodate simultaneous entry of a BILLING DOCUMENT and a CCIT record with the recovery). The simplest way to accomplish this is to follow directions to DELETE/ADD in RCM 9.10.166.
- If you are scanning a CCIT record some time after its initial entry (you use the SCAN command to access it) edit messages will not be displayed.
 - Type A in the ACTION field of the table action line.
 - Press the ENTER key.
 - Edit messages will now be displayed. If the message "ALL LINES ADDED" is displayed the CCIT record will be processed in the next production run.
- If you see an edit message with an E at the end, and you don't make necessary changes, no record will be added to CCIT.
- For directions to correctly complete a CCIT record (see RCM 9.10.79).

SAMPLE CCIT SCREEN

WITH KEY AND CHANGE FIELDS INDICATED

SEE EXHIBIT 65

- Fields in the above sample filled with alpha characters display one character per available positions in that field.

- Fields displaying "K" in the above sample, are key fields and cannot be changed after the record has been added to the PAR system. An attempt to change will result in the following message after pressing the ENTER key "L014 CHANGED RECORD DIFFERENT", and the change will not be made. A new record must be added with all fields correctly completed. Delete the bad record.
- Field displaying "C" in the above sample can be changed.
- If the contents of a field is blank in the above sample, the field
 - cannot be accessed for change,
 - is inferred from another table and must be changed by a different action if incorrect, and/or
 - is not used by ORSP.

9.10.178 Changing Information On Or Deleting Records From The INBT Table

- Records are added manually to the installment billing table; there is no way to mechanically add records to this table.
- Records can be DELETED from this table by manually entering the DELETE command (see RCM 9.10.155) if no installment bill has been generated.
- If an installment bill has been generated, a record can only be removed from the table by archiving. If a BILLING DOCUMENT with an active installment billing record must be modified to zero (PAYOR becomes deceased and the debt must be switched to a new PAYOR), remember to inactivate the installment billing record after your modification action is complete.
 - Type C in the ACTION field of the table action line.
 - Type N in the ACT IND field.
 - Press the ENTER key.
 - Since you already MODIFIED the receivable to 0 you don't have to worry about DUNNING notice being released. If a balance still existed on the BILLING DOCUMENT (you are taking your table actions at the same time you are scheduling your document MODIFICATION) you would need to LEAF to the OBDT table and change that record to have:
 - an "A" in the WAIV FLAG, and
 - an "N" in the DUNN FLAG field

to prevent erroneous charges from being charged (and changing the outstanding bill amount) and an erroneous reminder notice from being released.

- To reset an installment bill (only done by OPR), after entering C in the ACTION field of the table action line.
 - Type in the effective date of the new agreement in the EFFECTIVE DATE field:
 - the first two positions in the field are for the month (zero fill the first position if your effective date is the first through the ninth month of the year).
 - the next two positions in the field are for the day (zero fill the first position if the effective day is the first through the ninth day of the month),
 - the last two positions in the field are for the last two digits of the year (example: enter 92 if the year is 1992).
 - If the installment amount is different than it was for the original agreement, type in the new amount in the INST AMT field (if fewer positions are used in the new amount erase any extraneous characters displayed by pressing the space bar).
 - Reactivate the record by typing "Y" in the ACT IND field
 - Press the ENTER key and your INBT record is reset. Check the WAIV FLAG and DUNN FLAG fields to see if they contain the proper flags for the receivable. If not, change them. Your DUNN COUNT will now be zero and the LAST DUNN DATE will be blank (see ARHT). Be careful when determining if a reset record is in default, because the system currently will bring forward all past due amounts. When the system is corrected to mechanically default installment bills, records meeting criteria will also be corrected.
- When an installment bill agreement is in default (three consecutive bills issued since the EFFECTIVE DATE are currently unsatisfied and 30 days have elapsed since the last bill was issued) do the following after typing the change (C) command in the ACTION field of the table action line:
 - Type N in the ACT IND field, and
 - Press the ENTER key.

The DUNN CT field on ARHT and OBDT will now display a "1". A final reminder notice requesting the entire amount of the overpayment will be generated in the next production run and an AREF record will be created if none already exists. Check to see if an AREF record already exists. If one does, use the change command (C) or AREF to:

- change the entry in the REFERRAL STATUS field from "S" to "R",

- enter GENL in the DESTINATION CODE field, and
- enter a date in the REFERRAL DATE field equal to the current date plus 30 days.
- press the ENTER key.
- See RCM 9.10.82D for step by step instructions on:
 - Suspension of release of an installment bill, and
 - Change in an installment billing amount.

SAMPLE INBT SCREEN

WITH KEY AND CHANGE FIELDS INDICATED

SEE EXHIBIT 66

- Fields in the above sample filled with alpha characters display one character per available positions in that field.
- Fields displaying "K" in the above sample are key fields and cannot be changed after the record has been added to the PAR system. An attempt to change will result in the following message after pressing the ENTER key "*L014 CHANGED RECORD DIFFERENT", and the change will not be made. A new record must be added with all fields correctly completed. Delete the bad record if possible. If not possible, inactivate the bad record.
- Fields displaying "C" in the above sample can be changed.
- If the contents of a field is blank in the above sample, the field
 - cannot be accessed for change,
 - is inferred from another table and must be changed by a different action if incorrect, and/or
 - is not used by ORSP.

9.10.179 Changing Information On Or Deleting Records From The OBDT Table

- Records are added mechanically to the open billing document table when an initial BILLING DOCUMENT is processed. Records are deleted from this table as soon as a document transaction (CASH RECEIPT or BILLING DOCUMENT) is processed to close out the receivable amount (reduce the open balance to zero).

- The system will not DELETE a record when the delete (D) command is manually entered on the ACTION field of the table action line.
- Fields which can be changed on OBDT are:
 - the BILL PRINT FLAG (PRINT IND field),
 - the DUNNING FLAG (DUNN FLG field), and
 - the WAIVER FLAG (waiver of charges) (WAV FLAG field).
- Since seven records can be displayed at a time on OBDT always use the GET (G) command when changing a record on this table to eliminate risk of accidentally making an erroneous change on a record (see RCM 9.10.153).
- Follow standard directions in RCM 9.10.154 for making changes to these table records.
- When changing the BILL PRINT FLAG check your entry before pressing the ENTER key. If you incorrectly enter a Y, PARS will not let you type a change entry over it.
- Current system problems prevent the reopening of an OBDT record by:
 - CANCELLING a CASH RECEIPT DOCUMENT that closed a receivable,
 - MODIFYING a CASH RECEIPT DOCUMENT to a ZERO amount that closed a receivable, or
 - MODIFYING a closed BILLING DOCUMENT to add a charge (INTEREST, PENALTY or ADMINISTRATIVE COST) line.

In order to reopen the OBDT record (a CASH RECEIPT cannot be posted to an overpayment if there is no record on OBDT)

- Process a BILLING DOCUMENT MODIFICATION to increase the principal line (001 or 002 if there is no line 00) by \$1.00, and
- process a BILLING DOCUMENT MODIFICATION to decrease the BILLING DOCUMENT by \$1.00 after your action has been taken.

SAMPLE OBDT SCREEN

WITH KEY AND CHANGE FIELDS INDICATED

SEE EXHIBIT 67

- Fields in the above sample filled with alpha characters display one character per available positions in that field.

- Fields displaying "K" in the above sample are key fields and cannot be changed after the record has been added to the PAR system. An attempt to change it will result in the following message after pressing the ENTER key "L014 CHANGED RECORD DIFFERENT" and the change will not be made. The key fields on these table records are system generated, and can only be created by processing an initial BILLING DOCUMENT.
- Fields displaying "C" in the above sample can be changed.
- If the contents of a field is blank in the above sample, the field:
 - cannot be accessed for change,
 - is inferred from another table and must be changed by a different action if incorrect, and/or
 - is not used by ORSP.

9.10.180 Changing Information On Or Deleting Records From The PAYR Table

- PAYR table records are entered manually as part of the process of establishing an overpayment in the PAR system or are created mechanically by the social security mechanical or RAIL mechanical process if no record exists in PARS for the PAYOR. Without a PAYOR record a PAYOR NUMBER is not valid in PARS.
- There is no mechanical process for deleting or archiving PAYR records from the PAYR table.
- A record can be DELETED from the PAYR table if no PDIT record exists using the PAYOR NUMBER established on the records as one of its KEY fields. If you attempt to DELETE a PAYR record that is referenced by a PDIT record the following message will be displayed on the bottom of your screen:

"PPF2E CANNOT DELETE WHEN PDIT EXISTS".
- If you made an error in the PAYOR NUMBER on a PAYOR record you entered, and you haven't entered your PDIT record yet, follow the DELETE/ADD instructions in RCM 9.10.155. This will allow you to ADD the correct PAYOR NUMBER without having to retype entries in the other necessary fields.
- If you must change the NAME and ADDRESS fields on the PAYOR record, either just after it has been established and no PDIT record exists, or after the PDIT record exists but before a BILLING DOCUMENT referencing that PDIT record exists on the suspense file, follow standard table change directions in RCM 9.10.154.

- If an error is discovered in the PAYOR NUMBER after the BILLING DOCUMENT has been processed, follow directions in RCM 9.10.140.
- Changes to the NAME and ADDRESS fields will automatically change the contents of those fields on PDIT and ARCH.
- See RCM 9.10.56 for general directions for completing PAYR fields.

SAMPLE PAYR SCREEN

WITH KEY AND CHANGE FIELDS INDICATED

SEE EXHIBIT 68

- Fields in the above sample filled with alpha characters display one character per available positions in that field.
- Fields displaying "K" in the above sample, are key fields and cannot be changed after the record has been added to the PAR system. An attempt to change will result in the following message after pressing the ENTER key "*L014 CHANGED RECORD DIFFERENT", and the change will not be made. A new record must be added with all fields correctly completed. Delete the bad record if possible.
- Fields displaying "C" in the above sample can be changed.
- If the contents of a field is blank in the above sample, the field
 - cannot be accessed for change,
 - is inferred from another table and must be changed by a different action if incorrect, and/or
 - is not used by ORSP.

9.10.181 Changing Information On Or Deleting Records From The PDIT Table

- PDIT table records are entered manually as part of the process of establishing an overpayment on the PAR system or they can be created mechanically by either the social security mechanical or RAIL processes. Without a PDIT record a BILLING DOCUMENT ID NUMBER is not valid in PARS.
- A PDIT record will be deleted from the PAR system mechanically if:
 - Archiving/clearance programs are run and the closed receivable meets criteria,
 - The full amount of the overpayment is MODIFIED to zero, or

- The BILLING DOCUMENT is cancelled.
- A PDIT record cannot be DELETED if an ARHT record exists referencing its BILLING DOCUMENT ID field entry. The only way to DELETE the PDIT record would be to CANCEL or DELETE the BILLING DOCUMENT. Do not CANCEL or DELETE a BILLING DOCUMENT because a portion of the DOCUMENT ID was incorrectly completed according to current format. The only identifying field error which should result in CANCELLING or MODIFYING a BILLING DOCUMENT amount to zero and then establishing a new BILLING DOCUMENT is a PAYOR NUMBER error (see RCM 9.10.140). If the document is still on the suspense file see RCM 9.10.122 for directions.
- The only part of a PAYOR NAME that is changeable on PDIT is the second name line. Follow standard change instructions in 9.10.154. If your only change to the PAYOR NAME/ADDRESS is to the second line of the PAYOR NAME no additional action to the BILLING DOCUMENT are necessary (described in RCM 9.10.120 and 9.10.138) because the PAR system does not store the second NAME line on ARHT.
- The remainder of the fields on PDIT can be changed following standard directions for table changes in RCM 9.10.154.
- Changes made to the PDIT record will automatically change the contents of the same field displayed on ARCH.
- See RCM 9.10.57 for directions for completing PDIT fields.

SAMPLE PDIT SCREEN

WITH KEY AND CHANGE FIELDS INDICATED

SEE EXHIBIT 69

- Fields in the above sample filled with alpha characters display one character per available positions in that field.
- Fields displaying "K" in the above sample, are key fields and cannot be changed after the record has been added to the PAR system. An attempt to change will result in the following message after pressing the ENTER key "L014 CHANGED RECORD DIFFERENT", and the change will not be made. A new record must be added with all fields correctly completed. Delete the bad record if possible.
- Fields displaying "C" in the above sample can be changed.
- If the contents of a field is blank in the above sample, the field:
 - cannot be accessed for change,

- is inferred from another table and must be changed by a different action if incorrect, and/or
- is not used by ORSP.

9.10.182 Changing Information On Or Deleting Records From The RECR Table

- RECR table records are entered manually to allow the PAR system to generate CASH RECEIPT documents to post monthly recoveries due to full or partial withholding.
- An RECR record cannot be DELETED from the table by manually entering a DELETE command.
- An RECR record is only removed from the PAR system after a change (C) command (RCM 9.10.154) has been used to change the contents of the ARCHIVE FLAG field from "N" (no) to "Y" (yes).
- Never change the contents of the ARCHIVE FLAG field to Y if the amount displayed in the CURRENT BALANCE field is greater than zero. See RCM 9.10.80 for detailed instructions on archiving RECR records.
- Whenever monthly annuity is not being withheld (for example it is in suspense or the annuitant died), the contents of the hold indicator field (HOLD IND) must be changed from "N" (no) to "Y" (yes) to prevent erroneous CASH RECEIPTS from being generated and processed. If erroneous CASH RECEIPTS are processed the amount of the CASH RECEIPT DOCUMENTS must be MODIFIED to zero, each document individually.
- See RCM 9.10.80 (E)(I) for detailed instructions for changes to the RECR record (and associated actions) when an annuity is suspended while partial or full withholding is in effect.
- When an award action is taken to reinstate an annuity and recover the overpayment by partial withholding that was initially being recovered by full withholding the following PARS actions must be taken:
 - Enter a change command (C) in the ACTION field of the table action line.
 - Type 11B in the ACTION OUT field.
 - Type the new amount that will be withheld in the CURRENT OFFSET AMT field, use the space bar to erase extraneous characters in the field. This will be the amount of the CASH RECEIPT DOCUMENTS created by RECR effective with the next CASH RECEIPT to be created.

- Press the ENTER key. You have now corrected the RECR record.
- Look at the PPLIED OFFSET MONTHS field. The number displayed is the number of CASH RECEIPT DOCUMENTS you will have to modify.
- LEAF to the ARCL screen for the case you are correcting.
- Take a print of the screen(s) displaying the RECR CASH RECEIPT DOCUMENTS you will have to MODIFY to decrease the amount from the full withholding amount to the partial withholding amount. Note if there is one line or two lines for each CASH RECEIPT DOCUMENT you need to MODIFY. If there are two lines you will have to prorate the reduction to the CASH RECEIPT DOCUMENT. By decreasing the CASH RECEIPT DOCUMENT amounts the balance of the overpayment will increase to its correct level.
- To change the CURRENT OFFSET AMOUNT on full withholding recoveries to reflect cost-of-living increases (OPR):
 - Type the change command (C) in the ACTION field of the table action line,
 - Type the correct withholding amount in the CURRENT OFFSET field,
 - Do not change the OFFSET BEGIN DATE,
 - Press the ENTER key.
- If you do not take the action timely:
 - Calculate the amount of the increase times the months for which it was not posted.
 - Post this amount using a CCIT record (follow general instructions in RCM 9.10.79) with an AW TRANSACTION TYPE code and an 11C ACTION OUT CODE. This is simpler than MODIFYING all the CASH RECEIPT DOCUMENTS generated for an amount less than they should have been.

SAMPLE RECR SCREEN

WITH KEY AND CHANGE FIELDS INDICATED

SEE EXHIBIT 70

- Fields in the above sample filled with alpha characters display one character per available positions in that field.
- Fields displaying "K" in the above sample, are key fields and cannot be changed after the record has been added to the PAR system. An attempt to change will result in the following message after pressing the ENTER key "*L014 CHANGED

RECORD DIFFERENT", and the change will not be made. A new record must be added with all fields correctly completed. Inactivate the bad record (change HOLD INDICATOR to Y) and change the archive indicator to Y to delete it the next time archiving programs are run.

- Fields displaying "C" in the above sample can be changed.
- If the contents of a field is blank in the above sample, the field:
 - cannot be accessed for change,
 - is inferred from another table and must be changed by a different action if incorrect, and/or
 - is not used by ORSP.

9.10.183 Changing Information On Or Deleting Records From The WAIV Table

- WAIV table records are created mechanically when a BILLING DOCUMENT is processed.
- WAIV table records cannot be deleted by manually entering the delete (D) command.
- WAIV table records are deleted from the system mechanically when:
 - a BILLING DOCUMENT is cancelled,
 - the amount of a BILLING DOCUMENT is completely MODIFIED to zero, or
 - when a closed BILLING DOCUMENT meets criteria and archiving/clearance programs are run.
- When changing a WAIV record always access the record using a get (G) command so that you don't expose unnecessary records to the risk of being changed (see RCM 9.10.153).
- See RCM 9.10.154 for general instructions for using the change (C) command.
- See RCM 9.10.83 for general instructions for completing WAIV table fields.
- Be careful when changing the WAIVER EXPIRATION DATE, unless the WAIVER REQUEST is "Y" or there is an entry in WAIVER DENIAL DATE, because the entry in that field controls when interest is changed. If a BILLING DOCUMENT is MODIFIED to correct the original COLLECTION DUE DATE (the overpayment letter

was not released timely) the WAIVER EXPIRATION DATE on the WAIV table should be changed at the same time (the original dates should match).

- See RCM 9.10.83 (C) for detailed instructions on how to change the WAIV record when a request for waiver or reconsideration is received. An entry of "Y" in this field automatically:
 - Erases the DUNN COUNT in PARS,
 - Erases the LAST DUNN DATE in PARS, and
 - Blocks all charges if no CHARGE APPLY DATE exists. If a CHARGE APPLY DATE exists on ARHT for any charge
 - Change the WAIV FLAG on OBDT to A to block charges
 - MODIFY the BILLING DOCUMENT to remove all charges assessed. This will remove the CHARGE APPLY DATES.
 - Change the WAIV FLAG field back to a blank.
 - If the charges were modified to a zero amount before February, 1992 forward a print of the ARHT screen through your supervisor to the ORSP PAR system specialist to have the PAR SYSTEM ADMINISTRATOR remove the necessary APPLY DATES. Change the WAIV flag field to a blank (if appropriate) only after the erroneous APPLY DATE is removed.
- Everytime an action is taken in OPR or RECON on a case involving an overpayment the examiner should make the appropriate change in status code (STAT field) and change the date in the STATUS CHANGE DATE field. Charges in the latter will prevent cases from being erroneously listed in the report of cases without activity. See RCM 9.10.83(C) for codes to enter.
- See RCM 9.10.83(3)(F) for detailed steps to take for changes to the WAIV record should unfavorable ORSP decisions be appealed to the bureau of hearings and appeals (BHA).

SAMPLE WAIV SCREEN

WITH KEY AND CHANGE FIELDS INDICATED

SEE EXHIBIT 71

- Fields in the above sample filled with alpha characters display one character per available positions in that field.
- Fields displaying "K" in the above sample, are key fields and cannot be changed after the record has been added to the PAR system. an attempt to change will result

in the following message after pressing the ENTER key "*L014 CHANGED RECORD DIFFERENT", and the change will not be made. The key fields on these table records are system generated and can only be created by processing an initial BILLING DOCUMENT.

- Fields displaying "C" in the above sample can be changed.
- If the contents of a field is blank in the above sample, the field
 - cannot be accessed for change,
 - is inferred from another table and must be changed by a different action if incorrect, and/or
 - is not used by ORSP.

9.10.184 Changing Information On Or Deleting Records From The WROT Table

- Records are added to the write-off table
 - mechanically if the balance is greater than \$1.00 and criteria stored in the WROT table are met,
 - mechanically if the balance on the OBDT table is less than \$1.00 (these records are created with the WRITE-OFF FLAG set to "Y" an ACTION OUT CODE of 22B and will produce approved write-off cash receipts in the next production run if there is no intervention before then), or
 - manually by an OPR examiner if the receivable qualifies to be written off but did not meet system criteria for selection.
- All records on WROT are eligible to be deleted using the DELETE (D) command. An OPR examiner might want to delete a WROT record:
 - If the record manually added has a data entry error in the PAYOR NUMBER or BD ID field,
 - If the decision to add it to WROT was erroneous
 - If a corrective action is being taken on a case that has an automatic write-off cash receipt in WROT and you want to prevent a write off CASH RECEIPT from being created and processed.
- Follow standard directions in RCM 9.10.155 for using the DELETE command.

- When accessing a record in WROT to CHANGE or DELETE, always use the GET (G) command (see RCM 9.10.153) so that only the record you want is open to change. A WROT screen normally displays 14 records at a time.
- Records are not selected to refill the WROT table after production of write-off cash receipts if:
 - A write-off CASH RECEIPT has been produced, or
 - no OBDT records exists for the receivable or criteria are no met.
- If the WRITE OFF FLAG is not Y on the WROT record there is no reason to DELETE a record on which you are taking other close out action. Without the Y it will not create a CASH RECEIPT DOCUMENT. After your action it will not be reselected for WROT.
- If only part of the receivable is being write-off, change the contents of the TOTAL BILL AMOUNT field to the amount to be written-off. When you type the new amount, the field display will be left justified in the field, while the amount already established in the field will be right justified. Remember to erase the old amount using the space bar before pressing the ENTER key (see RCM 9.10.154 for standard instructions on the CHANGE (C) command). After the CASH RECEIPT DOCUMENT is created the contents of the P/F field must be changed to P before the document is processed (see the supervisor of OPR, special clearance is needed to access WR CASH RECEIPT DOCUMENTS).
- The following codes can be changed using standard CHANGE command procedure:
 - WRITE OFF FLAG,
 - WRITE OFF REASON,
 - ACTION OUT.
- See RCM 9.10.81(B) for step by step instructions for changes to write-off an existing WROT record and directions for field completion.
- See RCM 9.10.81(E) for special directions to take before making changes to write-off an existing WROT record if the PAYOR NAME or ADDRESS are incorrect.

SAMPLE WROT SCREEN

WITH KEY AND CHANGE FIELDS INDICATED

SEE EXHIBIT 72

- Fields in the above sample filled with alpha characters display one character per available positions in that field.

- Fields displaying "K" in the above sample, are key fields and cannot be changed after the record has been added to the PAR system. An attempt to change will result in the following message after pressing the ENTER key "*L014 CHANGED RECORD DIFFERENT", and the change will not be made. A new record must be added with all fields correctly completed. Delete the bad record.
- Fields displaying "C" in the above sample can be changed.
- If the contents of a field is blank in the above sample, the field:
 - cannot be accessed for change,
 - is inferred from another table and must be changed by a different action if incorrect, and/or
 - is not used by ORSP.

9.10.200 Recording Program Accounts Receivable Transactions

This section outlines situations where the Office of Retirement and Survivor Programs (ORSP) is required to establish or change an accounts receivable record and when to post a recovery. Any actions required on an accounts receivable record for a Medicare debt will be done by the Bureau of Disability and Medicare Operations (BDMO).

An account receivable record must be established on the Program Accounts Receivable System (PARS) anytime a railroad and/or a supplemental annuity overpayment occurs. A PARS record does not need to be established if a specific tolerance situation exists--please see RCM 6.2.56 A.4 for explanation.

There are two types of overpayment recoveries that are shown on PARS. These types are non-recurring cash receipts and recurring cash receipts.

Non-recurring cash receipts are those instances in which the RRB has a one-time recovery action. Examples of these are cash refund, credit card refund and withholding accrual payments to offset an overpayment.

9.10.205 Establishing A PARS Record When An Accrual Will Be Used To Offset An Overpayment

In all situations, the entire overpayment must be posted to PARS before an offset from the same or another account is processed. RCM 9.10.70 through 9.10.79 explains how to post a recovery on the Cash Collection Input Table (CCIT). The Action Out code used in this situation is 11A.

If you must complete Form T-200 for PARS entry, complete sections A and B to establish the overpayment and section D to establish the CCIT. See Exhibit 74.

EXAMPLE: John Doe's railroad annuity is overpaid by \$500.00 due to 1991 work deductions. His spouse, Jane Doe, is due a \$100.00 accrual for an annuity adjustment. John Doe's entire overpayment of \$500.00 must be established on PARS before the \$100.00 offset is established. A sample Accounts Receivable Case History Line Table (ARCL) for this situation is shown in Exhibit 73.

9.10.210 Establishing A PARS Record for Full Or Partial Withholding

Recurring cash receipts are those instances in which the RRB has a recurring (monthly) recovery action - partial or full withholding. When the annuity is adjusted for full or partial withholding, the accounts receivable record must be updated to establish a Recurring Cash Receipt Table (RECR). RCM 9.10.80 explains how to establish an RECR table on PARS.

If you must complete Form T-200 for PARS entry, complete Section C to establish an RECR table. See Exhibit 75.

Both the PAYOR CODE and the BILLING DOCUMENT IDENTIFICATION NUMBER assigned to the overpayment when the accounts receivable record was established must be known to complete a RECR record on PARS.

9.10.211 Establishing A PARS Record For Actuarial Adjustment

When an annuity is adjusted for actuarial adjustment, the accounts receivable record must be updated to reflect this recovery. The recovery is recorded on CCIT. RCM 9.10.70 through 9.10.79 explains how to post a recovery on CCIT. The Action Out code used in this situation is 15A.

If you must complete Form T-200 for PARS entry, complete Section D to establish the CCIT. See Exhibit 76.

9.10.215 PARS Action In Small Overpayment Recovery Situations

In small overpayment recovery situations it is not necessary for an RECR table to be established. Instead, the recovery must be recorded on CCIT. RCM 9.10.70 through 9.10.79 explains how to post a recovery on CCIT. The Action Out code used in this situation is 11C.

If you must complete Form T-200 for PARS entry, complete Section D to establish the CCIT. See Exhibit 77.

9.10.220 When To Correct An RECR Record

Partial or full withholding cases may require a change of the withholding type and/or the offset amount already established on PARS. This happens when notice is not received timely requesting partial withholding to recover an overpayment. The annuity is

suspended to recover the overpayment but the G-421 requesting partial withholding has not been matched to file. Once the G-421 is matched, the annuity is reinstated and partial withholding is started. At this time it is also necessary to correct the RECR table. RCM 9.10.182 explains how to correct an RECR record on PARS.

If you must complete Form T-200 for PARS entry, complete Section C with the new withholding information and/or corrected data. Note in the remarks section of the T-200 "RECR previously established-correction needed." See Exhibit 78.

9.10.225 Posting Cash Refunds To PARS

In August 1991, ORSP established a lockbox in which all cash refunds are deposited. The Beneficiary Services Unit-Payment Services Group (BSU-PSG) is responsible for all cash refunds and lockbox items. Lockbox processing is done in cooperation with First Chicago Bank. All cash refunds from field offices are forwarded to the bank where they are keypunched. The bank transmits all data to the RRB where it is loaded into PARS. The cash refunds are posted to the accounts receivable records. BSU-PSG monitors lockbox processing and handles all rejected items.

Occasionally, uncashed checks or money orders are incorrectly forwarded to the adjudicating units. In these instances the check or money orders should be walked to the Program Procedures and Project Analysis Section (PP&PAS)-Rosalie Klocek for lockbox processing.

9.10.230 Posting Credit Card Payments

Field offices forward all requests for repayment by credit card to PP&PAS for handling. PP&PAS secures approval from Citibank. PP&PAS will notify the appropriate adjudication unit of approval by entering "APPROVED" on the G-421 series form. The adjudication unit is responsible for posting the credit card repayment to PARS. RCM 9.10.70 through 9.10.79 explains how to post a recovery on CCIT. The Action Out code used in this situation is 13B.

If you must complete Form T-200 for PARS entry, complete Section D to establish the CCIT. See Exhibit 79.

9.11.1 Overview

The Survivor G-90 Expeditor (SURGE) system automates requests sent to the SEARCH system for a survivor earnings and computation record (G-90). Previously, G-90 requests were handled by completing and keypunching form G-73a.

The majority of survivor G-90 requests will be triggered automatically upon completion of the APPLE First Notice of Death (FNOD) screen for a deceased employee or enters a survivor application on APPLE. SURGE on-line data entry screens are available for use by claims examiners, development clerks and contact representatives for wage record requests in cases not submitted through APPLE.

Up to three mechanical requests for a wage record may be created based on the following criteria either entered via APPLE or SURGE. The disability freeze and/or alternative index year must be supplied in order for the multiple requests to be created by SURGE. SURGE will not do multiple requests if the information must be retrieved from the Master Benefit File. If the data is not provided by APPLE or by the examiner, only one request will be generated.

- I. If a disability freeze (DF) and an alternative index year (ALT) are provided (APPLE and/or examiner will provide DF from PREH), SURGE will format 3 SEARCH requests:
 - with ALT and DF (if DF > 12-31-1978); or
 - with ALT and without DF (if DF < 1-1-1979); and
 - with DF and without ALT ; and
 - without ALT or DF.
- II. If a DF is only provided, SURGE will format 2 SEARCH requests:
 - with DF; and
 - without DF.
- III. If an ALT is only provided, SURGE will format 2 requests:
 - with ALT; and
 - without the ALT.

Request data will remain on-line for at least 90 days. During this time modifications and corrections may be made to the original data and a request resubmitted.

9.11.2 Database Operation

Structure

- A. The SURGE system contains the G-90 request information only. No actions occurring after the request enters the SEARCH system are reflected on the database.
- B. Nightly processing - On a nightly basis, processing will occur to:
 - prepare a G-90 request file containing employees with current connections from the current day's SURGE APPLE transactions.
 - match the G-90 request file to the Employee Data Maintenance file (EDM) to pick up military service information where appropriate. Military service is taken from EDM in all cases except if the military service is entered directly on SURGE and an m/s "use code" is entered. (See 9.11.22 B below for details).
 - store the updated records (after EDM data is included) on the SURGE/APPLE database.
 - submit the G-90 requests to the SEARCH system.
- C. Monthly processing - Each month, records that have gone at least 90 days without data entry activity will be purged from the database.

9.11.10 Surge Operation

When notice of a railroad employee's death is received in a field office, the APPLE First Notice of Death (FNOD) screen is to be completed. The transmission of this death notification will trigger a survivor G-90 request by the SURGE system. A survivor G-90 request can also be triggered when a survivor application is entered on APPLE

- A. Data Used in the G-90 Request - Data from either the APPLE FNOD screens or the APPLE survivor application will be used to format a SURGE G-90 request. The following employee information will be completed by APPLE: name, date of birth, date of death, date last worked, sex code, annuity beginning date, filing date, disability freeze date, gross 59 code, "no ABD" flag, and ALT index year. If an ALT and/or DF is provided, SURGE will format multiple requests as indicated above in 9.11.1.

APPLE will automatically enter the DF date under the following circumstances:

- The DF is on PREH and the DF letter code is 1; and
- The date is on 3255-SSA-DIS-ONS-DT or

- The date is on 3255-DF-BEG-DT and the month is other than January.
- APPLE will automatically enter the ALT Index Year under the following circumstances:
- Widow's potential date of entitlement is not more than two years in the future; and
- Widow's information is on the First Notice of Death – when the wage record is being requested from the FNOD; or
- Widow is applying for an aged widow's annuity – when the wage record is being requested through APPLE.

Note: The ALT Index Year **will not be included** by APPLE if the widow is applying for a disability annuity.

- B. The Current Connection Code Is A Required Entry - To furnish SURGE with the information necessary to determine in which cases to request a G-90, the current connection (c/c) code on the FNOD screen must be completed. Previously, the c/c field was an optional entry.

A "Y" (yes) or "U" (unknown) entry in the c/c field will prompt a G-90 request. No G-90 will be requested for cases with an "N" (no) in this field.

9.11.15 Field Use Of SURGE

The use of SURGE by the field office may be required when additional proof such as MS is submitted after the application and/or FNOD has been processed. If an additional request is submitted and consideration is required, notify SBD via email. Otherwise, the APPLE FNOD will automatically initiate a SURGE request.

9.11.20 Direct On-Line Data Entry

Three screens have been developed for on-line entry, modification, and correction of survivor G-90 requests. These screens are the Basic Information, Military Service, and Lag Data/Prior Service screens.

All initial requests require the completion of the Basic Information screen. The two other screens are optional, based on the individual employee circumstances. Modifications or corrections may be done on any of the three screens, individually or in combination.

9.11.21 Sign On Procedure

To sign onto the SURGE system:

NOTE: Standard sign-on and sign-off procedures for field offices are in FOM 1525.

Signing onto the SURGE system:

- Open EXTRA and enter your user id and password followed by pressing ENTER twice.
- Select RRAPID from the menu.
- Select item 11, SURGE.
- Enter the prefix and claim number, press ENTER. If a SURGE request was previously submitted, the screen will be prefilled with the data previously entered; if not, a blank Basic Information screen will appear with only the prefix and claim number prefilled.

9.11.22 Entering Data On SURGE Screens

A. Basic Information Screen

Enter data in the appropriate fields according to the following instructions.

NOTE: Explanations of the functions of the various navigation and data entry keys can be found in Appendix A. Editing of the data is handled as explained in section 9.11.23.

SSN - Enter the deceased employee's social security number. This item will be prefilled if the deceased employee's social security number is also his railroad claim number.

NAME (FI - MI - LAST) - Enter the deceased employee's first initial, middle initial (if known), and surname.

SEX - Enter "M" if the deceased employee was male, "F" if female.

DATE OF BIRTH - Enter the month, day, century and year of the deceased employee's birth. Month, century and year are required entries. If the exact day of birth is unknown, enter "15" for the day entry.

DATE OF DEATH - Enter the month, day, century and year of the deceased employee's death. Month, century and year are required entries. If the exact day of death is unknown, enter "15" for the day entry.

DATE LAST WORKED - Enter the later of the date the deceased employee last worked for a railroad employer or the last date worked prior to retirement for a non-railroad employer. The EE date last worked can be found in PREH, Employee General Information Screen (EEINFO). If the exact day last worked is unknown, enter "01" for the day entry.

ANN EFF DATE - Enter the month, day, century and year of the deceased employee's annuity beginning date, if any. If the day the employee's annuity began is unknown, enter "03" for the day entry.

APPL FILING DATE - Enter the month, day, century and year the deceased employee filed his or her retirement application. If the filing date is not available, it can be found in the Rate History system on RRAPID, on the first page of the Annuitant General Information (BENE) screen. If the application filing day is unknown, enter "01" for the day entry.

DIS FREEZE DATE - If a period of disability under the Social Security Act has been established for the deceased employee, enter the disability freeze date. Obtain the disability freeze date from one of the following:

- Item 26 of Form G-325; or
- Item 15(A) of Form SSA-831-U5; or
- Item 24 of the On-Line Disability Decision Sheet (OLDDS) system; or
- Item 4 of Form SSA-415; or
- PREH, screen 3255, SSA-DIS-ONS-DT (If DF-LTR-CODE (3255) is not a '1' then this may be a Medicare only DF.).

NOTE: Do not enter the dates from the SSA-415 if there are checks before "Coordination" and "Conflict" and the folder does not show that the conflict has been resolved.

If the disability freeze period was established by SSA before 9-6-58, use the date(s) from the SSA allowance letter or other letter from SSA. The date(s) can also be found on Form T-216.

If a period of disability has not been established, leave this item blank.

ALT INDEX YEAR - If an alternative PIA is being requested, enter the alternative indexing year. If applicable, the date must be greater than 1976. Otherwise leave the prefilled value of '1900'.

Refer to RCM 8.9 G-364.1 instructions for information on determining the alternative indexing year.

GROSS 59 CODE (PREV SURVIVOR) - This field will be prefilled with an "N", meaning that compensation up to \$4550.00 will be considered for 1959.

Make no entry in this item unless a gross 1959 calculation is required. If PREH indicates a survivor award has been vouchered prior to 10/15/1987, enter "Y" for the gross 59 code. Entering a "Y" in this field will allow the use of compensation up to \$4800.00 (the SSA maximum for 1959) in the G-90 calculations.

NO ABD ("A" CASE) - This item will be prefilled with "N" for no. Enter a "Y" if an "A" prefix has been assigned to a deceased employee and no retirement annuity has been awarded.

AMC - (Average Monthly Compensation) - If the employee's annuity began to accrue before 1948 and was based on at least 10 years of service, consult your lead specialist or supervisor concerning the entry to make in this field.

AMR - WITH INC YEARS (Average Monthly Remuneration with Increment Years) - If all the following conditions apply:

- No entry has been made in the AMC field; and
- the employee died before 2-15-1968; and
- a survivor award based on the AMC was made after 9-5-1958,

consult your lead specialist or supervisor concerning the entries to make in these fields.

- B. Military Service Screen - The identifying information (prefix, claim number, etc.) on the first line of the screen will be prefilled.

Only enter military service (MS) information if the MS is either not on EDM or if it is different then what is on EDM. Please refer to the following chart concerning MS involvement.

If the MS is on SURGE	and the MS is on EDM	and SURGE MS use cd is	then the MS is from/type	EDM updated
Yes	No	None	SURGE/wage and/or comp	Yes
Yes	No	Wage or comp	SURGE/wage or comp	No
Yes	Yes	None	EDM/wage and/or comp	Yes
Yes	Yes	Wage or comp	SURGE/wage or comp	No

No	No	None	N/A	N/A
No	Yes	N/A	EDM/wage and/or comp	No

- MS information is not retrieved from the MBF/PREH on SURGE requests – it comes from SURGE and/or EDM.
- If SURGE has an MS use cd, then the MS is used as indicated on SURGE. The MS will not get updated to PREH nor EDM based on the wage record. Refer to G-59



MS instructions

- If SURGE does not contain an MS use cd, then the MS information will be updated to EDM if there is no other MS on EDM.
- NUMBER OF PERIODS - If active military service after 1936 is claimed:
- Enter "1" if there is one period of military service that has been claimed and verified.
- Enter "2", "3", "4", as appropriate, if multiple periods of military service are claimed and verified.
- Enter "5" if there are more than 4 periods of military service.
- 37-50 OVERLAP MOS - If military service was previously credited in this case and there are overlap months in the 1937-50 period, enter the number of overlap months in this field. Overlap months are calendar months containing both railroad and military service. The number of 1937-50 overlap months can be found in item 2 of the G-90 if military service was previously considered for the employee.

If the 1937-50 overlap months are not available, leave this item blank.

MS BEG DT (1-4) - Enter the month, day, century and year of the employee's entry into active duty for each period of military service.

MS END DATE (1-4) - Enter the month, day, century and year of the employee's discharge or release from active duty for each period of military service.

MS USE CODE (1-4) - Enter a "W" if the period of military service was previously determined to be creditable as wages. Enter a "C" if the military service was previously creditable as compensation.

An entry in this item will prevent the MS from being updated to EDM.

If no previous determination is available, leave this item blank.

MEANS OF ENTRY (1-4) - Enter an "I" if the employee's entry into military service in this period was involuntary. Enter a "V" if the employee entered military service voluntarily.

INT EARN (Intervening Earnings) (1-4) - This item will be prefilled with an "N" for no. Enter a "Y" only if the employee had non-RR earnings between the end of any military service which includes all or part of the 6-15-1948 through 12-15-1950 period and the return to railroad service. This information can be found in the following items on the survivor applications:

Application	Item
AA-17	11
AA-18	12
AA-20	12

OVERLAP MOS (1-4) - If there has been a previous creditability determination for this period of military service, enter the overlap months, if any. This is a separate count that includes 1937-50 overlap months even if they have already been entered in the 37-50 overlap field.

- C. **Lag Data/Prior Service Screen** - The identifying information (prefix, claim number, etc.) on the first line of the screen will be prefilled.

The first line of the lag data section represents the current year with the second line provided for prior year lag data. Lag data should be obtained from the AA-12 or G-88A.2 in the claim file. Only the lag year(s) and the number of service months credited for that year(s) should be entered. If neither form is in the file, leave this section blank.

YEAR - This item will be prefilled with the current or previous calendar year.

Service and earnings from a previous year are only considered "lag" until the data is posted at the RRB, usually no later than May 1 of the following year.

REPORTED MOS - Enter the number of reported service months from the AA-12 or G-88A.2.

DEEMED MOS - Enter the number of deemed months, if any. Refer to RCM Part 11, G-73a instructions, page 18, for information about deeming service months.

POSSIBLE LAG-DETAILS UNKNOWN - This field will be prefilled with "N" for no. If there is an indication that the employee worked for a RR employer in the

current or preceding year but no earnings information is available, enter a "Y" (yes) in this field.

- A. PRIOR SERVICE MOS - Enter the number of verified prior service months. Up to 360 months of service (subsequent service plus prior service) can be included in the employee's tier 2 computation. The prior service months can be obtained either from the retirement G-90, retirement award form, PREH, screen 3300, field PS-MO-USE-CNT or form G-367 in the claim file.
- B. PRIOR SERVICE AVG - If there is an entry in PRIOR SERVICE MOS, enter the prior service average from the retirement G-90, the retirement award form, PREH, screen 3300, field PS-AVG-MO-AMT or form G-367 in the claim file if available. Otherwise leave this item blank.

9.11.23 Editing SURGE Data

After all entries have been made, press PF-2 to activate the edit process (PF-3 if you are modifying existing data).

- A. Input Passes Edits - If the data passes the edits, this message will appear on the screen:

"DATA SUCCESSFULLY UPDATED"

- B. Input Does Not Pass Edits - If an invalid entry is made, the cursor will be positioned under the first invalid item, all errors highlighted in red and an error message will be displayed in red on the screen. SURGE can only display one error message at a time; therefore, after correcting an invalid item and pressing the PF-2 key (PF-3 if you are modifying existing data), the system may display a second error message. The fields are edited in the same sequence that they are entered. When all the data is valid, this message will appear on the screen:

"DATA SUCCESSFULLY UPDATED"

- C. EDIT MESSAGES

- CLAIM NUMBER MUST BE 6 OR 9 DIGITS
- NAME OF DECEASED MUST BE ENTERED
- NAME MUST CONTAIN ONLY ALPHABETIC CHARACTERS
- NAME MUST INCLUDE AT LEAST FIRST AND LAST NAMES
- DATE OF BIRTH INVALID
- DATE OF BIRTH MUST BE NUMERIC

- SEX CODE MUST BE M OR F
- APPL FILING DATE MUST BE NUMERIC
- APPLICATION FILING DATE CANNOT BE BEFORE 1935
- APPLICATION FILING DATE MUST BE LATER THAN DATE OF BIRTH
- APPLICATION FILING DATE CANNOT BE LATER THAN DATE OF DEATH
- APPLICATION FILING DATE REQUIRED IF ANNUITY EFFECTIVE DATE ENTERED
- DATE OF DEATH INVALID
- DATE OF DEATH MUST BE NUMERIC
- DATE OF DEATH CANNOT BE BEFORE 1935
- DATE OF DEATH CANNOT BE LATER THAN CURRENT DATE
- DATE OF DEATH MUST BE LATER THAN DATE OF BIRTH
- DATE LAST WORKED INVALID
- DATE LAST WORKED BE NUMERIC
- DATE LAST WORKED CANNOT BE BEFORE 1935
- DATE LAST WORKED MUST BE LATER THAN DATE OF BIRTH
- DATE LAST WORKED CANNOT BE LATER THAN DATE OF DEATH
- DATE LAST WORKED REQUIRED IF ANNUITY EFFECTIVE DATE ENTERED
- IF SURVIVOR INIT WAGE REQUEST IS B/4 10/15/1987 CONSIDER GROSS 59 = Y
- ALT INDEX YEAR MUST BE BETWEEN 1977 AND CURRENT YEAR
- NO ABD CODE MUST BE Y OR N
- ANNUITY EFFECTIVE DATE INVALID
- ANNUITY EFFECTIVE DATE MUST BE ENTERED OR NO ABD CODE MUST BE Y

- ANNUITY EFFECTIVE DATE MUST BE LATER THAN DATE LAST WORKED
- ANNUITY EFFECTIVE DATE CANNOT BE LATER THAN DATE OF DEATH
- ANNUITY EFFECTIVE DATE CANNOT BE BEFORE 1935
- ANNUITY EFFECTIVE DATE AND NO ABD CODE CANNOT BOTH BE ENTERED
- ANN EFF DATE MUST BE NUMERIC
- DISABILITY FREEZE DATE INVALID
- DISABILITY FREEZE DATE MUST BE NUMERIC
- DISABILITY ONSET DATE CANNOT BE LATER THAN DATE OF DEATH
- DISABILITY ONSET DATE CANNOT BE BEFORE 1935
- ALT INDEX YEAR IS N/A IF DISABILITY FREEZE DATE < 1979
- AMC AMOUNT CANNOT BE ENTERED IF ALT INDEX YEAR ENTERED
- ONLY ONE SPECIAL REQUEST FIELD CAN BE ENTERED

9.11.30 Data Modification And Deletion

During the 60 days SURGE records remain on the database, existing data may be modified or deleted. The modified record will be kept for at least 60 days from the date of modification.

- A. Modifying existing data. - Entering a prefix and claim number on the SURGE entry screen will display the latest information used in a G-90 request for that number. Any field displayed in white is "unprotected" and may be modified by tabbing to the field and keying over the existing data with the changed data or with spaces, if appropriate.

When the information displayed on the screen reflects all the changes wanted, press PF3 to store the revised data on the database. The message "DATA SUCCESSFULLY UPDATED" will appear at the bottom left of the screen if no edit errors are detected. Fields failing the edits will be highlighted in red until corrected. Error messages will be displayed at the bottom left of the screen.

Only the most recent information entered for a specific claim number is stored on the SURGE database. If it is necessary to retain a record of a previous request, a screen print should be made before modifying the data.

After the initial G-90 request is processed through the SURGE system, the latest entry date will appear in the field labeled "PREV SURGE DATE" in the lower left portion of the Basic Information screen. The "SUBMISSION NUMBER" at the lower right portion of the Basic Information screen starts at 1 with the initial request and increases with each subsequent modification after nightly processing is completed each time.

- B. Deleting data - Pressing PF4 will delete the information displayed on the screen. As a precaution, a confirmation is requested by the message "HIT PF4 TO CONFIRM DELETE". When PF4 is pressed a second time, the deletion is processed. A deletion action entered on the Basic Information screen will erase the entire record. Entering a deletion on the Military Service or Lag Data/Prior Service screen will delete the particular screen information but not the identifying data, i.e., claim number, name, etc.

9.11.40 Reject Referrals

- A. MBF Match Rejects - G-90 requests from APPLE for cases in current pay status on DATA-Q will pick up additional data such as annuity effective date, date last worked, etc., from the Research MBF. If the G-90 request does not find a matching MBF record in these cases, the record will be referred on a reject listing to the survivor operational unit for reconciliation. A referral message will appear on the screen if the case is accessed on-line after the nightly processing has occurred.
- B. Military Service Referrals - As a result of the 1988 amendments making 1948-50 voluntary service creditable under the Railroad Retirement Act, additional military service items are required by the SEARCH system. In April 1990, the MBF began storing the necessary military service data. However, military service records stored prior to that time are incomplete in terms of today's processing.

During the MBF match each night when military service is found, it will be checked for completeness. If it is incomplete, the G-90 request will be submitted to SEARCH without military service. A message, "MILITARY SERVICE IS INCOMPLETE" will appear on-line when the request is accessed after the nightly processing. If a G-90 with military service is needed, the information should be entered on the SURGE Military Service screen and a modified request submitted.

Appendices

Appendix A - Screen Navigation And Data Entry Keys

The following keys are used in the SURGE system to navigate between screens and to enter, modify, and delete data:

- PA 2 - used to exit from the SURGE system. Pressing this key will take you to a screen with the "ENTER NEXT TASK CODE" message. Pressing this key will not store the data on the screen.
- PF 2 - used to enter new requests through the SURGE on-line screens.
- PF 3 - used when modifying existing database information to submit a second request through the SURGE on-line screens. Each modification will produce a separate G-90.

Note: Pressing the ENTER key after typing in new or modified data will submit the information in the same way pressing PF 2 and PF 3 does.

- PF 4 - used to delete information from the SURGE system. Pressing the PF 4 key while at a screen will delete any data in unprotected (white) fields. On the Basic Information screen, PF 4 will delete the entire record from the SURGE/TRACK database. A G-90 will still be produced unless the deletion occurs before the initial nightly processing.
- PF 7 - used to "page backward" or view each screen in reverse order. Using this key will not store data.
- PF 8 - used to "page forward" or view each screen in sequence. Using this key will not store data.
- PF 20 - a "new record" key that will return you to the SURGE entry screen. Pressing this key will not store the data on the screen.
- PF 21 - used to access the Basic Information screen from either of the two other screens.
- PF 22 - used to access the Military Service screen from either of the two other screens.
- PF 23 - used to access the Lag Data/Prior Service screen from either of the two other screens.

NOTE: If PF 21, 22, or 23 is pressed after entering or modifying data, the message "SCREEN MODIFIED BUT NOT UPDATED, PRESS ENTER TO UPDATE" will appear.

Pressing enter will submit the new data. Pressing the navigation key again will take you to the requested screen without storing the data.

9.12.1 Overview

ONCORR is a system for correcting, on-line, manual awards that reject from the daily checkwriting system (DAISY/CHICO). Rejected awards from each DAISY/CHICO run are stored on the ONCORR database so that they can be corrected and authorized by claims examiners. ONCORR edits the award as it is being corrected, determines a voucher number and date, and resubmits the award to the DAISY system for payment.

Awards that are vouchered through BREA's correction subsystem (constructive awards or correction awards) and that reject are also stored on the ONCORR database so that they can be corrected and authorized by the unit that originated the award. The ONCORR vouchering process for these awards is different, as explained in RCM 9.12.16.

ONCORR produces daily and monthly reports. Reports that are used to control the reprocessing of the rejects on the ONCORR database are available each morning on HSL.

For general information on voucher rejects, refer to RCM 12.2.

9.12.2 General Description Of Reject Correction Using ONCORR

When ONCORR is used, the reject correction process works as follows:

- Rejects are assigned to examiners for correction and monitored using ONCORR reports available each day on HSL.
- Examiners access the award on ONCORR and enter the necessary corrections to the award form data displayed. When all corrections have been made, ONCORR sets a tentative voucher date for the award and updates its status to "pending authorization."
- An authorizer accesses the award, checks the corrections, and either approves the award or refers it back to the examiner for further corrections. When the authorizer approves the award, ONCORR resets the voucher date and updates the status of the award to "authorized."
- Each time there is a DAISY run, awards with the appropriate voucher date are extracted from the ONCORR database and processed through DAISY/CHICO. A voucher number is assigned and the status of the award is updated to "batched." Folder documentation is produced for each award.
- Awards may also be deleted from ONCORR if the examiner determines that they should not be revouchered. Authorized or deleted awards may be reopened by a supervisor if necessary.

9.12.10 Types Of Rejected Awards Handled By ONCORR

ONCORR handles all manual award rejects except for awards paid on Form G-359. Any G-359 awards that reject from DAISY/CHICO must be revouchered manually. Rejects of mechanical awards (e.g., RASI, SURCAL, PC award rejects, mass adjustment rejects) are not handled by ONCORR.

ONCORR also handles rejects of correction or constructive awards that are vouchered through the BREA correction subsystem.

Awards that will be passed to ONCORR for correction are identified on the DAISY/CHICO reject listing with the message: REJECT SENT TO ONCORR. Occasionally, awards that are identified as having been passed to ONCORR will not be available on the ONCORR database. This will occur if there is more than one award reject for the same claim number and payee code from the same voucher. Since ONCORR cannot always accurately match the reject to its keypunch record in this situation, these cases will be listed for manual handling, and the unit that vouchered the award will be notified.

9.12.11 Referrals

If the rejected award produced referral messages, they will be displayed on ONCORR along with the reject message(s). The award may contain up to 22 reject and referral messages. These messages appear on the ONCORR Reject/Referral Reason screen (RCM 9.12.24), and are explained in Appendices A and B. The cause of the referral message should be considered in determining the cause of the reject.

9.12.12 Controlling Rejects Handled By ONCORR

ONCORR produces three reports that can be used to assign rejected awards to examiners for correction and to monitor the awards to see that they are handled quickly. These are the current day's reject report, described in RCM 9.12.50; the claims pending report, described in RCM 9.12.51; and the Research reject report, described in RCM 9.12.56. The reports group the awards by claims adjudication unit. Both the current day's reject and claims pending reports are available daily on HSL after each DAISY run. The Research reject report is produced after each run of the Research subsystem, which is generally weekly. The latest ten generations of each report can be viewed on HSL.

Rejects for a particular adjudication unit can also be accessed using the Reject Selection screen (RCM 9.12.22).

9.12.13 Access To ONCORR

There are six levels of access to ONCORR:

- | | | |
|----|------------------------------|---|
| 1. | Inquiry access (INQ). | The status of awards may be viewed on the Reject Selection screen only. |
| 2. | Inquiry plus (INQ-PLUS). | Awards and the administrative tables may be viewed. |
| 3. | Examiner access (EXAM). | Awards may be corrected or deleted. |
| 4. | Authorization access (AUTH). | Awards may be authorized. |
| 5. | Supervisory access (SUPV). | Awards may be reopened. The examiner and authorizer number may be reassigned. |
| 6. | Administrative (ADMIN) | The check writing cut-off calendar, the access reject/referral reason table, the unit table, and the voucher number table may be updated. |

If a user attempts to perform a function for which he does not have the appropriate level of access, he will be given the edit message **YOU ARE UNAUTHORIZED FOR REQUESTED ACTIVITY** or **UNACCEPTABLE RESPONSE, PLEASE TRY AGAIN**. When requesting access to ONCORR, the user should list each level of access required, using the acronyms shown above.

9.12.14 How Corrections Are Processed (DAISY/CHICO Interface)

The source of ONCORR's rejected awards is the Daily Activity Input System/Checkwriting Integrated Computer Operations system (DAISY/CHICO). ONCORR extracts rejected manual railroad and social security awards from the DAISY/CHICO output. It also extracts rejected awards from the BREA correction subsystem. It then matches each reject with its keypunch record. The keypunch record and the reject reason(s) are loaded onto the database.

After an examiner has corrected a payment reject and an authorizer has approved it, ONCORR extracts the award for processing through DAISY. Depending on the voucher date assigned by ONCORR, the award will be extracted for processing in the next DAISY run, or will pend until the first of the following month when it will be extracted for processing through DAISY.

Authorized BREA rejects are extracted whenever BREA is ready to reprocess them through its correction subsystem, which is generally once a week.

When the award is extracted from ONCORR, ONCORR formats it into a complete keypunch record so that the award processes through DAISY and the BREA correction subsystem like any other manual award.

9.12.15 Vouchering And Other Functions Performed By ONCORR

A. Vouchering

(The vouchering process described in this section applies to payment rejects. Rejects from BREA's correction subsystem are vouchered as described in RCM 9.12.16.)

ONCORR assigns a voucher date and voucher number to the award. Each examining unit has one of its railroad and one of its social security voucher numbers reserved for use by ONCORR.

The voucher date is based on the type of activity (final, recert, etc.) and the cut-off dates for that month. ONCORR sets a tentative voucher date after the award is corrected and resets the voucher date after the award is authorized. The voucher date will be set for either the next day, the date of one of the two DAISY runs that occur during the post-period, or the first of the following month. The date will be the first of the following month, if it would not be possible to extract the award for processing by the last DAISY run for that month in which it could be included.

Example: The last DAISY run of the pre-period is January 18. If a recert award is corrected on the 18th, the voucher date will be set for February 1. If it were corrected on the 17th, the voucher date would have been set for the 18th.

If the award can be paid in the post period, and it is corrected after the cut-off for pre-period awards but before the beginning date of the post-period, the voucher date will be set as the post-period beginning date. If it is corrected on or after the post-period beginning date but before the post-period ending date, the voucher date will be set as the post-period ending date.

The voucher date can be viewed on the Reject Selection screen after the award is corrected.

ONCORR uses the voucher date that was set when the award was authorized to determine when to extract the award. When the award is extracted for processing through DAISY, ONCORR gives it the extraction date as the voucher date, if the voucher date previously set was earlier.

ONCORR also edits the month and year through which the award is accrued to ensure that they are consistent with the voucher date that was set. (See RCM 9.12.28.)

Each month the analyst responsible for preparing the calendar of monthly computer operations also updates the ONCORR checkwriting cut-off calendar screen by entering next month's cut-off dates and indicating the types of awards that can be processed in the post period. ONCORR uses this information to

determine voucher dates. Anyone with inquiry plus access to ONCORR can view the checkwriting cut-off calendar. (See RCM 9.12.34.)

- B. Setting Accompanying Forms Indicators.--ONCORR determines what forms are attached to the award, both when it loads the award onto the database and when it extracts the award from the database for reprocessing. It sets the accompanying forms indicators on Form G-357 or Form G-364 based on what is attached. The indicators may not be changed by the examiner.

9.12.16 Awards That Reject From The BREA Correction Subsystem

Awards that reject from BREA's correction subsystem are loaded onto ONCORR for correction. These include awards that the examining units forwarded to BREA (constructive and correction awards) and awards prepared by BREA. BREA assigns four-digit voucher numbers to these awards. The last three digits of the voucher number correspond to the regular voucher numbers of the unit that prepared the award. This allows ONCORR to assign the award to the unit that prepared it.

Rejects from the BREA correction subsystem are placed on their own HSL report (see RCM 9.12.56). These awards are corrected and authorized in the same way as payment rejects, but the vouchering process is different. ONCORR assigns a voucher number to the award. It does not assign a voucher date. BREA has the ability to extract awards from the ONCORR database whenever it runs its correction subsystem. When the awards are extracted, usually weekly, a voucher date of the 28th of the month is assigned. BREA's voucher process does not follow the same cut-offs that are applied to awards that are affecting a payment. BREA continues to process awards that will affect that month's MBF (Master Benefit File) into the following month.

If a BREA correction subsystem award that was corrected on ONCORR rejects again, it will be loaded onto ONCORR again and assigned to the same unit. If the award rejects a second time after being corrected on ONCORR, it will not be recycled through ONCORR again. Instead, the award will be updated to the Research record and BREA analysts will review the award and make any necessary corrections to the MBF.

ONCORR determines whether the award is being corrected for the first or second time based on the voucher number that was assigned to the award. The first time the award is corrected, it gives the award the unit's three-digit ONCORR voucher number preceded by the same first digit as was on the original award. If that award should reject again ONCORR knows that it has already rejected once because it has an ONCORR voucher number. When the award is vouchered on ONCORR the second time, it assigns it a unique voucher number. This voucher number indicates that the BREA award has been corrected for the second time. As explained above, if this award rejects, it will not be loaded onto ONCORR.

BREA awards that are corrected on ONCORR produce two copies of the folder documentation, one for the file and one for BREA. Any awards that are deleted from the database are listed on a report for BREA (see RCM 9.12.57).

9.12.20 Overview Of Screens And Functions

This section provides a general description of the ONCORR screens. Further information on each screen can be found in the section referenced.

- Reject Selection screen - First screen displayed. Allows user to select claims and indicate the function (view, correct, authorize, reopen, or reassign) to be performed. Provides information on the status of each claim. Provides access to the administrative table screens. (See RCM 9.12.22 and 9.12.23.)
- Reject/Referral Reasons - Displays reject/referral messages associated with the rejected award. (See RCM 9.12.24.)
- Form Selection screens - Allows user to select a particular retirement or survivor award form or to delete a form from the award. (See RCM 9.12.25.)
- Form Correction screens - A series of screens displaying data keyed from the award forms. The following forms can be corrected on ONCORR:

G-357	(10 screens)
G-364	(6 screens)
G-369	(2 screens)
G-354Sup	(3 screens)
G-357A	(3 screens)
G-354	(3 screens)
G-354.1	(7 screens)
G-354.1A	(4 screens)
G-354.WF	(2 screens)
G-354.3	(5 screens)
G-355	(3 screens)
G-355.1	(3 screens)
G-355.1B	(3 screens)
G-355WF	(2 screens)

G-364.1 (11 screens)

RR-1e (3 screens)

(See RCM 9.12.26, 9.12.27.)

- Reassign Examiner Number - Available to users with supervisory level access only. Allows supervisor to change the examiner and/or authorizer number on the rejected award. (See RCM 9.12.31.)
- Administrative Table - Allows user to select a particular Selection Screen table for view or update purposes. These tables allow user analysts to update variable data required for ONCORR processing. (See RCM 9.12.33).
- Checkwriting Cut-off Calendar screen - Only designated user analysts may update this screen but all other users may view it. Contains the beginning and ending dates of the DAISY/CHICO pre and post periods and indicates the types of awards that can be paid in the post period. (See RCM 9.12.34.)
- Reject/Referral Reasons Table Screen - Only designated user analysts may update this screen but other users may view it. Gives the reject/referral status of a particular edit and the message associated with it. (See RCM 9.12.35.)
- Unit Table Screen - Only designated user analysts may update this screen but other users may view it. Gives the voucher numbers associated with a particular unit. (See RCM 9.12.36.)
- Voucher Number Table - Displays all active units and their voucher numbers. No information may be changed on this screen. (See RCM 9.12.37.)

9.12.21 Sign On Procedure

To sign on to ONCORR:

- With the TRAIN logo displayed on the CRT screen, type RRAPID and press ENTER.
- When the message "ENTER NEXT TASK CODE" appears, type SIGNON and your signon name and press ENTER.
- The "ENTER PASSWORD" message will then appear. Type your password and press ENTER.
- You will receive a "SIGNON COMPLETE" message with information about your last system access. Press ENTER and a screen with "ENTER NEXT TASK CODE" will appear.

- Type MENU and press ENTER. The RRAPID Main Menu will appear.
- Select ONCORR (10) and press ENTER. The Reject Selection screen will appear. Select awards using this screen as explained in the following section.

9.12.22 Selecting ONCORR Award Records

Awards on the ONCORR database are accessed using the Reject Selection screen, the first screen displayed when the user signs onto the system. The user may select claim(s) by entering either a specific claim number or the acronym of an examining unit and pressing the ENTER key. A line of identifying and status information will then be displayed for all awards on the database for that claim number or unit. Status information is explained in RCM 9.12.23.

Up to eight records may be displayed on one screen. If there are more than eight records that meet the selection criteria entered, they may be viewed by paging forward and backward using PF7 and PF8.

- A. Selecting Awards by Claim Number Enter the beneficiary symbol, prefix, and claim number of the award and press ENTER. If there are no awards with this claim number on the database, this message will be displayed:

NO AWARDS FOUND FOR SELECTION CRITERIA ENTERED

A sample of the Reject Selection screen with a claim number selected is shown below.

SEE EXHIBIT 4

If there is an award or awards with this claim number on the database, one line of data will be displayed for each award. If more than one award is on the database, the user can determine which record to select based on this data. There may be more than one award on the database for a particular claim number if, for example, a railroad and social security award were paid simultaneously and both rejected, or an award that was vouchered on ONCORR rejects again.

Survivor family groups paid using one G-364.1 with multiple G-364's attached are treated as one award and only one line of data will be displayed on the Reject Selection screen, even if more than one family member rejected.

- B. Selecting Rejects by Unit - To display awards for a particular examining unit, enter the unit's acronym and press ENTER. The unit selected must have a specific range of voucher numbers assigned to it. Valid acronyms are ICS, RPS, CBS, RBT, RSC, SIS, SPS, BCS, DPS, MPS and RES. Units whose awards are vouchered by another unit should enter the vouchering unit's acronym to display their rejects.

A sample of the Reject Selection screen with a unit selected is shown below.

The user may limit the awards displayed for a particular unit by choosing a specific status or reject date.

1. Status code - The status code is a one-letter code that indicates the status of the award on the ONCORR database. The status codes are:

- R Reject - The award has not been corrected.
- P Pending Authorization - The award has been corrected, but not authorized.
- A Authorized - The award has been corrected and authorized.
- B Batched - The award has been corrected, authorized and extracted from the ONCORR database for processing through DAISY/CHICO.
- D Deleted - The award has been earmarked for deletion from the database.

2. Reject date - This is the date the award was stored on the ONCORR database, which should be the date it rejected from DAISY. This date is generally used to limit the awards displayed to those that rejected in the previous night's DAISY run.

- C. Selecting the Action To Be Taken - Enter the number (from 1-8) of the record to be selected. (Record number 1 is pre-filled on the screen but can be typed over.) Then indicate the action to be taken on the record (correct, authorize, etc.) by pressing the appropriate PF key. The status of the claim must be consistent with the action to be taken or an edit message will be displayed. PF keys and their functions are:

PF 3 - Correct. Allows corrections to the award. The status of the award must be REJ (reject) or PNDA (pending authorization).

PF 4 - Delete. Earmarks the award for deletion. Awards with the status BCHD (batched) cannot be deleted.

PF 5 - View. Allows the award to be viewed; no corrections may be made.

PF 6 - Authorize. Allows authorization of the award. The status of the award must be PNDA (pending authorization).

PF 9 - Reopen. Allows a supervisor to reopen the award for further corrections. The status of the award must be AUTH (authorized) or DLET (deleted).

PF 10 - Reassign. Allows a supervisor to reassign the award to another examiner and/or authorizer. Awards with the status BCHD (batched) or DLET (deleted) cannot be reassigned.

If the user does not have access to the function selected, this message will be displayed:

UNACCEPTABLE RESPONSE, PLEASE TRY AGAIN.

If PF 3, 5, or 6 is selected, the user is transferred to the Reject/Referral Reason screen (see RCM 9.12.24).

If PF 10 is selected, the user is transferred to the Reassign Examiner Number screen (see RCM 9.12.31).

If PF 4 or 9 is selected, the status is changed immediately on this screen.

9.12.23 Viewing The Status Of Award Records

After the desired claim number or unit is entered on the Reject Selection screen, a line of identifying and status data is displayed for each award that meets the selection criteria entered. Up to eight lines of data may be displayed on one screen. If there are more than eight awards to be displayed, they may be viewed by paging forward and backward using PF 7 and 8.

A sample of the Reject Selection screen with awards in various stages of correction is shown below.

SEE EXHIBIT 5

The following information is displayed for each award record:

- CLAIM NO - The beneficiary symbol, prefix and claim number
- PC - Payee code. If there is more than one payee code on the award (survivor family group), the payee code of the first G-364 will be displayed.
- VOUCHER DATE/NO - The voucher date and voucher number of the original award. Social security awards have voucher numbers in the 900 range; voucher numbers below 900 belong to railroad awards. Voucher numbers greater than 999 indicate that the award was vouchered through BREA's correction subsystem and is not a payment reject.
- EXM NO - The number of the examiner who completed the original award. The number will not change unless the award is reassigned by a supervisor.

- AUT NO - The number of the examiner who authorized the original award. The number will not change unless the award is reassigned by a supervisor.
- UNIT - The examining unit that vouchered the award.
- REJECT DATE - The date the award was stored on ONCORR. This is generally the date the award rejected from DAISY.
- STATUS DATE - The date of the last action taken on the award. The date the status of the award changed to the status displayed in the next column.
- STAT - The status of the award on the ONCORR database. One of the following will be displayed:
 - REJ (reject) - The award is pending correction by an examiner.
 - PNDA (pending authorization) - The award has been corrected by a corrected by an examiner and is ready to be authorized.
 - AUTH (authorized) - The award has been authorized and is ready to be extracted for processing through DAISY at the appropriate time.
 - BCHD (batched) - The award has been corrected, authorized and extracted for processing through DAISY.
 - DLET (deleted) - The award has been earmarked for deletion.
- NEW VOU DATE/NO - The voucher date and number assigned to the corrected award by ONCORR. The date assigned will be either in the current month or the first of the following month. The date will be filled after the award is corrected. The voucher number is the last voucher number from the range of railroad and social security voucher numbers assigned to the unit that vouchered the original award.

Note that the voucher date may change unless the status of the award is "batched" (BCHD).

9.12.24 Determining The Reject And Referral Reason(s)

The reason the award rejected is displayed on the Reject/Referral Reasons screen. The Reject/Referral Reasons screen is the next screen displayed after a particular award is selected on the Reject Selection screen.

The screen displays the same reject message(s) shown on the DAISY/CHICO reject listing. Up to 22 DAISY and rate history messages may be displayed. Each message is identified as either a reject (REJ) or referral (REF), and the number of the reject or referral is given. These messages are explained in the Appendices. Rejects and referrals are numbered as follows:

0001 - 0999	DAISY/CHICO edits	Appendix A
over 1000	Rate history edits	Appendix B

If the award has more referral messages than can be displayed on one screen, the user may page backward and forward using PF7 and PF8.

To access the Reject/Referral Reasons screen from the Form Selection or Form Correction screens, press PF23. To return to that screen from the Reject/Reason screen, press CLEAR.

A sample of the Reject/Referral Reason screen is shown below.

SEE EXHIBIT 6

- A. Survivor Family Groups - When a survivor family group that was paid using one set of forms rejects, the award is treated as one record on the ONCORR database. All of the reject/referral reasons for the family group are displayed on the same Reject/Referral Reasons screen. Use the payee code displayed after each reject/referral reason to determine the corrections to be made to each payee.
- B. Referrals - While correcting the cause of the reject, also investigate and correct, if necessary, the cause of any referrals.

9.12.25 Selecting Award Forms For Correction

For railroad awards, the next screen displayed after the Reject/Referral Reason screen is the Retirement or Survivor Form Selection screen. Use this screen to select the form(s) to be corrected; to access a blank form, if the correction requires that a form be added; or to delete a form, if necessary. An arrow is displayed in front of each form that is part of the award. When data on the award form has been changed, an asterisk is displayed in front of the form.

For social security awards, the next screen displayed is the first screen of Form RR-1e.

If a form is requested that was not part of the award as originally keyed, and the user is in view mode, a blank Form Correction screen will be displayed with the message: (FORM) NOT FOUND. In the correction mode, forms may be added as explained in C.

A. Retirement Form Selection Screen

The Retirement Form Selection screen is a menu of the employee and spouse awards available for correction on ONCORR. If a form has been deleted, a "D" is displayed in front of the form. The Retirement Form Selection screen is shown below.

SEE EXHIBIT 7**B. Survivor Form Selection Screen**

The Survivor Form Selection screen is a menu of the survivor forms available for correction on ONCORR. The Survivor Form Selection screen is shown below.

SEE EXHIBIT 8

The Survivor Form Selection screen allows for three occurrences of both Form G-364 and Form G-369. As many as three G-364's and three G-369's may be attached to one G-364.1 as one award form set. This award form set is also treated as one record on ONCORR and each G-364 and G-369 belonging to the payees that rejected are accessed from the Form Selection screen. The payee code of the G-364/G-369 stored in each occurrence is displayed.

If one or more payees in the group did not reject, the G-364 and G-369 for those payees will not be displayed on ONCORR. Only data from the rejected payee(s) will be displayed in the first and/or second occurrence of the G-364/G-369.

- C. Adding a Form - To add a form that was not included in the original award, select the form from this screen. A blank form will appear with the message: (Form) DOES NOT EXIST - WILL BE CREATED. Fill in the items on the blank screen and complete the normal correction process.

Form G-369 may be added to a survivor award only if there is a single G-364 in the award form set. G-364's may not be added.

ONCORR will set the appropriate accompanying forms indicator(s), so it is not necessary to change that item on Form G-357 or G-364 when adding a form.

- D. Deleting a Form - To delete a form that was included in the original award, select the form and press PF5 (DELETE FORM). A message will appear advising that PF5 must be pressed again to actually delete the form.

Since each award must have a G-357 or G-364 attached, Form G-357 and the last G-364 may not be deleted. If the entire award is to be deleted, use the delete award function on the Reject Selection screen.

Special form deletion rules apply to survivor awards. If there is a G-364.1 attached to the award, and a G-369 is deleted, the associated G-364 will also be deleted. If there is no G-364.1 attached, the G-369 will be deleted without deleting the G-364, but the G-369 must be the first and only occurrence. If a G-364 is deleted, the associated G-369 will also be deleted.

If the first occurrence of Form G-364 and G-369 is deleted, the second occurrence of the forms will become the first occurrence and the third

occurrence, if any, will become the second occurrence. Likewise, if the second occurrence is deleted, the third occurrence will become the second.

ONCORR will also delete the appropriate accompanying forms indicator(s), so it is not necessary to change that item on Form G-357 or G-364 when deleting a form.

9.12.26 Correcting The Award

- A. Access the Reject Selection screen (RCM 9.12.22), select the award to be corrected, and press PF3 (CORRECT).

The status of the award to be corrected must be "reject" (REJ) or "pending authorization" (PNDA). If the status of the award is "pending authorization," it will revert to "reject" if further corrections are made.

- B. Review the reject and referral messages on the Reject/Referral Reasons screen (RCM 9.12.24), the next screen displayed, to determine the corrections to be made.
- C. If the reject is a railroad award, select the form to be corrected on the Form Selection screen (RCM 9.12.25). A form may also be added or deleted from this screen. If the reject is a social security award, the next screen displayed will be the first screen of Form RR-1e.
- D. Enter corrections on the form correction screens by moving the cursor to the appropriate item and typing the new or changed data.

Data from the award forms is displayed in a series of screens. The numbers of the screen items correspond with the award form item numbers. When a form is selected on the Form Selection screen, the beginning of the form is displayed first. Access other screens for that form by pressing the appropriate PF key. The item numbers that will be displayed for each PF key are shown at the bottom of the screen.

Not all award form items are displayed on the screens; only items that are keyed are displayed. Exhibit 1 shows the data that is keyed from the attached retirement award forms. Most data from Form G-357 is keyed, but exceptions are noted. Refer to this exhibit to resolve questions about what data from the form should be entered on the screen.

Some general screen format features are:

- Items are arranged from left to right and down, since that is how the cursor moves.

- Data that cannot be changed is displayed in green. There are only a few items that cannot be changed: the original voucher number and date; the accompanying forms indicators on Form G-357 and G-364; the number of G-357s on the G-357, the number of sets on the G-364 and the examiner and authorizer numbers (these can only be changed by a supervisor). For survivor awards with multiple G-364's, if the claim number and accrual period ending date are changed, they must be changed on the first occurrence of Form G-364. Those items will be updated to be the same on the other occurrence(s) automatically.
- When an item requires entry of a code, the acceptable values are usually displayed in parentheses after the item caption. A translation of the code is displayed in gold after the code itself.

Some screen items require that a code be entered where the corresponding form item allowed a numbered box to be checked. In those situations, enter the number of the box that would have been checked on the form.

Example: **7 TYPE OF CERT (0-3, 6-9): 1 RECERT**

- When an award form item required that a single box be checked, the appropriate screen entry is an "X."

Example: **13 TOLERANCE APPLIES (X): X * 5**

- When the award requires that a box be checked to indicate "yes" or "no", the appropriate screen entry is "Y" or "N."

Example: **19 SS BEN RECEIPT CD (Y/N): Y**

- Money amounts that were not filled in on the award will be displayed as ".00". When entering a money amount, it is not necessary to position the decimal point exactly where it is positioned on the screen, but a decimal point must be entered to indicate how the dollars and cents are to be formatted.
- When the award form has three columns of data, the screen also displays three columns. Some items contain a "computation" (left) block and a "rate" (right) block. In some items of this type, only the computation block or only the rate block is keyed. As much as possible, this data is aligned to the left or right on the screen to indicate whether it is computation data or rate data. Refer to Exhibit 1, for information on what data from the retirement forms is keyed.
- The group mark should be entered in the first line of the address by pressing SHIFT and 1 on a standard terminal or the right-hand bracket () on the PC terminal.

- When a question mark appears in an item, it means that the data was miskeyed and the appropriate code could not be displayed. Determine what the correct entry should be.
- When changes are successfully updated to the screen, pink asterisks appear after the new or changed data.

E. After all of the necessary corrections have been made to a screen, press one of the following keys to take the action shown.

1. To update any changes that were made to the screen, press one of the following keys:

PF24 (DONE) - Corrections have been completed. No further changes have to be made to any of the forms for the award. (See F below.)

ENTER - To update changes to the screen and confirm that they were accepted. Pressing ENTER causes the screen to be edited. If no errors are detected, asterisks will appear behind the changed data to confirm that the changes were accepted. Press one of the other keys depending on the next action to be taken. If errors are detected, they must be corrected before processing may continue.

PF11-21 - To update changes to the screen and go to another screen within the same award form. Pressing one of these PF keys causes the screen to be edited. If no errors are detected, the requested screen will be displayed. If errors are detected, they must be corrected first.

PF22 (FORM SELECT) - To update changes to the screen and go to another form for the same award via the Form Selection screen. This also causes the screen to be edited.

PF23 (REJ REASON) - To update changes to the screen and to view the reject/referral reasons. This also causes the screen to be edited.

2. If any of the following keys are pressed before pressing ENTER or one of the other keys listed above, any changes made on that screen will not be updated to the screen.

CLEAR - To leave without updating the changes and to transfer to the Form Selection screen (if a railroad award) or the Reject Selection screen (if a social security award).

PA1 - To transfer to the Reject Selection screen.

PA2 - To exit the system.

- F. After all corrections have been made to the award, press PF24 (DONE). Correct any errors that are detected. This may require that other forms within the award be accessed. If corrections had to be made, press PF24 again after all corrections have been made.

When PF24 is pressed, ONCORR

- edits the screen the user is on
- performs edits that involve comparing items on more than one screen. These edits may involve more than one screen within a form, or more than one form within an award. It also edits for the completion of required items.
- determines a voucher date. The voucher date is tentative and may be changed when the award is authorized.
- edits the date through which the award was accrued to make sure it is consistent with the voucher date.

(See RCM 9.12.28 for more detailed information on the edit process.)

When the award passes all edits, this message will appear:

PROCESSING SUCCESSFULLY COMPLETED - STATUS CHANGED TO "PNDA"

The award is now ready to be authorized.

- G. Exit ONCORR by pressing PA2 or return to the Reject Selection screen to access other awards by pressing PA1.

9.12.27 Authorizing The Award

- A. Access the Reject Selection screen (RCM 9.12.22), select the award to be authorized, and press PF6 (AUTHORIZE). The status of the award to be authorized must be "pending authorization" (PNDA).

Examiners cannot authorize awards that they have corrected. If this is attempted, the message "EXAMINERS CANNOT AUTHORIZE OWN WORK" will appear on the Reject Selection screen.

- B. Review the reject and referral messages on the Reject/Referral Reasons screen, the next screen displayed, to determine what corrections should have been made by the examiner.
- C. Review the corrections made by the examiner. The Form Selection screens will display an asterisk in front of any forms that were corrected. Every item on the form that was corrected by the examiner will have an asterisk after it.

- D. If errors are found, refer the award to an examiner for correction. Changes cannot be made to the award while it is being authorized.
- E. If the award is approved, press PF24 (DONE).

ONCORR will set a final voucher date and edit the date through which the award was accrued to make sure it is consistent with the voucher date. (See RCM 9.12.28.) The voucher date then becomes part of the status information for that award on the Reject Selection screen.

If an error is detected, refer the award to an examiner for correction. If no errors are detected, this message will be displayed: PROCESSING SUCCESSFULLY COMPLETED - STATUS CHANGED TO "AUTH."

The award will be extracted from the ONCORR database at the appropriate time for processing through DAISY.

- F. Exit ONCORR by pressing PA2 or return to the Reject Selection screen to access other awards by pressing PA1.

9.12.28 How Awards Are Edited

ONCORR performs two edit processes when an award is corrected.

- A. It edits each item on every award form screen the examiner accesses (unless the screen is exited without attempting to update it).

Data is checked to see that it is alpha or numeric as required by the item, that any codes entered are acceptable, that dates entered are valid, that mandatory items are completed, and that items that have some relationship are consistent. Errors are highlighted in red and an error message is displayed at the bottom of the screen. Any changes made to a screen cannot be updated unless the item edits for that screen are passed. If the examiner does not access a screen, only items on that screen that are affected by a relational edit (as explained below) are edited.

- B. When the examiner indicates that all corrections to the award have been completed by pressing PF24, ONCORR edits for the completion of required items, performs interscreen relational edits and edits the accrual period ending date.
 1. Relational edits. Relational edits are edits between two items that bear some relationship. For example, both items are required (if the tier summary total is completed, then the tier summary total code must be completed); or if one item is a certain value, the other item must be a certain value (if the cert code is recert, the last monthly check rate must be greater than zero).

An interscreen edit may involve items on different screens within the same form, or items on different forms within the same award.

When an error message for an interscreen edit appears on the screen after PF24 has been pressed, it may be necessary for the examiner to leave the screen he is on and go to another screen to make the correction. The error message will identify the form that contains the error. If a survivor award involves multiple payees, the payee code will be displayed in front of the relational edit error message. The examiner should continue to make corrections and press PF24 until this message is displayed:

PROCESSING SUCCESSFULLY COMPLETED - STATUS CHANGED TO "PNDA"

2. "Paid through" date edit. The date through which the award was accrued is compared to the voucher date set by ONCORR. ONCORR assumes that the award is to be vouchered on the earliest possible date. It always sets the voucher date as either the next day, the date of one of the two DAISY runs in the post period, or the first of the following month depending on whether or not the award can be processed before the cut-off date.

Whenever the examiner adds or changes the accrual dates on an award, a warning message appears to remind the examiner that the accrual amounts must agree with the accrual period shown. ONCORR does not recompute accruals.

A recurring award should be accrued through the month before the voucher month. If it is not, one of the following error messages is displayed:

- "PAID THROUGH DATE ERROR - REEXTEND OR DELETE." This message appears if the award is accrued through a month that is earlier than the month before the voucher month. Extend the accrual through the correct month or delete the award from ONCORR.
- "PAID THROUGH DATE ERROR - CUT BACK OR DELETE." This message appears if the award is accrued through the same month as the voucher month or a later month. Adjust the accrual to extend it through the correct month or delete the award from ONCORR. It is also possible to let the award pend on the database and have it authorized later, when the system would set a voucher date consistent with the paid through date.

Exception: During the correction process, ONCORR will allow the award to be accrued through the same month as the voucher month or a later

month. This is to allow for the situation in which the examiner has extended the accrual because he knows the award will not be authorized before the current month's cut-off. However, the following warning message will be displayed: WARNING - PAID THRU DATE IN FUTURE - CUT BACK OR DELETE IF NECESSARY

One-payment-only awards are also edited to make sure that the paid through date is not later than the month before the voucher month. It can be earlier.

The paid through date must be completed on all awards except for cert code 6, one-payment-only awards. The paid through date on these awards may be "00/00" (blanks are not acceptable). The paid through date is not keyed from Form RR-1e. The examiner must enter the accrual paid through date on all RR-1e's in the item provided on screen 2 of Form RR-1e, accessed by pressing PF12.

When a paid through date error is detected on Form G-364 and there are multiple G-364's attached to one G-364.1, it is only necessary to change the paid through date on the first G-364. ONCORR assumes that the paid through date on all awards should be the same.

(See RCM 9.12.34 for an explanation of how to determine the "paid through" date based on the checkwriting cut-off calendar.)

9.12.29 Deleting Awards

If it is determined that the award will not be resubmitted for vouchering on ONCORR, the award should be deleted from the database. To delete an award, select the award on the Reject Selection screen (RCM 9.12.22), and press PF4 (DELETE). The award that was selected for deletion will be highlighted in yellow and this message will appear:

HIT PF4 TO CONFIRM DELETION OR PF11 TO CANCEL

Press PF4 again to delete the award. Press PF11 to cancel the request to delete. A confirmation message will appear.

Deleted awards remain on the database through the end of the month after the month in which they are deleted. During that time they may be viewed and can be reopened by a supervisor for correction, if necessary.

Awards originally vouchered through the BREA subsystem (voucher number greater than 999) that are deleted are listed on a report. (See RCM 9.12.57.)

9.12.30 Reopening Awards

No further corrections can be made to an award after it has been authorized unless the award is reopened. Supervisors may reopen awards by accessing the Reject Selection screen, selecting the award to be reopened, and pressing PF9. The award that was selected for reopening will be highlighted in yellow and this message will appear:

HIT PF9 TO CONFIRM REOPEN OR PF11 TO CANCEL

Press PF9 again to reopen the award. Press PF11 to cancel the request to reopen. A confirmation message will appear. The status of the award will revert to "reject" (REJ). The examiner can then access the award and make corrections.

Only awards with a status of "authorized" (AUTH) or "deleted" (DLET) may be reopened. Awards with a status of "batched" (BCHD) cannot be reopened. These awards have already been extracted from the database for processing through DAISY. Although the award remains in the database for viewing, no further corrections are possible. It would not be necessary to reopen awards with a status of "reject" (REJ) or "pending authorization" (PNDA), since corrections may be made to these awards.

9.12.31 Reassigning Awards

When an award is corrected on ONCORR, the examiner number and authorizer number entered on the original award are retained on the ONCORR award. Production credit for the ONCORR award is given to the original examiner and authorizer. Supervisors have the authority to change the examiner and/or authorizer on an award, if they determine that production credit should be given to the correcting examiner(s).

To reassign the examiner/authorizer number(s), the supervisor accesses the Reject Selection Screen, selects the award to be reassigned, and presses PF10. The Reassign Examiner Number screen, showing the current examiner and authorizer numbers, will be displayed. The supervisor enters the new examiner and/or authorizer numbers. The system will not accept a new number that is identical to the old number. If no change is being made to a number, leave the number blank. When ENTER is pressed, the new number(s) become part of the award record.

9.12.32 Introduction

Four tables are maintained on ONCORR. They are the Checkwriting Cut-off Calendar, the Reject/Referral Reason Table, the Unit Table and the Voucher Number Table. These tables are used by the system to identify rejects, to organize the rejects after they have been extracted from DAISY/CHICO, and to set voucher numbers and dates for corrected rejects. The tables are maintained by user analysts in the Division of Adjudicative Services in the Office of Retirement and Survivor Programs. They are the only users who can update a table. Other users may view them.

9.12.33 Table Selection Screen

A table is chosen for viewing or updating by using the Table Selection screen. This screen is entered from the Reject Selection screen by pressing PF-22 (for viewing) or PF-23 (for updating).

The Table Selection screen lists the four tables maintained on ONCORR. A table is accessed by entering its number at the cursor and pressing enter. The mode used to enter the Table Selection screen (inquire or update) carries through to each table selected from the screen.

SEE EXHIBIT 9

9.12.34 Checkwriting Cut-Off Calendar

A checkwriting cut-off calendar is maintained on ONCORR so that the system can set appropriate voucher dates for awards. User analysts in the Division of Adjudicative Services in the Office of Retirement and Survivor Programs are the only users who can update the calendar.

In the event that the cut-off calendar for a particular month is not updated by the first of that month, examiners attempting to process awards on ONCORR will receive the message: "NO CUT-OFF CALENDAR - NOTIFY SUPERVISOR." Examiners should notify their supervisor, who will contact the user analyst responsible for updating the calendar.

- A. Viewing the Calendar - Access the calendar screen from the Table Selection screen by entering "1" and pressing ENTER. Enter the month and year of the calendar to be viewed. If ONCORR does not have a calendar for that month, this message will be displayed: NO CALENDAR RECORD FOUND. Otherwise, the pre and post period beginning and ending dates and the type of post period will be displayed.

The screen also indicates the types of awards that can be processed in that month's post period.

Assuming that the calendar month is the current month, all recurring awards corrected and authorized through the day before the pre-period ending date should be accrued through the month before the calendar month. ONCORR will give these awards a voucher date of the next day.

Any awards that can be handled in that month's post period that are corrected and authorized through the day before the post-period ending date should be accrued through the month before the calendar month. ONCORR will give these awards a voucher date of the beginning date of the post period (if the award is corrected and authorized before that date) or the ending date of the post period (if the award is corrected and authorized after the post-period beginning date but

before the post-period ending date). The beginning and ending dates of the post period are the only two dates in the post period on which there are DAISY runs.

Other recurring awards should be accrued through the calendar month, since ONCORR will set the voucher date as the first of the following month.

- B. Updating the Calendar - Enter the Table Selection screen in update mode (PF23). Access the calendar screen from the Table Selection screen by entering "1" and pressing ENTER. Enter the month and year of the calendar to be updated. If information was previously entered for this calendar month, it will be displayed and may be corrected. ONCORR will not allow a month that is earlier than the current calendar month to be corrected, however.

If no information was previously entered for this month, the screen displayed will have certain information pre-filled and the rest of the information should be entered. The pre and post period beginning and ending month and year will be pre-filled based on what they should be for the calendar month and year entered. Enter the required dates. Place an "X" in front of the appropriate post period.

When ENTER is pressed, the screen is edited. In some cases the error messages will be warnings only, for example: "WARNING-POST PERIOD ENDING DAY SHOULD BE THIRD-TO-LAST BUSINESS DAY." These warning messages provide guidelines for entering dates, but may be overridden if the dates for a particular month do not conform to the usual rules.

SEE EXHIBIT 10

9.12.35 Reject/Referral Reason Table

The Reject/Referral Reason Table contains a code which tells the DAISY/CHICO system which reject/referral numbers are rejects and which are referrals. The reject/referral descriptive messages are also stored on this table. The Reject/Referral Table screen allows a user to request an individual reject/referral number in order to see its reject code and its descriptive message. The entire table cannot be viewed at one time.

If the screen is entered in update mode, the reject code and the descriptive messages can be changed. User analysts in the Division of Adjudicative Services in the Office of Retirement and Survivor Programs are the only users who can update the table. Any change in the status of a reject or referral must be made with the concurrence of the other bureaus affected--the claims operations bureaus and the bureaus of taxation and research and employment accounts.

Enter the Reject/Referral Table screen by entering "2" on the Table Selection screen and pressing ENTER. When the screen is displayed, enter the number of the desired reject/referral and press ENTER. What happens next depends on what mode the user is in.

- A. Inquiry - If the number is not found in the table, the message REQUESTED RECORD NOT FOUND is displayed and the user can enter another number. If the number is in the table, the reject code and the descriptive message are displayed. All fields are protected (green) except the number request field.
- B. Update - If the number is not found in the table, the message REQUESTED RECORD NOT FOUND-WILL BE CREATED is displayed. The number field is protected. The Type Code and Description fields are unprotected and the cursor moves to the Type Code field. Type in a reject code (y=reject, n=referral) and a descriptive message and press ENTER to create a new record. Note: The Description field is limited to 38 characters.

If the number is in the table, the current information is displayed as unprotected (white) so that changes can be made.

New entries are edited. If an error is found, an error message is shown and the incorrect field is highlighted. When all edits are passed, the message REJECT/REFERRAL RECORD SUCCESSFULLY UPDATED is displayed. If no changes are made the message NO DATA CHANGED - NO UPDATE DONE is displayed.

After all edits are passed, the Type Code and Description fields are protected, the number request field is unprotected and the cursor moves to the number request field. If new entries are made on the screen, but the user exits the screen by pressing CLEAR, PA1 OR PA2 without first pressing ENTER, the new data is not updated to the table. No message is given.

NOTE: Any DAISY/CHICO edits that are performed in the CHICO update program (P26311) cannot be converted to rejects using this table. Changes to P26311 would be required. This table affects only edits done in P26530 or edit modules called by P26530. Likewise, DAISY edits with numbers below 100 cannot be converted to referrals using this table.

A sample of the Reject/Referral Reasons Table screen is shown below.

SEE EXHIBIT 11

9.12.36 Unit Table

The Unit Table screen allows the user to view the voucher numbers associated with a specific operating unit. The screen also allows users to update the voucher number information maintained on the Voucher Number Table. User analysts in the Division of Adjudicative Services in the Office of Retirement and Survivor Programs are the only users who can use the Unit Table for updating.

- A. Entering the Table for View Only. While in inquiry mode, access the Unit Table screen from the Table Selection screen by entering "3" and pressing ENTER. A

blank Unit Table screen is displayed. Type the desired unit's initials in the unit field and press ENTER. If the unit has no records that were effective during the current fiscal year, the message NO RECORDS FOUND FOR UNIT ENTERED is displayed. If records do exist for the unit, the current record, as well as any other records that were effective during the current fiscal year are displayed with all fields protected (green). The unit field will remain unprotected (white) so that another unit request can be entered.

- B. Entering the Table for Updating. While in update mode, access the Unit Table screen from the Table Selection screen by entering "3" and pressing ENTER. A blank Unit Table screen is displayed. Type the desired unit's initials in the unit field and press ENTER. If the unit has no records on the Voucher Number Table, the message NO ACTIVE RECORDS FOUND FOR UNIT ENTERED-WILL BE CREATED is displayed. If records do exist, all the active records for the unit are displayed. (An active record is one whose ending date is in the future or unspecified). Fields which can be changed are displayed in white. Protected fields are displayed in green.

A sample of the Unit Table screen is shown below.

SEE EXHIBIT 12

Using the Unit Table to update is the only way that the entries on the Voucher Number Table can be modified. When a change is made to a unit's records, the change is edited against all the other records within the unit to make sure that there are no overlapping voucher numbers or dates. The new entry is then edited against all the other unit records in the Voucher Number Table to make sure that no voucher numbers overlap during the same dates. There are several restrictions imposed on updating to ensure that the edits are carried out properly:

- Only one record in a unit can be modified, added or deleted at a time.
- Dates earlier than the current date cannot be changed.
- Dates earlier than the current date cannot be entered.
- If an actual ending date is not entered, the ending date must be 99/99/99.
- Neither the voucher numbers nor the sort code can be changed in a record with at least one date that is earlier than the current date.
- Only the ending date can be changed in a record that has a beginning date before the current date.
- A new record can be added only if the beginning date is the current date or later and the beginning date is later than the ending date of all the other records in the unit.

- To delete a record the beginning date and the ending date must be the current date or in the future.

When the unit's active records are displayed type an "M" under the "Act" to modify a record and enter the changes to the record. Type a "D" to delete a record. A new record can be added by completing the entire last line (line 10) on the screen. Only one action can be taken at a time. If more than one action is attempted, the message MULTIPLE ACTION INVALID is displayed.

When adding a new record, enter the acronym of the organization to which the unit belongs (e.g., BDMO). Enter "V" (voucher number sort) or "T" (terminal digit sort) under "SEQ" to indicate the sort sequence of the awards for that unit on the Current Day's Reject Report. Units with a sequence code of "V" have their awards sorted by voucher number, then claim number; units with a sequence code of "T" have their awards sorted in terminal digit order.

After the activity code and the new entries have been typed, press ENTER. If the new entry fails an edit, an error message is displayed. If the cause of the error is on the screen, the incorrect item is highlighted in red. If the error is caused by a conflict with entries in another unit's record, the message will identify the unit. To help locate the error, the active records for all the other units are available on the Voucher Number Table. Press PF-9 to view those records. To return to the Unit Table from the Voucher Number Table, press CLEAR.

When the new entry passes all the edits, the message UNIT TABLE ENTRY SUCCESSFULLY UPDATED is displayed. The changed record is highlighted in turquoise and the other records are in protected green. The cursor returns to the unit field. While making a change, pressing PF-5 will return (refresh) the screen to the entries that were originally displayed. None of the changes made to the record are kept. After the Unit Table is successfully updated, the Voucher Number Table is also changed.

Helpful hint: When records for more than one unit are changed at one time, enter an ending date in each of the units to be changed before making any modification to the unit entries or adding new records to the units. This will prevent the new entries from editing against invalid old entries.

BREA-DSS should be informed of any changes made to the unit table, since they will be assigning four-digit voucher numbers to awards processed through their correction subsystem based on the voucher numbers designated for each unit.

9.12.37 Voucher Number Table

A voucher number table is maintained in ONCORR so that the system can determine to which unit a rejected award belongs and assign the appropriate ONCORR voucher number when corrected awards are extracted from the data base for vouchering.

The table contains the railroad and social security voucher number ranges for each operating unit and the dates those voucher numbers are active. It also contains the railroad and social security ONCORR voucher numbers assigned to each operating unit as well as a special "cycle 2" voucher number used for awards which rejected from the BREA correction system. Finally, it contains a code which designates how a unit's rejects will be sorted for display on the HSL Current Day's Reject Report, either by voucher number (V) or in terminal digit order (T). User analysts in the Division of Adjudicative Services in the Office of Retirement and Survivor Programs are the only users who can update the Table. All other users may view it.

All units with active voucher numbers are shown on the Voucher Number Table. (Active voucher numbers are those whose ending dates are either in the future or unspecified.) These active records are viewed by using the Voucher Number Table screen. This is a view only screen. Changes to the table must be made by using the Unit Table screen. (See 9.12.36.)

A sample of the Voucher Number Table screen is shown below.

SEE EXHIBIT 13

Access the Voucher Number Table screen through the Table Selection screen or the Unit Table screen (while in update mode).

- A. Viewing the Voucher Number Table by Using the Table Selection Screen.
Access the Table Selection screen from the Reject Selection screen by pressing PF-22 (if inquiring) or by pressing PF-23 (if updating). Enter "4" on the Table Selection screen and press enter. All units with active voucher numbers are displayed.
- B. Viewing the Voucher Number Table by Using the Unit Table. It is possible to access the Voucher Number Table from the Unit Table while in update mode by pressing PF-9. All units with active voucher numbers are displayed. Press clear to return to the Unit Table Screen.

9.12.40 How Long Rejects Remain On ONCORR

Rejects remain on the database and are available for viewing until the month after the month they were batched for processing through DAISY or were deleted from the database. Once an award has been batched for processing through DAISY, no further corrections can be made to the award. Deleted awards that are still on the database can be corrected if they are reopened.

9.12.41 Corrected Awards

Corrected rejects are extracted from the ONCORR database and processed through DAISY with other manual award activity (see RCM 9.12.14). It is possible that the ONCORR award may reject from DAISY/CHICO if an error condition exists in the

ONCORR award. In general, DAISY/CHICO does not perform other edits with reject numbers less than 100 once it finds one in that range. So it is possible that the award may reject again if it has other error conditions that were not detected by DAISY/CHICO or by the ONCORR edits. It is also possible that a new Rate History reject reason may be produced. If the ONCORR award rejects, it will be recycled through ONCORR for correction. ONCORR awards appear on the DAISY/CHICO award and reject listings.

9.12.42 Folder Documentation

- A. Description - The folder record Form G-380 documents all of the changes that were made to the award. All changed or deleted data is listed by form and item number on the right-hand side of the record. Basic rate information from the award (tier rates, net annuity rate, net amount paid) is shown on the left-hand side. A sample of the folder documentation is in Exhibit 3.

For awards that were originally vouchered through the BREA subsystem, a second set of folder documents is produced for BREA.

- B. Handling - Folder documentation is produced for every award that is extracted from ONCORR for processing through DAISY. The central control group will deliver the documents to each vouchering unit. All folder documents, including those for awards that reject, should be filed on the left-hand side of the folder.

If an ONCORR award rejected and if it is followed by another ONCORR award that paid, it will be necessary to look at the changed items from both folder documents (the one produced by the reject and the one produced by the award that paid) to determine which items on the original award were changed.

9.12.50 Current Day's Reject Report

The current day's reject report lists payment rejects that were loaded onto the ONCORR database from the latest DAISY/CHICO run. A new report is available on HSL after each DAISY run and can be used to assign rejects to examiners for correction. HSL stores the last ten reports in order from newest to oldest. The title of the report shows the date the report was updated.

The rejects listed on the report are grouped by examining unit. Within each unit, the awards are sorted either by voucher number and then in claim number sequence (CBS, ICS, RPS, RBT, RSC) or in terminal digit order (all other units). CBS, ICS, RBT, RPS and RSC are displayed first on the report followed by all other units in alphabetical order.

A sample of the report is shown below.

SEE EXHIBIT 14

The following information is displayed for each award.

- UNIT - The examining unit that vouchered the reject. ONCORR determines the unit based on the voucher number of the award. If it is not able to determine the unit for a particular voucher number it will assign the award to RPS or SPS. When that happens, an asterisk will appear after the unit name on the report. If the award does not belong to RPS or SPS, they should notify the unit to which the folder is charged so that the reject will be handled.
- CLAIM NUMBER
- PC - payee code.
- VOUCH and DATE - voucher number and voucher date of the award.
- EXAM - examiner number.
- AUTH - authorizer number.
- TYPE - type of certification (initial, recert, etc.)
- STATUS - status of the award on ONCORR. This will always be "REJECT."
- The reject and/or referral reasons are displayed in the second and following lines.
- The total number of rejects for each unit is displayed after its rejects.

9.12.51 Claims Pending Report

The claims pending report lists all awards pending on the ONCORR database for one or more days that have not been corrected and authorized. It can be used to monitor rejects to make sure that they are being handled quickly and to see that rejects that will not be corrected on ONCORR are deleted from the database.

A new report is available on HSL after each DAISY run. HSL stores the last ten reports in order from newest to oldest. The title of the report shows the date the report was updated.

The report shows the number of days each award has been pending on the ONCORR database. The report groups awards by organization and then by unit. Within each unit, the awards pending the longest are listed first. Organizations (compliance, disability/medicare, retirement, and survivor) and units are listed in alphabetical order. The status of awards on this list is always "reject" or "pending authorization."

A summary page gives the total number of awards pending correction or authorization for each unit for one, two, three, four, five, six, and seven days, and more than seven days; totals for each organization; and grand totals.

A sample of the report is shown below.

SEE EXHIBIT 15

SEE EXHIBIT 16

9.12.52 Examiner/Authorizer Error Reports

Reports of all award rejects loaded onto ONCORR during the month are produced at the end of each month. Two reports are produced. One is sorted by examiner number; the other by authorizer number. Awards that were deleted from ONCORR are identified.

Sample reports are shown in Exhibit 2.

9.12.53 Reject/Referral Reason Reports

Four reports are produced that give counts of the number of manual awards that rejected for a particular reject reason. One report is produced daily and is available on HSL. The other reports are produced monthly. These reports can be used to detect program errors and to identify training needs.

The reports are described below:

- Daily report of reject and referral reasons in order of frequency.
- Monthly report of reject and referral reasons in order of frequency.
- Monthly report for each unit of its reject and referral reasons in order of frequency.
- Monthly report of reject and referral reasons in numeric order.

Each report shows the number of each reject and referral reason, identifies it as a reject or referral, and gives a breakdown of the number of retirement, survivor, and social security awards for each reason. If no awards rejected for a particular reason, that reason will not be in the report. The reason associated with each reject/referral number is included in the monthly reports. They also can be found in the Appendices for this chapter.

A sample of the daily report is shown below. Samples of the monthly reports are in Exhibit 2.

SEE EXHIBIT 17

9.12.54 Counts

ONCORR counts the number of awards that reject, the number that are batched from ONCORR for processing through DAISY, the number that were deleted from ONCORR, and the number that reject again within a given month. Each month a report summarizing these totals is produced. The report gives the number of awards in each

category for each adjudication unit, totals for each organization, and grand totals. The report also gives totals for the fiscal year to date.

Beginning and ending effective dates are specified for each unit. If the voucher numbers assigned to a unit change during the fiscal year, or a unit is added during the fiscal year, a new line of totals with a new effective date will be added.

A sample of this report is in Exhibit 2.

9.12.55 Time Lapse Reports

Two monthly reports track how long it takes to process rejects on ONCORR. The first report tracks the number of days that elapse between the time the award rejects and the time it is authorized. The second report tracks the number of days that elapse between the time the award rejects and the time it is batched for processing through DAISY. The first report can be used to assess how quickly awards are handled by examiners; the second, to assess overall turnaround time for rejects. Examiner handling of an award is completed once the award is authorized. However, some awards must wait until the first of the following month to be extracted from the database for processing through DAISY.

On each report, the time elapsed is counted in one-day increments for the first 10 days, then in increments of 11-20 days, 21-30 days and more than 30 days. The number of awards handled by each unit in each time frame is shown, as well as each unit's monthly and fiscal-year-to-date totals and average processing time for the month and year; subtotals for each organization; and grand totals.

Beginning and ending effective dates are specified for each unit. If voucher numbers assigned to a unit change during the fiscal year, or a unit is added during the fiscal year, a new line of totals with a new effective date will be added.

A sample of this report is in Exhibit 2.

9.12.56 Research Reject Report

The Research Reject Report lists the award rejects that were loaded onto the ONCORR database from the latest run of the BREA correction subsystem.

A new report is available on HSL each time the BREA correction subsystem runs, which is usually weekly. The report can be used to assign rejects to examiners for correction. HSL stores the last ten reports in order from newest to oldest. The title of the report shows the date the report was updated.

The rejects listed on the report are grouped by unit, and then by claim number within each unit.

The following information is displayed for each award.

- UNIT - The unit that vouchered the reject. ONCORR determines the unit based on the voucher number of the award. If it is not able to determine the unit for a particular voucher number, it will assign the award to Research. When that happens, an asterisk will appear after the unit name on the report.
- CLAIM NUMBER
- PC - Payee code.
- VOUCH AND DATE - voucher number and date of the award.
- EXAM - examiner number.
- AUTH - authorizer number.
- TYPE - type of certification (initial, recert, etc.)
- The reject and referral reasons are displayed in the second and following lines.
- The total number of rejects for each unit is displayed after its rejects.
- A grand total of all rejects is displayed at the end of the report.

A sample of the Research Reject report is shown below.

SEE EXHIBIT 18

9.12.57 Research Deletion Report

The Research Deletion Report lists cases that rejected from the BREA correction subsystem, were loaded onto ONCORR for correction, and were deleted from ONCORR. This report is produced for BREA each time they extract awards from the ONCORR database for reprocessing through their subsystem, which is usually weekly. Since awards remain on the database through the end of the month after the month they are earmarked for deletion, awards earmarked for deletion will continue to appear on the reports until they are dropped from the database.

The report gives the following information for each deleted award: unit, claim number, payee code, voucher number, voucher date, examiner number, authorizer number, and type of award. The awards are listed by unit, and then by claim number within unit.

A sample of the report is in Exhibit 2.

Appendices

Appendix A - DAISY/CHICO Edit Messages

ON-LINE CORRECTION SYSTEM (ONCORR)

DAISY/CHICO EDIT MESSAGES

Messages numbered from 0001-0189 are DAISY/CHICO edit messages. All of the edits numbered less than 100 and some of the edits numbered from 101-189 cause payment rejects. Edits identified with "(REF)" below the edit number may require corrective action but do not, of themselves, prevent payment.

- 0001 MASTER IN PAY STATUS - A record is already in pay status and another award action (other than a recertification or one payment only) is being attempted. The DAISY listing for this type of reject will show two records. The first record shows the award activity data and the reject message. The second record gives a printout of the current information on the master file. This reject may be caused by one of the following:
- A. An incorrect prefix and/or claim number or payee code used. If any of these items are incorrect, the name and address on the rejected award will be different from the name and address on the rejected award printout section of the DAISY listing.
 - B. Termination or suspension action not processed or never attempted. A reinstatement or reinstatement-recertification award will reject when the G-96 or FAST-S/T transaction to suspend or terminate the annuity failed to process.
 - C. The award was coded other than recertification when it should have been coded "recert".
 - D. Duplicate awards were processed. This usually happens when a manual award is attempted after a mechanical award (i.e., RASI, PAM) is processed and vice versa.
 - E. A suspended award should have been terminated. This can happen when a survivor award is processed and the employee record has only been suspended.
 - F. A social security initial (current pay) award will reject for this reason if there is an SS rate in the master. This usually happens when an SS award is processed for a spouse and the master shows a terminated SS benefit for the previous spouse. Delete the previous spouse record with a

G-96, or FAST-S/T transaction coded 62 and resubmit the initial SS award.

- 0002 NO MASTER RECORD - An award action other than a final or partial is being attempted, and no previous award action is in the master file. This type of reject can be caused by an incorrect claim number and/or prefix or a wrong payee code. This reject can also be the result of a previous record established under an incorrect claim number.
- 0003 RATES NOT EQUAL - The last monthly railroad or social security rate on the rejected award does not agree with the last monthly railroad or social security rate in the master file. (This type of reject should only appear on "Recert" awards.) Two records will appear on the DAISY/CHICO listing for this type of reject. The first record will give the reject reason "RATES NOT EQUAL", and the second record will provide a master file printout which includes the last monthly check rate.
- 0007 MASTER NOT IN PAY STATUS - A recertification (recert) award action is being taken, but the master record has been suspended or terminated. The DAISY listing for this type of reject will show two records. The first record shows the award activity data and the reject message. The second record gives a printout of the current information on the master file. There are several reasons that might cause this type of reject.
- A. An incorrect prefix and/or claim number or payee code used. If any of these items are incorrect, the name and address on the rejected award will be different from the name and address shown on the master file printout section of the DAISY listing.
 - B. A returned payment, G-96, or FAST-S/T transaction suspended or terminated payments.
 - C. An award was coded recertification when it should have been coded one payment only, reinstatement or reinstatement-recertification.
 - D. A STAZA award was attempted but the RR annuity was not in current pay status.
- 0009 REINST-RATE NOT EQUAL - The monthly rate on a reinstatement (reinst) award action is not the same as the rate on the suspended or terminated master file. Two records are shown on the DAISY listing for this type of reject. The first record gives the reject reason. The second record includes the rate that was in effect at the time of suspension. On a reinstatement award the monthly annuity payable should be the same as the rate on the master file. This type of reject could also occur if the claim number or prefix is incorrect.

0011 BASIC/SUP CODE INVALID OR INCONSISTENT - There are several possible causes for this type of reject.

- A. The incorrect box, or no box, was checked in TYPE OF PAYMENT (Reg Ann, Sup Only, Reg and Sup) on Form G-357.
- B. In survivor cases, the A or D prefix is not preceded by symbols such as W or WC or, in retirement cases, a Sup payment is attempted (Reg and Sup box checked) and there is an entry prior to the A prefix (M, L, X, etc.)
- C. On a one payment only award, the SUP ACCRUAL is zero and the SUP/REG ANN recovery box is not coded for transfer of money to Reg Ann.
- D. On a recurring award, the MO SUP ANN CHECK RATE is zero and the RRA MAX REDUCTION, REDUCTION IN SUP ANN and SUP LEGAL PROCESS DEDUCTION are all zero.
- E. On a recurring award, the MO SUP ANN CHECK RATE plus the REDUCTION IN SUP ANN exceeds \$70.11.
- F. If the TYPE OF PAYMENT is Sup Only, the TYPE OF CERTIFICATION (activity code) must be either one payment only or recertification.

0012 RECERT IN POST UPDATE PERIOD - The award is a recertification and was processed after recert cut-off. Either the type of certification (activity code) was entered incorrectly or the award was not processed by the recert cut-off. If the award is resubmitted on ONCORR, re-extend the accrual if necessary; ONCORR will set the voucher date and edit to make sure that the paid through date is consistent with the voucher date it has set.

Note: Since initial SUP awards are considered recertifications, they must be processed before recert cut-off.

0013 INVALID ACTIVITY CODE - The type of certification (activity code) was keyed incorrectly.

0014 BEN/SYM NOT CONSISTENT WITH PREFIX - The beneficiary symbol used is inconsistent with the prefix. This type of reject will usually occur in survivor cases. Symbols for survivor cases are W, WC, P and J. The symbols immediately precede the prefixes A, D or H in the claim number section of the award form. Survivor prefixes and common corresponding symbols are:

- Widow over age 60 - WA or WD
- Joint and Survivor - JA

- Young Widow with Children - WCA or WCD
- Child(ren) Only - WCA or WCD
- Disabled Widow - WA or WD
- Widow or Child of pensioner - WH or WCH
- Parent - PA or PD

0015 LUMP SUM CODE FOR RECURRING ACTIVITY - The type of certification is "OPO" and recurring payment information (monthly rate, last monthly rate) was completed.

0016 INVALID BENEFICIARY SYMBOL - (See 0017.)

0017 INVALID PREFIX - The beneficiary symbol and/or prefix was omitted or DAISY/CHICO did not recognize the symbol or prefix given.

Valid beneficiary symbol prefix combinations for survivor awards are shown in reject message 0014. Retirement awards can have a prefix of A or H and a beneficiary symbol of blank, M or X.

0018 NO CLAIM NO., INVALID SS ACCOUNT NO. - (See 0019.)

0019 NO SS ACCOUNT NUMBER; INVALID CLAIM NUMBER - A six-digit claim number was omitted from the award or an invalid employee social security number was entered. An invalid social security number will result when the number was keyed or actually written as:

- All 9's or
- With the first digit(s) being 6 or
- With the first digits greater than 730.

It is also possible that one or more of the numeric characters were keyed as alphabetic, for example, letter O for zero, letter I for one, or letter B for eight.

0020 INVALID SUPP ANN EFF DATE - The supplemental annuity effective date on Form G-354 Sup is after the accrual period or the type of payment is "REG and SUPP" and no G-354 Sup was attached to the award and one was required. (A G-354 Sup must be attached to the award if the type of payment is "regular and supp" unless the supp is being reinstated or is being recertified only to apply LPS work deductions or a legal process deduction. If the award is a reinst-recert., Form G-354 Sup must be attached.

- 0021 INVALID SUPP RED NON-ZERO B/S CODE - The type of payment was coded "REG ANN" and either a Form G-354 Sup was attached to the award showing a reduction in supp ann or an employer tax credit, or an employer tax credit was entered on Form G-357. The type of payment should be "REG and SUP."
- 0023 RUIA, SUP, RET AMT/CODE INCONSISTENT - An amount was entered in one of the transfer of funds items but no box was checked. Either a code and amount must both be entered or both should be blank.
- 0024 RECERT WITHOUT OLD MONTHLY RATE - On a recert award, the last previous monthly rate was not entered in the last monthly payment rate box.
- 0025 INVALID SMIB RECURRING RATE - A monthly SMI premium amount was entered on Form RR-1e. Since the SMI premium is deducted mechanically, that item should be left blank.
- 0026 REGULAR MONTHLY RATE MISSING - The monthly rate was omitted or the wrong type of activity was checked (e.g., "recert" instead of "OPO").
- 0027 SUPP ANN RATE EXCEEDS \$70 - Either the monthly supplemental annuity rate, the reduction in the supplemental annuity for an employer pension or the employer tax credit amount was greater than \$70.
- 0030 MAN AMT ZZZZZ.ZZ - COMP AMT ZZZZZ.ZZ - Balance control is a check and balance for individual awards to assure that the money amounts being released have been correctly keyed into the computer payment system. To accomplish this, designated amounts from the award form are totalled and entered into the balance control box on the individual award form. The computer payment system also determines a balance control amount using the same designated items. If the amounts differ, the award rejects. The manual and computer system payment amounts are both shown in the reject message. The discrepancy between the two amounts must be reconciled before the award can be paid.

If the award is being corrected on ONCORR, the Reject Reason screen will display the balance control items that were keyed from the award. These items must be checked against the award to verify that they were keyed correctly.

- Keypunch error in the balance control item(s): If the balance control items were not keyed correctly, the items should be corrected. ONCORR will automatically recompute the balance control when the examiner indicates that the award has been completed.
- Balance control items correctly keyed; balance control amount on the award is incorrect: It is not necessary to correct the balance control amount. ONCORR will automatically recompute the balance control when the examiner indicates that the award has been completed.

0031 INVALID NO ADDRESS AWARD - A diagonal line has been used in the address section of the award indicating that the address has not changed and the system should take the name and address from the checkwriting master. However, there was no address on the checkwriting master.

NOTE: If the TYPE OF CERTIFICATION (ACTIVITY CODE) is marked partial or final or, on a one payment only, when the master record for the payee code is terminated, the full name and address must be completed.

This reject occurs in the following situations:

- A. There is no master name and address for the payee code on the award and no name and address is shown on the award.
- B. There is a death termination on the master for the payee code shown on the award and a one-payment-only award is processed without a name and address.
- C. A one-payment-only award is processed without a payee code or name and address.
- D. An SS award is processed without the name and address and the RR RATE is omitted.

0032 ONE PAYMENT WITHOUT ACCRUAL - DAISY/CHICO can only process a one-payment-only award if there is an accrual or a recovery amount for RUIA, SSA, RR or Sup. Cases involving a "TRANSFER OF FUNDS ONLY" can be vouchered as a one-payment-only without an accrual.

0041 DUE PROCESS O/P INVOLVED - A mechanical award cannot be paid because of an earmarking in CHICO.

0042 SS CERT - RECOVERY/ENTITLE CODE CONFLICT - The entire social security accrual is being paid yet a railroad annuity is being paid without a reduction for social security benefits. The SS benefit award will reject if the correct code is not shown in the RRB Code box on the RR-1e.

0043 SS CERT - RR-SUSP - NO FORCE CODE - The railroad annuity is in suspense and a social security award is being attempted.

0044 SS CERT - RR TERM - The railroad annuity has been terminated and a social security award is being attempted.

0045 SSEB PIA AMOUNT MISSING - The SSEB PIA amount was not entered on Form G-354 and the employee is age 61 11/12 or older or the SSEB PIA amount was not entered on Form G-355 and both the employee and spouse are age 61 11/12 or older.

- 0046 SSEB PIA CODE MISSING OR INVALID - The SSEB PIA code was not entered or an invalid code was entered on Form G-354 and the employee is age 61 11/12 or older, or the code was not entered or an invalid code was entered on Form G-355 and both the employee and spouse are age 61 11/12 or older.
- 0047 RR CERT - ENTITLEMENT CODE CONFLICT - The railroad annuity is being processed without a reduction for social security benefits but a social security benefit is in pay status.
- 0048 RR CERT - SS TERM/DEATH - The social security benefit was terminated because of death and a railroad award is being attempted.
- 0057 INVALID EFFECTIVE DATE - There is a problem with the voucher accounting date. This field may have been keyed incorrectly or an improper date may have been stamped on a voucher of awards.

Example: The accounting date of the award is either 04-03-90 or 03-04-91 and DAISY is geared to process April 1991 vouchered awards. Awards with the 1990 accounting year would reject because DAISY is looking for awards with a 1991 accounting year. Awards with an 03 accounting month would reject because DAISY is looking for awards with an 04 accounting month.

- If the reject is the result of a keypunch error and the correction is being processed on ONCORR, check to be sure the award has been accrued through the correct month and resubmit the award. ONCORR will set a voucher date and edit the award to ensure that it has been extended through the correct month.
 - If the accounting date shows as a prior date, DAISY may have been trying to reprocess work. Notify the Program, Procedures, and Project Analysis section in the Division of Adjudicative Services. Take no action on revouchering the awards.
 - If the accounting date shows as a future date, the work may have been released from the adjudication unit too early. If this is the case, notify the Program, Procedures, and Project Analysis section in the Division of Adjudicative Services. Hold the work for the proper accounting period.
- 0062 NO BA NUMBER, CB OR PENSION INDICATED - The BA number is blank, but the CB code has been checked or a tax credit amount has been entered. Either the BA number should be entered or both items should be blank.
- 0063 TAX CREDIT/SUPP ANNUITY INCONSISTENT - Both a monthly supplemental annuity rate and a tax credit amount have been entered, and the total of the two amounts exceeds \$70.11.

- 0064 NEGATIVE TAX WITHHOLDING - The tax accounting system computed a negative tax withholding amount. Refer the folder to the bureau of taxation, Chief of Taxation Analysis-Section A.
- 0081 WARNING - POSSIBLE DUP ACCRUALS - Two recurring awards to the same payee were attempted in the same voucher month.
- 0082 WARNING - POSSIBLE DUP PAYMENT FOR PREV MONTH - A suspension/termination and a reinstatement or reinstatement-recertification award containing an accrual were processed in the same vouchering month.
- 0083 O/P NOT FULLY RECOVERED - ACCRUAL PAID - The total railroad overpayment amount shown on the RR-1e was larger than the amount withheld from the award, and a social security accrual is being paid.
- 0084 NEGATIVE RATE OR ACCRUAL - Tax withholding was attempted from the award and the withholding amount exceeded the net annuity rate or net accrual amount payable. Refer the folder to the bureau of taxation, Chief of Taxation Analysis-Section A.
- 0085 G-369 MISSING - Form G-357 or Form G-364 indicated that Form G-369 was attached but the form was not attached or was not keyed.

If the edit occurs because the form was not attached or was not keyed and should have been, the form may be added using ONCORR. If the edit occurs because the form ID(15) was not keyed or the accompanying form indicator was checked in error, no corrective action would be required, other than to reprocess the award, since those errors would have been corrected when the case was loaded onto ONCORR.

- 0086 SUPP ACCRUAL INCONSISTENT - G-357 item 83 must equal the sum of:
- the supplemental accrual amount (G-354 SUP item 27c),
- + the SUPP ACCRUAL DUE AFTER O/P - RECOVERED (Item 51B),
- + the NET O/P SUPP (Item 85B),
- Minus the sum of:
- the amount transferred to REG ANN (Item 66),
- + the amount transferred to SUP (item 66) if there is a SUP O/P on G-354SUP item 27C.

0087 TIER SUMMARY TOTAL UNIDENTIFIED - The tier summary total is not equal to zero, and the box indicating whether the amount is an accrual or an overpayment was not checked.

0088 TIER SUMMARY TOTAL INCONSISTENT - The sum of the tier 1, tier 2, and vested dual benefit accrual amounts less the overpayment amounts on Form G-369 does not equal the tier summary total on Form G-357 or G-364.

0089 NET AMOUNT PAID INCONSISTENT - The sum of all of the accrual amounts less the sum of all of the deduction amounts does not equal the NET AMOUNT PAID on Form G-357 or Form G-364 Shown as R for 357's and S for 364's below. DAISY will make the following calculations. The sum of:

the ACCRUAL DUE AFTER OVERPAYMENT - RECOVERED (R 51A; S 64),

+ the TIER SUMMARY TOTAL (if coded 1 - accrual) (R 50; S 63),

+ the SS AMOUNT (R 52; S 65),

+ the OTHER BENEF'Y AMOUNT (R 53; S 66),

+ the NON-TAXABLE AMOUNT (R 54; S 67),

+ the RR TAX REFUND (R 55),

+ the LUMP SUM (SALSA) PAYMENT (R 56),

+ the ACT ADJ REFUND (R 57; S 68),

+ the TRANSFER ACCRUED FUNDS FROM RUIA (R 58),

+ the NET O/P REG (R 85A; S 94)

Minus the sum of:

the TIER SUMMARY TOTAL (if coded 2 - OP) (R 50; S 63),

+ the TAXABLE RECOVERY - OTHER CLAIM NO. (R 61; S 73),

+ the TAXABLE RECOVERY - THIS CLAIM NO. (R 62; S 74),

+ the NON-TAXABLE RECOVERY - ANY CLAIM NO. (R 63; S 75),

+ the RLS REPD (S 76),

+ the TRANSFER TO RUIA (R 64; S 77A 4),

+ the TRANSFER TO SSA (R 65; S 78),

+ the TRANSFER TO SUPP OR REG ANN G-357, item 66 (code 3) not included; S 77A

+ any PARTIAL WITHHOLDING (R 67; S 82), ACT ADJ (R 68; S 83), WAIVER (R 69; S 84), LEGAL PROCESS-PARTITION (R 70; S 85), ASSIGN/LEGAL PROCESS-NON-PARTITION (R 71; S 86), SMI PREMIUM (R 72; S 87), SMI PREVIOUSLY TRANSFERRED (R 73; S 88) deductions from the accrual.

- 0090 CLAIM NUMBER MISSING - The railroad claim number and/or social security number is missing from Form RR-1e.
- 0091 SS NUMBER MISSING OR INVALID - The social security claim number is missing from Form RR-1e, or it is an invalid number (i.e., the first digit is a 6 or the first three digits are greater than 730).
- 0092 SS BENEFICIARY'S NAME MISSING - The beneficiary's name (item 10 of Form RR-1e) was omitted or was not keyed.
- 0094 BIC DATA MISSING OR INVALID - The beneficiary identity code is missing or an incorrect code is being used.
- 0095 ENTITLEMENT DATA MISSING OR INVALID - Item 13 of Form RR-1e (DOEC - Date of Entitlement-Current) was omitted or was not keyed.
- 0096 BENEFIT CODE MISSING OR INVALID - Item 14 of Form RR-1e was omitted or was not keyed.
- 0097 INVALID RR RATE - The last monthly railroad rate on Form RR-1e is incorrect. This amount should be the railroad rate after SMIB deductions and before tax withholding.
- 0098 STAZA AWARD WITH INVALID DATA - There is an inconsistency in the award that will not allow it to process as a STAZA. The reason could be one of the following:
- A. One or more fields on the award form was improperly keypunched.
 - B. An amount is shown in the Net Amount Paid box.
 - C. The last monthly RR check rate is not shown.
 - D. The social security monthly check rate is equal to or greater than the last monthly railroad retirement check rate and the type of activity is initial.
 - E. The last monthly social security check rate is equal to or greater than the social security monthly check rate and the type of activity is recertification.

F. The dollar difference between the last monthly social security check rate and the social security monthly check rate on recertification is equal to or greater than the last monthly railroad retirement check rate.

- 0099 FORCED REJECT - SEE OTHER PAYEE - When one survivor award rejects, other awards being paid on the same claim number that are on the same voucher and have the same activity code are rejected with this message.
- 0101 INVALID SUPP ANN CLOSING DATE - The supplemental annuity denial (REF) indicator on Form G-357a was keyed incorrectly.
- 0102 BA NO. MISSING OR CB CODE NEEDED - A supplemental annuity is being reinstated using Form G-357 and the BA number and Employer Pension items are blank.
- 0103 CB CODE INVALID - The CB Code on Form G-354 Sup or Form G-357 may have been keyed incorrectly.
- 0104 REP P/C NOT CONSISTENT WITH NM-ADDR - There is a group mark at the beginning of line 2 and a representative payee code. The group mark would normally be at the beginning of lines 3 or 4 when representative payee information is present.
- 0105 GRP MK INSERTED AT BEGIN OF LINE 2 - A group mark was not found at the beginning of line 2, 3, or 4. The mark was arbitrarily placed at the beginning of line 2 after shifting the contents of this line one position to the right. This move may have caused the rightmost position on line 2 to be lost. It may also have confused the representative payee information.
- 0106 SINGLE LINE ADDRESS INDICATED - Check the address to make sure it was formatted correctly.
- 0107 ZIP CODE NOT PRESENT, MAY BE FOREIGN - There is no matching city and state on the RRB ZIP Code Master. If the case is domestic, enter the zip code. If the case is foreign, and the check is being sent to one of the countries listed below, no action is necessary. Check to be sure the country is spelled or abbreviated as shown below. If the country is not listed below, refer the folder to the Division of Adjudicative Services to obtain the correct geographical code and prepare a code 8 G-607 with the code name GCNNN to enter the geographic code on the CHICO master. (See RCM 9.4, G-607 instruction.)

Afghanistan	Cyprus	Leeward Is	Singapore
Algeria	Czechoslovakia	LTSR	Spain
Angola	Denmark	Malta	Sri Lanka

Anguilla	Ecuador	Mexico (or Mex or Mx)	Sudan
Argentina	Erie	Nepal	Sweden
Australia	England (or Engl)	Neth Antilles	Switzerland
Austria	Ethiopia	Netherlands	Syria
Azores	Finland	Nicaragua	Taiwan
Bahamas	France	Niger	Tobago
Barbados	Great Britain	Nigeria	Trinidad
Belgium	Greece	N. Ireland	Tunisia
Bermuda	Haiti	Nova Scotia	Turkey
Bolivia	Hong Kong	Panama	United Kingdom (or UK)
Brazil	Hungary	Paraguay	Uruguay
Bulgaria	India	Peru	USSR
Burma	Iran	Philippines (or Philippines or PI)	Venezuela
Canada (or Can)	Israel	Poland	Wales
Cayman Is	Italy	Portugal	West Germany
Ceylon	Indonesia	Ontario (or Ont)	West Indies
Chad	Jamaica	Romania	Windward Isl
Chile	Japan	Scotland	Yugoslavia
Colombia	Lebanon	Senegal	Zambia

0108 CASE REINSTATED AFTER TERMINATION - Review the award to ensure
(REF) that the payment should be made.

0109 WERE UNDELIVERABLE CHKS INCLUDED IN AWD - The case was a code
(REF) 98 (undeliverable)suspension and DAISY/CHICO is now processing a manual reinstatement or reinstatement/recertification award.

- 0113 (REF) ADDRESS NOT EQUAL NO COMBINED MAIL - The employee and spouse addresses are different. Make sure this is not due to an error in the address on the award.
- 0115 (REF) TYPE OF BENEFIT CODE MISSING - DAISY cannot determine the type of beneficiary from the type of annuity. Verify that the type of annuity item on Form G-357a or the beneficiary symbol on Form G-364 was completed correctly. If the problem cannot be corrected on the award form, prepare a code 8 G-607 with the code name TOBNN to enter this information on the CHICO master.
- 0116 (REF) BEN AMT LESS THAN SMIB - SMIB ZEROED OUT - SMIB premiums are no longer being deducted from the RR or SS benefit because the benefit is less than the monthly SMIB premium.
- 0117 (REF) WARN - POSSIBLE DUPLICATE SMIB RECOVERY - A MIRTEL reinstatement or reinst-recert award containing IPD data is processed on a case that had a manual award with an IPD in the same month or in the two prior months.
- Medicare program section (MPS) examiners must check for duplication of the manual SMIB deduction and refund any over-deduction.
- 0130 (REF) LAST ZIP CODE DIGITS INACCURATE - The RRB ZIP Code Master shows that the city is a multi-ZIP code city, but the SSA ZIP Master does not contain the final two digits. The award will process with "00" shown in the final two digits. If the correct ZIP Code was entered, forward the folder to the control services group to have the SSA ZIP Code Master updated.
- 0131 (REF) ZIP CODE INCOMPLETE - The RRB ZIP Code Master for a single - ZIP code city does not match the ZIP code shown on the award form. The award will process with the ZIP code from the RRB ZIP Code Master. If the correct ZIP code was entered, forward the folder to the control services group to have the RRB ZIP Code Master updated.
- 0132 ADDRESS TOO LONG TO ACCEPT ZIP CODE - The address as entered with the ZIP code creates a name and address with more than five lines or a fifth line that has more than 19 characters. The address should be shortened.
- 0133 NO POSTAL ADDRESS CODE - ITALY
- 0134 NO POSTAL ADDRESS CODE - YUGOSLAVIA - The postal address code for these countries was not entered or was entered improperly. Check to see that the 5-digit postal address code is the first entry in the last line of the address, e.g., nnnnn Yugoslavia.
- 0151 MECH LINK CD INVALID - Item 86 on Form G-357 wasn't completed or has an

entry in the first box that is greater than the entry in the second box. Item 2 on Form G-364 wasn't completed or has an entry in the first box that is greater than the entry in the second box.

- 0152 SURV YNGST CHILD DOB INVALID - G-364 item 49 must be a valid date. The year must show all four positions.
- 0153 PREV EST OP TXRCV OTHNO - NO OTHNO RECV CLMNO - On Form G-357, Taxable recovery - Other Claim Number (Item 61) was completed but Other Recovery Claim Number (Item 59) was not completed. On Form G-364, Taxable recovery - Other Claim Number (Item 73) was completed but Other Recovery Claim Number (Item 71) was not completed. Please complete items 59 or 71.
- 0160 DATE OF BIRTH NEEDED - On a current pay SS award, the DOB was omitted or the DOB was invalid.
- 0161 DISAB ONSET DT MISSING OR INVALID - The beneficiary is entitled to Medicare based on disability, and the disability onset date was omitted from the SS award or the onset date is later than it should be.
- 0162 (REF) PAYMT CNTR CD MISSING OR INVALID - The code of the social security payment center was omitted or an invalid code was entered.
- 0163 (REF) RR CERT-SS TERM/NOT DEATH - A railroad award is being paid and the social security benefit of that annuitant has been terminated for a reason other than death. Check to be sure that the annuitant's railroad annuity would not be affected for the same reason.
- 0164 (REF) SS CERT-FORCE ENTITLEMENT - The RRB code entered on Form RR-1e is an "X," an RR overpayment recovery is being made and the CHICO master does not have an indication of an SS reduction. The code in the CHICO master has been changed to a 1 to indicate that there is an SS reduction.
- 0165 (REF) RR ENTITLE CD3 - SS PAYMENT IN FORCE - The annuitant's SS benefit entitlement code is a 3 (unknown-partial RR rate-SS not considered) but there is no indication of a partial rate being paid. Check to be sure the railroad annuity is being adjusted correctly.
- 0182 ONE PAY WITH RREM8 - NO PAYEE CD - The award must have a payee code in order for the earmark to be removed from the CHICO master.
- 0183 (REF) ONE PAY WITH RREM8 - NO MASTER OR TERM - There is no active CHICO master record from which to remove the earmark.
- 0184 EMPLOYEE - SS ACCT NOS DIFFER - There is a discrepancy between the RR employee's social security number and the beneficiary's social security number on the employee's social security award.

- 0185 BEN ACCT NO MAY BE INCORRECT - The SS beneficiary is not the employee and the beneficiary's social security number is the same as the RR employee's social security number.
- 0186 BIC-SS CLM NO DISCREPANCY - The BIC code is A and the beneficiary's own account number is not the same as the SS claim number.
- 0187 RECOV AMT EXCEEDS TOTAL O/P - The amount of benefits withheld from a social security award to recover a railroad overpayment exceeds the total overpayment amount entered.
- (REF) 0188 RECOV AMT SHOWN - NO TOTAL O/P - Benefits are being withheld from a social security award to recover a railroad overpayment, but the total overpayment amount has not been entered.
- (REF) 0189 TOTAL O/P SHOWN - NO RECOV AMT - A total overpayment amount was entered on the social security award, but no benefits are being withheld to recover the overpayment.

Appendix B - Rate History Edit Messages

Messages with numbers greater than 1000 are rate history edit messages. These edits detect missing or inconsistent data or calculation errors. They are numbered as follows: employee edits (1000-1128), spouse edits (2010-2245), survivor edits (3001-3085), comparison edits (5001-7025), retirement and survivor date and record ID edits (9001-9168). Except for the comparison edits, most of the edits cause payment rejects. Edits that are identified with "(REF)" below the edit number may require corrective action but do not, of themselves, prevent payment.

EMPLOYEE RATE HISTORY EDIT MESSAGES

1001	<u>MONTHLY RATE NOT EQUAL TO NET ANN RATE</u> - The net annuity rate on Form G-357 (NET ANN RATE) must equal the monthly check rate (MO REG ANN RATE).
1002	<u>SUP AFT DEDUCT NOT EQUAL TO SUP CK RT</u> - The supplemental annuity rate after deductions on Form G-357 (SUP AFT DEDUCT) must equal the monthly supplemental annuity check rate (MO SUP ANN CHECK RATE).
1003	<u>BEN SYM AND PAYEE CODE INCONSISTENT</u> - If the award is not a one-payment-only (general) and the beneficiary symbol entered on Form G-357 is blank (i.e., not M or X), the payee code must be 01.
1004	<u>TYPE CERT REQUIRES RATE EFF DT</u> - If the award is not a partial award

	or one-payment-only (general), then the latest rate effective date on Form G-357 must be completed. The type of payment must also be numeric.
1005 (REF)	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is regular annuity only, the annuity formula is railroad, and the award is a final or one-payment-only initial certification, Forms G-354.1, G-354 Sup and G-354.3 should not be attached. (There are a few situations, e.g., an erroneous deletion, in which a 37/74 Act employee must be paid as an initial award and this edit can be ignored.)
1006	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is regular annuity only, the annuity formula is railroad, and the award is a recert, reinstate-recert or a one-payment-only recert, Form G-354 Sup should not be attached.
1007	<u>FORMS, FORM SET NOT FIRST OR PAYMENT SET</u> - If the form set is not the first or payment set (G-357, item 86 - first number not equal to 0 or 1), then the bypass codes set in the rate history record must be "bypass" for the Research and CHICO portions of the record. ONCORR will set G-357 item 86 to indicate the payment (1) record. Note: only the payment G-357 will be recycled on ONCORR. Correct all other edits and issue the done command.
1008	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is regular annuity only, the annuity formula is railroad, and the award is a reinstatement, no forms should be attached except Form G-369.
1011 (REF)	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is regular annuity only, the annuity formula is O/M, and the award is a final certification, Forms G-354.1, G-354.3 and G-354 Sup should not be attached. (The O/M should not be paid as an initial award.)
1012	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is regular annuity only, the annuity formula is O/M, and the award is a recert, reinstate-recert, or one-payment-only recert, then Form G-354 Sup should not be attached.
1014	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is regular annuity only, the annuity formula is O/M, and the award is a reinstatement, no forms should be attached except Forms G-354.3 and G-369.
1017	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is supplemental annuity only, and the award is a recertification or reinstate-recert, then the only forms that should be attached are Forms G-357a, G-354 Sup and G-369.

1018	<u>REG WD'S, EFF DT NOT > 0; END DT NOT = 0</u> - If regular work deductions are in force (G-357, item 29 > 0 and G-357, item 23 = 0), then if the Tier 1 WD amount (item 16(A)) > 0, the regular WD effective date (item 17(C)) must be completed.
1019	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is supplemental annuity only, and the award is a reinstatement, then the only forms that should be attached are Forms G-354 Sup and G-369.
1020	<u>REG/LPE WD'S, COMPONENTS DO NOT EQUAL TOTAL WD AMT</u> - If regular or LPE WD's are in force (G-357, item 29 > 0 and G-357, item 23 = 0), the T1 WD amount G-357, item 16(A)) plus the T2 WD amount (item 16(C)) plus the VDB WD amount (item 16(D)) must equal item 29.
1021	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment
(REF)	is regular and supplemental, the annuity formula is railroad, and the award is a final or a one-payment-only initial certification, Forms G-354.1 and G-354.3 should not be attached. (There are a few situations, e.g., an erroneous deletion, in which a 37/74 Act employee must be paid as an initial award and this edit can be ignored.)
1022	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is regular and supplemental, the annuity formula is railroad, and the award is a recert, reinstate-recert, or one-payment-only recert, Form G-354.3 should not be attached.
1023	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is regular and supplemental, the annuity formula is railroad, and the award is a reinstatement, then the only forms that should be attached are Forms G-354 Sup and G-369.
1024	<u>LPE WD'S, EFF DT NOT > 0; END DT NOT = 0</u> - If LPE work deductions are in force (G-357, item 29 > 0 and G-357, item 23 = 0), then if the T2 WD amount (item 16(C)) > 0, the LPE WD effective date (item 17(D)) must be completed.
1025	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment
(REF)	is regular and supplemental, the annuity formula is O/M, and the award is a final certification, Forms G-354.1 and G-354.3 should not be attached. (The O/M should not be paid as an initial award.) (There are a few situations, e.g., an erroneous deletion, in which a 37/74 Act employee must be paid as an initial award and this edit can be ignored.)
1026	<u>LEGAL PROCESS TYPE CODE NOT > 0</u> - If the "LP-PARTITION" or

	"ASSIGN/NON-PN" amounts in G-357, item 30 > 0 and the ending date in item 23 = 0, then the legal process type code (item 44) must be > 0.
1027	<u>GROSS TIER I AND DRC'S INCONSISTENT</u> - If PIA 1 is not a special minimum PIA, DRC's apply, and the employee's year of eligibility on Form G-357a is after 1978 and before 1987, the G-354 gross tier 1 must equal PIA 1 times 1 plus (.0025 times the number of DRC's), dropping dimes and cents.
1028	<u>FORMS, TYPE PAYMENT/CERT INCONSISTENT</u> - If the type of payment is regular and supplemental, the annuity formula is O/M, and the award is a reinstatement, then the only forms that should be attached are Forms G-354.3, G-354 Sup, and G-369.
1029	<u>TOTAL RR RATE NOT EQUAL TO TIERS</u> - The TOTAL RR RATE on Form G-357 must equal the sum of the net tier 1, net tier 2, and the VDB after cutback. (If Forms G-354, G-354.1, G-354.1A, or G-354 WF are attached, the tier rates from those forms are used in the edit. If not, the rates entered on Form G-357 are used.)
1030 - 1040 (REF)	<p><u>NET ANN RATE NOT EQUAL TO TIERS LESS DEDUCT</u> - The regular annuity rate on Form G-357 (MO REG ANN RATE) should equal the latest TOTAL RR RATE (if the annuity formula is railroad) or O/M Rate (if the annuity formula is O/M) minus the following:</p> <ul style="list-style-type: none"> the work deduction adjustment amount (W/D ADJUST) if the "withhold W/D amount" code for either regular or LPS work deductions is checked. the legal process/partition amount (LP-PARTITION) the assignment/non-partition amount (ASSIGN/NON-PN) the actuarial adjustment amount (ACT ADJ) the waiver amount (WAIVER) the partial withholding rate (PARTIAL WITHHOLDING), if the W/H recovery date is later than the current date. <p>(This edit message may occur when it should not if a legal process-partition, assignment/non-partition, actuarial adjustment, or waiver deduction applies to some but not all effective dates on Form G-357. In this situation, the edit can be ignored provided the deductions have been subtracted correctly.)</p>
1041	<u>AGE ON ABD AND TYPE ANN INCONSISTENT</u> - If the type of annuity on Form G-357a is full age 65, the age on ABD (as determined from the DOB

	and ABD on Form G-357) must be greater than or equal to 65.
1042	<u>AGE ON ABD AND TYPE ANN INCONSISTENT</u> - If the type of annuity on Form G-357a is reduced age or reduced 60/30, then the age on ABD (as determined from the DOB and ABD on Form G-357) must be greater than or equal to 60 and less than 65.
1043	<u>AGE ON ABD AND TYPE ANN INCONSISTENT</u> - If the type of annuity on Form G-357a is full 60/30 then the age on ABD (as determined from the DOB and ABD on Form G-357) must be greater than or equal to 60.
1044	<u>TIER 1 DOE IS BEFORE ABD</u> - The Tier 1 DOE on Form G-357a must be the same as or later than the ABD.
1047 - 1048	<u>AGE RED MOS AND TYPE ANN INCONSISTENT</u> - If age reduction months are entered on Form G-357a, then the employee's type of annuity must be reduced age or reduced 60/30, or if the employee's type of annuity is reduced age or reduced 60/30, then the age reduction months must be greater than 0.
1049	<u>TYPE OF ANNUITY MISSING</u> - If the award is a final certification, the type of annuity on Form G-357a must be completed.
1050	<u>TYPE OF COMPUTATION MISSING</u> - If the award is a final certification, the type of annuity on Form G-357a must be completed.
1051	<u>FILING DATE MISSING</u> - If the award is a final certification, the application filing date on Form G-357a must be completed.
1052	<u>ABD MISSING</u> - If the award is a final certification, the ABD must be completed.
1053	<u>DLW (RR) MISSING</u> - If the award is a final certification, the date last worked for the railroad on Form G-357a must be completed.
1054	<u>BA NUMBER MISSING</u> - If the award is a final certification, the BA No. on Form G-357a must be completed.
1055	<u>CC CODE MISSING</u> - If the award is a final certification, the current connection code on Form G-357a must be completed.
1057	<u>WC OR PDB RED TERM EFF DATE NOT > 0</u> - If the worker's compensation termination code in G-354, item 7 is completed, the termination effective date must be completed.
1058	<u>INAPPROPRIATE DRC % APPLIED PER DRC</u> - If the DOB \geq 01-02-25, the gross T1 amount (G-354, item 17) must equal PIA 1 multiplied by (1 + the

	appropriate DRC percentage) times the number of DRC months (the result is dime rounded for reduced 60/30 employees; otherwise, the result is dollar rounded).
1059	<u>NON-DISABILITY ANN; DRR MISSING</u> - If the award is a final certification and not a disability annuity, then the date rights relinquished (DRR) on Form G-357a must be completed.
1060	<u>AGE REDUCED ANN; AGE RED MOS INVALID</u> - If the award is a final certification and is a reduced age or reduced 60/30, then the age reduction months on Form G-357a must be greater than 0 and less than 37.
1061	<u>T1 FORM, FORM ID, OR EFF DT MISSING</u> - Form G-357 shows Form G-354 as an accompanying form, but a tier 1 rate history record was not created. This could occur if the G-357 form indicator was incorrect and Form G-354 was not attached, or the G-354 Form ID (03) was not keyed, or the effective date on Form G-354 is missing. If the error was in the form indicator or form ID, ONCORR would have corrected it when the award was loaded onto the database.
1062	<p><u>NET T1 NOT EQUAL TO GROSS TIER 1 LESS RED</u> - If Form G-354 is attached and the tier 1 not payable code is blank, then the net tier 1 must equal the gross tier 1 minus the following:</p> <ul style="list-style-type: none"> • the worker's comp reduction (WC REDUCTION) • the public disability benefit (PDB REDUCTION) • the tier 1 age reduction • the social security benefit reduction (SS BEN REDUCTION).
1063 - 1064	<u>T1 FORM, FORM ID, OR EFF DT MISSING</u> - (See 1061.)
1065	<u>WC EFF DATE AND WC RED INCONSISTENT</u> - If the worker's compensation reduction effective date on Form G-354 is before or equal to the current date, and the worker's compensation termination effective date is later than the current date, then the worker's compensation reduction amount (WC REDUCTION) or the public disability benefit amount (PDB REDUCTION) must be entered on Form G-354.
1066	<u>WC TERM DATE AND WC RED INCONSISTENT</u> - If the worker's compensation termination effective date is earlier than the current date, then nothing should be entered on Form G-354 in the worker's compensation reduction amount (WC REDUCTION) or the public disability benefit amount (PDB REDUCTION) for any occurrence with a tier 1

	effective date after the worker's compensation reduction termination date.
1067	<u>GROSS TIER 1 AND DRC'S INCONSISTENT</u> - If PIA 1 is not a special minimum PIA, DRC's apply, and the employee's year of eligibility on Form G-357a is before 1979, the G-354 gross tier 1 must equal the PIA 1 times 1 plus (.0008333 times the number of DRC's), dropping dimes and cents.
1068	<u>GROSS TIER 1 AND DRCS INCONSISTENT</u> - If PIA 1 is not a special minimum PIA, the award is not a RASI award, and the eligibility year is not available (there is no G-357a attached), but there are DRC's, then the gross tier 1 must be greater than PIA 1.
1069	<u>GROSS TIER 1 AND PIA 1 INCONSISTENT</u> - If PIA 1 is not a special minimum PIA and there are no DRC's, then the G-354 gross tier 1 must be less than or equal to PIA 1.
1070 - 1071	<u>T1 FORM, FORM ID, OR EFF DT MISSING</u> - (See 1061).
1072	<u>T1 AGE RED AMT, RED DATA INCONSISTENT</u> - If the age reduction months are entered on Form G-357a for an 81 Amendment case, then the tier 1 age reduction must equal the number of age reduction months divided by 180 times the gross tier 1 after worker's compensation.
1073	<u>T1 AGE RED AND TYPE ANN INCONSISTENT</u> - If the employee's type of annuity on Form G-357a is not age reduced, then there should be no age reduction amount shown on Form G-354.
1074	<u>T1 AGE RED AMT, RED DATA INCONSISTENT</u> - If age reduction months are entered on Form G-357a for a 37 or 74 Act case, then the tier 1 age reduction on Form G-354 must be less than or equal to 1/3 of the gross tier 1 after social security reduction.
1075	<u>T1 AGE RED AMT, RED DATA INCONSISTENT</u> - If age reduction months are entered on Form G-357a for an 83 Amendment case with a half age reduction, then the tier 1 age reduction on Form G-354 must equal 1/2 of the age reduction months divided by 180 times the gross tier 1, rounded up to the dime.
1076	<u>T1 AGE RED AMT, RED DATA INCONSISTENT</u> - If age reduction months are entered on Form G-357a for an 83 Amendment case with a full age reduction, then the tier 1 age reduction on Form G-354 must equal the age reduction months divided by 180 times the gross tier 1, rounded up to the dime.
1077 (REF)	<u>T1 ABD PIA 1 MISSING</u> - Except for partial awards, if PIA 1 is not a special minimum PIA, the ABD PIA 1 must be entered on Form G-354. (Entry is not

	required for 37 Act cases and the edit can be ignored.)
1078 - 1080	<u>T2 FORM, FORM ID, OR EFF DT MISSING</u> - Form G-357 shows Form G-354.1 as an accompanying form, but the appropriate rate history records were not created. This could occur if the G-357 form indicator was incorrect and Form G-354.1 was not attached, or the Form G-354.1 ID (04) was not keyed, or the effective date on Form G-354.1 is missing. If the error was in the form indicator or form ID, ONCORR would have corrected it when the award was loaded onto the database.
1081 (REF)	<u>T2 BASIC ANN, CALC DATA INCONSISTENT</u> - If a G-357a and G-354.1 are attached, then the basic annuity must equal the AMC 1 total years and months of service through 1974 times the AMC factor (3.58% of the first \$50.00 of the AMC 1 plus 2.69% of the next \$100.00 plus 1.79% of the balance). If the case is a 37 or 74 Act case and the employee has a current connection, the minimum basic annuity could apply. This is the lowest of \$89.35, or AMC 1 times 118%, or the AMC 1 total years and months of service through 1974 times \$5.35. If this is higher than the regular basic annuity, the minimum basic annuity becomes the basic annuity. (Because of a rounding problem with this edit, it can sometimes be produced even though the computation is correct. It can be ignored in that case.)
1082	<u>PRE 12-84 T2, GUARANTY CD INCONSISTENT</u> - If Form G-354.1 is attached, the tier 2 effective date is earlier than 12-1-84, and the \$10.00 guaranty applies, then the net tier 2 must be \$10.00.
1083	<u>PRE 12-84 T2 NOT EQUAL TO COMPONENTS</u> - If Form G-354.1 is attached, the tier 2 effective date is earlier than 12-1-84, and the \$10.00 guaranty does not apply, then the net tier 2 must equal the sum of net component 1 (the first non-zero occurrence of items 33, 32, or 31) plus net component 2 (the first non-zero occurrence of items 41, 40, 39 or 38) plus net component 3 (the first non-zero occurrence of items 49, 48, 47, 46 or 45).
1084	<u>T2 AGE RED AND TYPE ANN INCONSISTENT</u> - If Form G-354.1 is attached and the type of annuity on Form G-357a is reduced age 62, then the tier 2 age reduction for component 1 should be greater than 0.
1086	<u>T2 AGE RED AND TYPE ANN INCONSISTENT</u> - If Form G-354.1 is attached and the type of annuity on Form G-357a is not a reduced age 62, then the tier 2 component 1 age reduction should be 0.
1087 - 1089	<u>T2 FORM, FORM ID, OR EFF DT MISSING</u> - (See 1078-1080, substituting Form G 354.1A.)

1090	<u>T2 BASIC ANN, CALC DATA INCONSISTENT</u> - If Form G-354.1A is attached, the basic annuity must equal the total months of service divided by 12 times the AMC times .007.
1091	<u>PRE 12-84 T2, GUARANTY CD INCONSISTENT</u> - If Form G-354.1A is attached, the tier 2 effective date is before 12-1-84 and the \$10.00 guaranty applies, the net tier 2 must equal \$10.00.
1092	<u>T2 AFTER SEC 3(g) COL INCORRECT</u> - If Forms G-354.1A and G-354 WF are attached, the ABD is given, and tier 2 is not reduced to zero, then the tier 2 after 3(g) increase must equal the basic annuity minus 25% of the gross windfall minus the RRA maximum reduction, times the applicable 3(g) COL increases based on the ABD.
1093	<u>T2 AFTER SEC 3(g) COL INCORRECT</u> - If Form G-354.1A is attached, the ABD is given, the net vested dual benefit equals 0, the gross windfall equals 0, and tier 2 is not reduced to zero, then the tier 2 after 3g increase must equal the basic annuity minus the RRA maximum reduction, times the applicable 3(g) COL increase based on the ABD.
1094	<u>T2 AGE RED AMT, RED DATA INCONSISTENT</u> - If Forms G-357a and G-354.1A are attached, the employee is not an 83 Amendment case, age reduction months are given, and tier 2 is not reduced to 0, then the tier 2 age reduction must equal the first non-zero occurrence of items 19, 18, 17 or 16, times the number of age reduction months divided by 180.
1095	<u>DRCS IN ACTIVITY RECORD NOT EQUAL</u> - The number of DRC's in the Research and Rate History activity records do not agree. (Edit applies only to RASI awards.)
1096	<u>T2 AGE RED AND TYPE ANN INCONSISTENT</u> - If Forms G-357a and G-354.1A are attached and the type of annuity is not reduced age, then the tier 2 age reduction amount should be 0.
1097 - 1098	<u>VDB FORM, FORM ID, OR EFF DT MISSING</u> - Form G-357 shows Form G-354WF as an accompanying form, but a windfall rate history record was not created. This could occur if the G-357 form indicator was incorrect and Form G-354WF was not attached, or the G-354WF Form ID (06) was not keyed, or the effective date on Form G-354WF is missing. If the error was in the form indicator or form ID, ONCORR would have corrected it when the award was loaded onto the database.
1101	<u>VDB AFTER COL INCORRECT</u> - The VDB after COL increase must equal the RIB/DIB VDB plus the COL increase based on the ABD, if Form G-354WF is attached, the employee is vested on his own earnings record, and the VDB DOE is after 1-1-75.

1102	<u>RIB/DIB VDB AND VDB PIA'S INCONSISTENT</u> - The RIB/DIB VDB must equal PIA 4 plus PIA 7 minus PIA 8, if Form G-354WF is attached, the employee is vested on his own earnings record, and the VDB DOE is after 1-1-75.
1103	<u>VDB PIA(S) MISSING</u> - There must be entries for PIA's 4, 7, and 8, if Form G-354WF is attached, the employee is vested on his own earnings record, and the VDB DOE is after 1-1-75.
1104	<u>VDB AFTER COL INCORRECT</u> - The VDB after COL increase must equal the AUX VDB plus the COL increase based on the ABD, if Form G-354WF is attached, the employee is vested as a spouse, and the VDB DOE is after 1-1-75.
1105	<u>AUXILIARY VDB AND VDB PIA'S INCONSISTENT</u> - The AUX VDB must equal the lesser of PIA 8 or 50% of PIA 21 (rounded up to a dime) minus PIA 4, if Form G-354WF is attached, the employee is vested as a spouse, and the VDB DOE is after 1-1-75.
1106	<u>VDB PIA'S MISSING</u> - PIA 8 or PIA 21 must be entered if Form G-354WF is attached, the employee is vested as a spouse, and the VDB DOE is after 1-1-75.
1107	<u>VDB AFTER COL INCORRECT</u> - The VDB after COL increase must equal the AUX VDB plus the COL increase based on the ABD, if Form G-354WF is attached, the employee is vested as a widow, and the VDB DOE is after 1-1-75.
1108	<u>AUXILIARY VDB AND VDB PIA'S INCONSISTENT</u> - The AUX VDB must equal the lesser of PIA 8 or PIA 21 minus PIA 4, if Form G-354WF is attached, the employee is vested as a widow, and the VDB DOE is after 1-1-75.
1109	<u>VDB PIA(S) MISSING</u> - Either PIA 8 or PIA 21 must be given, if Form G-354WF is attached, the employee is vested as a widow, and the VDB DOE is after 1-1-75.
1110	<u>VDB AGE RED AMT, RED DATA INCONSISTENT</u> - If Forms G-357A and G-354WF are attached, age reduction months are given and the tier 1 only age reduction code does not apply, then if the case is paid under the 81 Amendments, the VDB age reduction must equal the age reduction months divided by 180 times the VDB after COL increase.
1111	<u>VDB AGE RED AMT, RED DATA INCONSISTENT</u> - If Forms G-357a and G-354WF are attached, age reduction months are given and the tier 1 only age reduction code does not apply, then if the case is not paid under the 81

	Amendments, the VDB age reduction amount must be greater than 0.
1112	<u>VDB AGE RED AND TYPE ANN INCONSISTENT</u> - If Forms G-357a and G-354WF are attached and the tier 1 only age reduction code does not apply, then if the type of annuity is given and it is not a reduced age 62, the VDB age reduction amount must be zero.
1115 -	<u>SUPP FORM, FORM ID, OR EFF DT MISSING</u> - Form G-357 shows Form
1116	G-354 Sup as an accompanying form, but a supplemental annuity rate history record was not created.
	This could occur if the G-354 Sup form indicator was incorrect and Form G-354 Sup was not attached, or the G-354Sup Form ID (08) was not keyed, or the effective date on form G-354 Sup is missing. If the error was in the form indicator or form ID, ONCORR would have corrected it when the award was loaded onto the database.
1117	<u>TAX CREDIT/SUPP ANNUITY INCONSISTENT</u> - If Form G-354 SUP is attached and the SUP ANN beginning date is given and is after 12-31-74, then the SUP annuity check rate on Form G-357 (MO SUPP ANN CHECK RATE) plus the employer tax credit must be less than or equal to \$43.00.
1118	<u>TAX CREDIT/SUPP ANNUITY INCONSISTENT</u> - If Form G-354 SUP is attached and the SUP ANN beginning date is before 1-1-75, then the SUP annuity check rate on Form G-357 plus the employer tax credit must be less than or equal to \$70.00.
1119	<u>NET T2 AND GUARANTY CD INCONSISTENT</u> - If Form G-354.1 is attached, the tier 2 effective date is after 11-30-84 and the \$10.00 guaranty applies, then the net tier 2 must be \$10.00.
1120	<u>NET T2 NOT EQUAL TO ITS COMPONENTS</u> - If Form G-354.1 is attached, the tier 2 effective date is after 11-30-84, and the \$10.00 guaranty does not apply, then the net tier 2 must equal the sum of items 35, 36, 42, 51 and 52.
1121	<u>PRE 12-84 T2, CALC DATA INCONSISTENT</u> - If Form G-354.1A is attached, the tier 2 effective date is before 12-1-84, and the \$10.00 guaranty does not apply, then the net tier 2 must equal the first non-zero occurrence of items 19, 18, 17 or 16 minus the tier 2 age reduction minus the first takeback.
1122	<u>12-84 T2 AND GUARANTY CD INCONSISTENT</u> - If Form G-354.1A is attached, the tier 2 effective date is 12-1-84 and the \$10.00 guaranty applies, the net tier 2 must be \$10.00.

1123	<u>12-84 T2 AND T2 CALC DATA INCONSISTENT</u> - If Form G-354.1A is attached, the tier 2 effective date is 12-1-84, and the \$10.00 guaranty does not apply, the net tier 2 must equal the first non-zero occurrence of items 19, 18, 17, or 16 minus any tier 2 age reduction minus the first takeback, times .011 (rounded to 2 decimal places) minus the second takeback.
1124	<u>POST-84 T2, GUARANTY CD INCONSISTENT</u> - If Form G-354.1A is attached, the tier 2 effective date is after 12-1-84, and the \$10.00 guaranty applies, then the net tier 2 must be \$10.00.
1125	<u>POST-84 T2, T2 CALC DATA INCONSISTENT</u> - If Form G-354.1A is
(REF)	attached, the tier 2 effective date is after 12-1-84, and the \$10.00 guaranty does not apply, then the net tier 2 must equal the tier 2 after the second takeback plus the post-84 COL increases.
1126	<u>AGE RED AMT MUST BE GREATER THAN ZERO</u> - If the award is a final certification and is an 83 Amendment 60/30 case with a half or full age reduction, then the ABD age reduction amount (60/30 EE AGE RED AMOUNT ON ABD) on Form G-357a must be greater than 0.
1127	<u>SUSP/TERM CODE MISSING</u> - If the award is a one-pay-only initial or one-pay-only recert award, then the suspension/termination code (SUSP/TERM CD) must be entered on Form G-357.
1128	<u>SUSP/TERM EFFECTIVE DATE MISSING</u> - If the award is a one-pay-only initial or one-pay-only recert award, then the suspension/termination effective date (SUSP/TERM EFF) must be entered on Form G-357.

SPOUSE RATE HISTORY EDIT MESSAGES

2010	<u>MONTHLY RATE NOT EQUAL TO NET ANN RATE</u> - The net annuity rate on Form G-357 (NET ANN RATE) must equal the monthly check rate (MO REG ANN RATE).
2020	<u>BEN SYM AND PAYEE CODE INCONSISTENT</u> - If the beneficiary symbol/prefix entered on Form G-357 is MA, the payee code must be 2.
2030	<u>BEN SYM AND PAYEE CODE INCONSISTENT</u> - If the beneficiary symbol/prefix entered on Form G-357 is XA, the payee code must be greater than 2.
2031	<u>FORMS, FORM SET NOT FIRST OR PAYMENT SET</u> - If the form set is not the first or payment set (G-357, item 86 - first number not equal to 0 or 1), then the bypass codes set in the rate history record must be "bypass" for

	the Research and CHICO portions of the record. ONCORR will set G-357 item 86 to indicate the payment (1) record. Note: only the payment G-357 will be recycled on ONCORR. Correct all other edits and issue the done command.
2040	<u>ACCOMP. FORMS, TYPE CERT INCONSISTENT</u> - If the award is a reinstatement, no forms should be attached except Form G-369.
2050	<u>ACCOMP. FORMS, BEN SYM INCONSISTENT</u> - If the award is for a divorced spouse and is not a reinstatement, only Forms G-357a, G-355 and G-369 may be attached.
2060	<u>TOTAL RR RATE NOT EQUAL TO TIERS</u> - The TOTAL RR RATE on Form G-357 must equal the sum of the net tier 1, net tier 2, and VDB after cutback. (If Forms G-355, G-355.1, G-355.1B or G-355WF are attached, the tier rates from those forms are used in the edit. If not, the rates entered on Form G-357 are used.)
2071 (COLA) (REF)	<p><u>NET ANN NOT EQUAL TO TIERS LESS DEDUCT</u> - The regular annuity rate on Form G-357 (MO REG ANN RATE) should equal the TOTAL RR RATE (if the annuity formula is railroad) or the O/M RATE (if the annuity formula is O/M) minus the following:</p> <ul style="list-style-type: none"> the work deduction adjustment amount (W/D ADJUST) if the "withhold W/D amount" code for either regular or LPS work deductions is checked. the legal process/partition amount (LP-PARTITION) the assignment/non-partition amount (ASSIGN/NON-PN) the actuarial adjustment amount (ACT ADJ) the partial withholding rate (PARTIAL WITHHOLDING), if the W/H recovery date is later than the current date. (This edit message may occur when it should not if a legal process-partition, assignment/non-partition, actuarial adjustment or waiver deduction applies to some but not all effective dates on Form G-357. In this situation, the edit can be ignored provided the deductions have been subtracted correctly.)
2072 (COLB) (REF)	
2073 (COLC) (REF)	
2074	
2074	<u>REG/LPE WD'S, COMPONENTS DO NOT EQUAL TOTAL WD AMT</u> - If regular or LPE WD's are in force (G-357, item 29 > 0 and G-357, item 23 = 0), the T1 WD amount G-357, item 16(A)) plus the T2 WD amount (item 16(C)) plus the VDB WD amount (item 16(D)) must equal item 29.

2075	<u>LPE WD'S, EFF DT NOT > 0; END DT NOT = 0</u> - If LPE work deductions are in force (G-357, item 29 > 0 and G-357, item 23 = 0), then if the T2 WD amount (item 16(C)) > 0, the LPE WD effective date (item 17(D)) must be completed.
2076	<u>LEGAL PROCESS TYPE CODE NOT > 0</u> - If the "LP-PARTITION" or "ASSIGN/NON-PN" amounts in G-357, item 30 > 0 and the ending date in item 23 = 0, then the legal process type code (item 44) must be > 0.
2077	<u>REG WD'S, EFF DT NOT > 0; END DT NOT = 0</u> - If regular work deductions are in force (G-357, item 29 > 0 and G-357, item 23 = 0), then if the Tier 1 WD amount (item 16(A)) > 0, the regular WD effective date (item 17(C)) must be completed.
2081	<u>AGE ON ABD AND TYPE ANN INCONSISTENT</u> - If the spouse/divorced spouse type of annuity on Form G-357a is full age 65, then the spouse's age on ABD (as determined from the DOB and ABD on Form G-357) must be greater than or equal to age 65.
2082	<u>AGE ON ABD AND TYPE ANN INCONSISTENT</u> - If the spouse type of annuity on Form G-357a is based on child in care, then the spouse's age on ABD (as determined from the DOB and ABD on Form G-357) must be less than 65.
2083	<u>AGE ON ABD AND TYPE ANN INCONSISTENT</u> - If the spouse/divorced spouse type of annuity on Form G-357a is reduced age, then the spouse's age on ABD (as determined from the DOB and ABD on Form G-357) must be 62-64.
2084	<u>AGE ON ABD AND TYPE ANN INCONSISTENT</u> - If the spouse type of annuity on Form G-357a is reduced age under the 83 Amendments, then the spouse's age on ABD (as determined from the DOB and ABD on Form G-357) must be 60-64.
2090	<u>TIER 1 DOE IS BEFORE ABD</u> - The tier 1 DOE on Form G-357a must be the same as or later than the ABD.
2100	<u>AGE RED MOS CANNOT EXCEED 36</u> - The number of age reduction months on Form G-357a cannot exceed 36.
2111	<u>AGE RED MOS AND TYPE ANN INCONSISTENT</u> - If age reduction months are entered on Form G-357a, then the spouse's type of annuity must be reduced age, or 83 Amendment 60/30 with a full or half age reduction.
2112	<u>AGE RED MOS AND TYPE ANN INCONSISTENT</u> - If the spouse's type of

	annuity is reduced age, and the type of computation is not 83 Amendment 60/30 with a half or full age reduction, then there must be age reduction months entered on Form G-357a.
2113	<u>AGE RED MOS AND TYPE ANN INCONSISTENT</u> - If the spouse is an 83 Amendment 60/30 with a half or full age reduction, and Form G-355 shows that the 60/30 spouse was recomputed at age 62, then there must be age reduction months entered on Form G-357a.
2120	<u>TYPE ANN/COMP, ABD, OR FIL DT MISSING</u> - If the award is a final certification, then the following must all have entries: <ul style="list-style-type: none"> • type of annuity • type of computation • ABD • filing date
2131	<u>YOUNGEST C'S DOB BLANK, NO DIS CHILD</u> - If the spouse annuity is based on a child and the youngest minor child's DOB is not entered on Form G-357a, then the spouse annuity must be based on a disabled child or grandchild.
2132	<u>CHILD MUST BE UNDER 16 OR DISABLED</u> - If the youngest minor child's DOB is entered on Form G-357a and tier 1 is payable, then the child must be younger than 16 or the minor child rated disabled code must be checked.
2133	<u>EE/SPOUSE TYPE COMP INCONSISTENT</u> - If the spouse is not a divorced spouse and the EE type of computation is 37 Act, 74 Act or 81 Amendment, then the spouse type of computation must be 37 Act, 74 Act or 81 Amendment.
2134	<u>EE/SPOUSE TYPE COMP INCONSISTENT</u> - If the spouse is not a divorced spouse and the EE type of computation is 83 Amendment 60/30 with no age reduction, then the spouse type of annuity must agree.
2135	<u>EE/SPOUSE TYPE COMP INCONSISTENT</u> - If the spouse is not a divorced spouse and the EE type of computation is 83 Amendment 60/30 with a half age reduction, then the spouse type of annuity must agree.
2136	<u>EE/SPOUSE TYPE COMP INCONSISTENT</u> - If the spouse is not a divorced spouse and the EE type of computation is 83 Amendment 60/30 with a full age reduction, then the spouse type of annuity must agree.

2137	<u>DIV SP TYPE COMP MUST BE 81 AMEND</u> - If the award is for a divorced spouse, then the type of computation must be 81 Amendment.
2141 (COLA)	<u>NET T1 NOT EQUAL TO GROSS T1 LESS RED</u> - If the tier 1 not payable code is blank, the net tier 1 on Form G-355 must equal the SS FORMULA BENEFIT minus the following:
2142 (COLA)	<ul style="list-style-type: none"> the worker's comp reduction (WC REDUCTION)
2143 (COLB)	<ul style="list-style-type: none"> the public disability benefit (PDB REDUCTION)
2144 (COLB)	<ul style="list-style-type: none"> the public service pension reduction (PUB PEN REDUCTION)
2145 (COLC)	<ul style="list-style-type: none"> tier 1 age reduction
2146 (COLC)	<ul style="list-style-type: none"> the SS benefit reduction (SS BEN REDUCTION)
	<ul style="list-style-type: none"> the employee annuity reduction (OWN EE ANN REDUCTION)
2150	<u>WC EFF DATE AND WC RED INCONSISTENT</u> - If the worker's compensation reduction effective date is before or equal to the tier 1 effective date and the worker's comp termination effective date is later than the tier 1 effective date, then the worker's comp reduction amount or the public disability benefit amount must be entered on Form G-355.
2160	<u>WC TERM DATE AND WC RED INCONSISTENT</u> - If the worker's comp termination effective date is earlier than the current date, then nothing should be entered on Form G-355 in the worker's comp reduction amount or the public disability benefit amount for any occurrence with a tier 1 effective date after the worker's comp reduction termination date.
2170	<u>PSP RED TERM CD, PSP RED INCONSISTENT</u> - If the public pension reduction termination code is 9, then the public pension reduction in the latest date break on Form G-355 must be 0.
2171	<u>PSP RED TERM CD, PSP TERM DT NOT > 0</u> - If the public pension reduction termination code in G-355, item 9 is completed, the public pension reduction termination effective date must be completed.
2174 (COLA)	<u>T1 AGE RED AMT, RED DATA INCONSISTENT</u> - If the spouse is an 83 Amendment case with a half age reduction and age reduction months are entered on Form G-357a, then the tier 1 age reduction must equal .5 times

2175 (COLB) (REF)	the age reduction months divided by 144 times the gross tier 1 minus WC reduction and minus PDB reduction, rounded up to the dime.
2176 (COLC) (REF)	
2181 (COLA)	<u>T1 AGE RED AMT, RED DATA INCONSISTENT</u> - If the spouse is an 81 Amendment case with age reduction months entered on Form G-357a, then the tier 1 age reduction must equal the number of age reduction months divided by 144 times the gross tier 1 minus WC reduction minus PDB reduction minus public pension amount, dollar rounded, with the result rounded to a penny.
2182 (COLB)	
2183 (COLC)	
2184 (COLA)	<u>T1 AGE RED AMT, RED DATA INCONSISTENT</u> - If the spouse is a 37 or 74 Act case, then the age reduction amount must not exceed 20% of the gross tier 1 minus WC reduction, minus PDB reduction, minus public pension, dollar rounded, minus SS benefit, and minus own EE annuity.
2185 (COLB)	
2186 (COLC)	
2187 (COLA)	<u>T1 AGE RED AMT, RED DATA INCONSISTENT</u> - If the spouse is an 83 Amendment case with a full age reduction and age Reduction months are entered on Form G-357a, then the tier 1 age reduction equals the age reduction months divided by 144 times the gross tier 1 minus WC reduction and minus PDB reduction, rounded up to the dime.
2188 (COLB)	
(REF)	
2189 (COLC) (REF)	
2190	<u>T1 AGE RED AND TYPE ANN INCONSISTENT</u> - If no age reduction months are entered on Form G-357a and it is a non-reduced type of annuity, then the tier 1 age reduction on Form G-355 must be 0.
2201 (COLA)	<u>RESTOR DT, RESTORED AMT INCONSISTENT</u> - If the net tier 2 is greater than 0 and the effective date of the tier2 restoration is earlier - The EE's DO to the effective date of tier 2 for the date break being edited, then the restored amount on Form G-355.1 or G-355.1B must be greater than 0.
2202	

(COLB) 2203 (COLC)	
2213	<u>NET T2 AND CODE INCONSISTENT</u> - If Form G-355.1 is attached, the tier 2 effective date is after 11-30-84, and the \$10.00 guaranty applies, the net tier 2 must equal \$10.00.
2214	<u>NET T2 AND T2 CALC DATA INCONSISTENT</u> - If Form G-355.1 is attached, the tier 2 effective date is after 11-30-84, and the \$10.00 guaranty does not apply, the net tier 2 must equal the T2 after 12-84 takeback plus the post-84 COL increase.
2215	<u>NET T2 AND GUARANTY CD INCONSISTENT</u> - If Form G-355.1B is attached, the tier 2 effective date is after 11-30-84, the \$10.00 guaranty applies, and the T2 reduced to zero code does not apply, then the net tier 2 must equal \$10.00 minus the RRA Max reduction and minus the age reduction.
2216	<u>NET T2 AND T2 CALC DATA INCONSISTENT</u> - If Form G-355.1B is attached, the tier 2 effective date is after 11-30-84 and the \$10.00 guaranty and the tier 2 reduced to zero code do not apply, then the net tier 2 must equal the tier 2 after 12-84 COL increase plus the post-84 COL increase minus the age reduction.
2220	<u>VDB INPUT SHEET, TYPE COMP INCONSISTENT</u> - If Form G-355WF is attached, the type of computation on Form G-357a must be 1937 Act or 1974 Act.
2231 (COLA) 2232 (COLB) 2233 (COLC)	<u>VDB AGE RED AMT, RED DATA INCONSISTENT</u> - If Form G-357a is attached and age reduction months are entered, then the VDB age reduction on Form G-355WF must be less than or equal to .2 times the spouse total VDB before age reduction.
2241 (COLA) 2242 (COLB) 2243 (COLC)	<u>VDB AMT AND VDB CALC DATA INCONSISTENT</u> - The gross VDB on Form G-355WF must equal the sum of the net VDB plus the cutback amount plus the age reduction amount.

2244	<u>SUSP/TERM CODE MISSING</u> - If the award is a one-payment-only initial or one-payment-only recert award, and is not an assignment, garnishment, transfer of funds, or SF-1166 award, then the susp/term code must be entered on Form G-357.
2245	<u>SUSP/TERM EFFECTIVE DATE MISSING</u> - If the award is a one-payment-only initial or one-payment-only recert award, and is not an assignment, garnishment, transfer of funds, or SF-1166 award, then the susp/term effective date must be entered on Form G-357.

SURVIVOR RATE HISTORY EDIT MESSAGES

3001	<u>MONTHLY RATE NOT EQUAL TO NET ANN</u> - For recurring awards the Monthly Rate on the G-364 must equal the net annuity calculated on the G-364.1.
3002	<p><u>NET ANN NOT EQUAL TO TIERS LESS DEDUCT</u> - The net annuity rate on the G-364.1 must equal the sum of the tiers minus the total deductions. This referral could be covered by any one of the following:</p> <ul style="list-style-type: none"> • If a Basic EE annuity reduction code is checked on the G-364.1, an EE annuity reduction amount must be entered. • Tier total entries, i.e., net tier 1, net tier 2, VDB, must be entered (depending on the type of beneficiary). • Total deductions on the G-364.1 must equal the sum of all the withholding amounts on the G-364 (part W/H, waiver amt, act. adj. amt., partition and non-partition amts). • The sum of EE deductions and total deductions on the G-364.1 must equal the deductions on the G-364. • The annuity rate (G-364.1) must equal the annuity rate (G-364). • The net annuity (G-364.1) must equal the monthly rate (G-364). • The partial withholding recovery date (G-364) must be later than the voucher month and year.
3003	<u>SUSP/TERM CODE MISSING</u> - The susp/term (G-364) code must be completed if an award is an OPO Recert, OPO Initial, or constructive award.
3004	<u>SUSP/TERM EFFECTIVE DATE MISSING</u> - The susp/term (G-364) date must be completed if an award is an OPO Recert, OPO Initial or

	constructive award.
3005	<u>ORIGINAL BEGINNING DATE MISSING</u> - The OBD (G-364) must be entered for initial awards.
3006	<u>EE's MONTH OF DEATH MISSING</u> - The EE's month of death (G-364.1) must be entered for initial awards and must be less than 13.
3007	<u>EE's YEAR OF DEATH MISSING</u> The EE's DOD (G-364.1) must be entered for initial awards.
3008	<u>EE's MONTH OF BIRTH MISSING</u> - The EE's month of birth (G-364.1) must be entered for initial awards and must be less than 13.
3009	<u>STAT SHARE/SHARE OF MAX INCONSISTENT</u> - An entry or "zero code" must be made in the statutory share or share of max (G-364.1) box or a "zero code" must be entered in the net tier 1 (G-364.1) box. This edit is not performed if there are no post-36 earnings (G-364.1).
3010	<u>MARITAL STATUS CODE MISSING</u> - The marital status (G-364.1) must be checked for initial awards.
3011	<u>BEN SYM MISSING OR INCONSISTENT</u> - The ben sym (G-364) must be entered and it must be a valid code as listed in the RCM G-364 instructions.
3012	<u>REGULAR PIA CODE MISSING</u> - One of the four regular PIA codes (G-364.1) must be checked.
3013	<u>AIME/AMW INDICATION MISSING</u> - An entry must be made in the AIME/AMW (G-364.1) box.
3014	<u>PIA 1 MISSING</u> - An entry must be made in the PIA 1 (G-364.1) box.
3015	<u>STAT SHARE/SHARE OF MAX MISSING</u> - An entry must be made in the statutory share or share of max (G-364.1) box.
3016	<u>DEEMED PIA INCONSISTENT WITH ORIG RATE</u> - If a widow has a deemed PIA (G-364.1) and the family maximum does not apply, then the statutory share or share of max (G-364.1) must be grIA used (G-364.1).
3017	<u>AGE RED/RIB RATE IS GREATER THAN PIA</u> - If a widow has an RIB limit (G-364.1) or 82.5% of the PIA applies, or if the widow has an age reduction and the deemed PIA does not apply, then the first adjusted rate (G-364.1) must be less than the PIA used (G-364.1).
3018	<u>FORMS, FORM SET NOT FIRST OR PAYMENT SET</u> - If the form set is not the first or payment set (G-357, item 86 - first number not equal to 0 or 1), then the bypass codes set in the rate history record must be "bypass" for

	the Research and CHICO portions of the record. ONCORR will set G-364 item 2 to indicate the payment (1) record. Note: only the payment G-364 will be recycled on ONCORR. Correct all other edits and issue the done command.
3019	<u>ADJ RATE INCONSISTENT WITH ORIG RATE</u> - If a widow has an age reduction and the Fictional RIB and Sole Survivor Minimum do not apply, the adjusted rate (G-364.1) plus the amount of the age reduction must equal the statutory share or share of max (G-364.1).
3020	<u>NET T1 NOT EQUAL TO ITS COMPONENTS</u> - The net tier 1 (G-364.1) must equal the sole survivor minimum, the first adjusted rate or the original rate minus the public pension amount, the social security benefit amount, and the widow's own employee annuity tier 1 (if the basis for the employee reduction is net tier 1).
3021	<u>T2 DOES NOT EQUAL 30% OF BASIS</u> - If the type of computation (G-364.1) is "1974 Act" or "Conversion", then the tier 2 starting point (G-364.1) must equal 30% of the basis (G-364.1) for the tier 2 computation.
3022	<u>GROSS T2 GREATER THAN 50% OF EE T2</u> - If the type of computation (G-364.1) is "1981 Amends", then the widow's share of EE's tier 2 (G-364.1) must be greater than zero and must not be greater than 50% of the OBD tier 2 (G-364.1).
3023	<u>T2 RATE THRU 6/83 COL INCORRECT</u> - The tier 2 rate thru 6/83 (G-364.1) must not be greater than the gross tier 2 increased by the maximum COL percentage increase through 6/83 (3.53%). If the OBD (G-364) is after 5/83, no COL should be applied through 6/83.
3024	<u>T2 AGE RED RT MISSING OR INCONSISTENT</u> - If the type of computation (G-364.1) is "1981 Amends", there must be an age reduced rate in tier 2 if there is one in tier 1.
3025	<u>EE REST AMT CODE INCONSISTENT WITH AMT</u> - If the "zero code" box is checked in the EE restored amount (G-364.1) item, then the restored amount must equal zero.
3026 (REF)	<u>W REDUCED FOR EE T1, NO REST AMT ENTRY</u> - If a widow's tier1 is reduced for her own railroad annuity, then either an amount must be entered in the EE restored amount (G-364.1) or the "zero code" must be checked.
3027	<u>T2 SP MIN GUAR AMT IS INCORRECT</u> - The spouse minimum (G-364.1) must equal the sum of the net tier 1 (G-364.1), the tier 2 total before the spouse minimum amount, and the spouse minimum additional amount (G-364.1).

3028	<u>T2 AGE RED INCONSISTENT WITH 37/74 ACT</u> - If the type of computation (G-364.1) is "1974 Act" or "Conversion", then a widow's tier 2 should not contain an age reduction rate (G-364.1).
3029	<u>EQUALIZED AMT SHOWN IN NON-37 ACT CASE</u> - An equalized amount (G-364.1) must be entered only if the type of computation (G-364.1) is "Conversion".
3030	<u>PSP RED CD MUST BE > 0</u> - If there is a public service pension reduction, then the PSP reduction status code must be completed.
3031	<u>PSP RED SOURCE CD MUST BE > 0</u> - If there is a public service pension reduction, then the PSP reduction source code must be completed.
3032	<u>T1 SHARE SHOULD BE GREATER THAN ZERO</u> - If the young mother/father has a minor disabled child in care (G-364), the young mother/father's statutory share or share of max (G-364.1) must be greater than zero.
3033	<u>GROSS T2 SHOULD BE 0</u> - If the ben sym (G-364) indicates that the annuitant is a remarried or a divorced type, then there should be no tier 2 entries on the G-364.1.
3034	<u>NET T2 SHOULD BE 0</u> - If the ben sym (G-364) indicates that the annuitant is a remarried or a divorced type, then there should be no tier 2 entries on the G-364.1.
3035	<u>T1 SHARE IS GREATER THAN 75% OF PIA</u> - If the ben sym (G-364) indicates that the annuitant is a young mother/father, child, or non-phase-out student, and a sole survivor minimum does not apply, then the statutory share or share of max (G-364.1) must not be greater than 75% of the PIA used (G-364.1).
3036	<u>NET T1 NOT EQUAL TO ITS COMPONENTS</u> - The net tier 1 (G-364.1) must equal the original or reduced for maximum rate minus the public pension, the social security benefit, and the annuitant's own employee annuity tier 1 (if the basis for the employee reduction is net tier 1).
3037	<u>T2 DOES NOT EQUAL 30% OF BASIS</u> - If the type of computation (G-364.1) is "1974 Act" or "Conversion", then the tier 2 starting point (G-364.1) must equal 30% of the basis (G-364.1) for the tier 2 computation.
3038	<u>GROSS T2 GREATER THAN 50% OF EE T2</u> - If the type of computation (G-364.1) is "1981 Amends" and the ben sym (G-364) indicates the annuitant is a young mother/father, then the share of E/E's tier 2 (G-364.1) must not be greater than 50% of the OBD tier 2 (G-364.1).

3039	<u>GROSS T2 GREATER THAN 35% OF EE T2</u> - If the type of computation (G-364.1) is "1981 Amends" and the ben sym (G-364) indicates the annuitant is a parent, child, or non-phase-out student, then the share of EE's tier 2 (G-364.1) must not be greater than 35% of the OBD tier 2 (G-364.1).
3040	<u>NET T2 NOT EQUAL TO ITS COMPONENTS</u> - If the type of computation (G-364.1) is "1974 Act" or "1981 Amends", the net tier 2 (G-364.1) for children or parents must equal the tier 2 COL increase rate (G-364.1). The net tier 2 (G-364.1) for young mothers/fathers must equal the tier 2 COL increase rate plus any spouse minimum additional amount (G-364.1) plus any EE restored amount (G-364.1).
3041	<u>NET T2 NOT EQUAL TO ITS COMPONENTS</u> - If the type of computation (G-364.1) is "Conversion", the net tier 2 (G-364.1) for children or parents must equal the tier 2 COL increased rate (G-364.1) plus any equalized amount (G-364.1). The net tier 2 (G-364.1) for young mothers/fathers must equal the tier 2 COL increased rate (G-364.1) plus any spouse minimum additional amount (G-364.1) plus any EE restored amount (G-364.1) plus any equalized amount (G-364.1).
3042	<u>T2 SHOULD BE 0 (RM, KM, LP, LF)</u> - If the ben sym (G-364) indicates the annuitant is a 1983 amendment parent, a remarried young mother/father, or a divorced young mother/father, then there should be no tier 2 entries on the G-364.1).
3043	<u>VDB SHOULD BE 0</u> - If the ben sym (G-364) indicates that the annuitant is a minor or disabled child, a non-phase-out student, or a parent, then the vested dual benefit after cutback (G-364.1) must be 0.
3050	<u>APPLICATION FILING DATE MISSING</u> - The filing date (G-364) must be completed for all initial awards.
3051	<u>ALT PIA LESS THAN REGULAR PIA</u> - If the PIA used is the ALT PIA (G-364.1), it must be greater than the PIA 1 (G-364.1).
3052	<u>ALT PIA NOT USED IN COMPUTATIONS</u> - If the ALT PIA is entered on the G-364.1, it must be greater than the PIA 1 (G-364.1) and must be entered as the PIA used.
3053	<u>NET T2 MUST EQUAL REST AMT AND SP MIN</u> - If the EE had no post 36 earnings (G-364.1), then the net tier 2 (G-364.1) must equal the sum of the EE restored amount (G-364.1) and the spouse minimum amount (G-364.1).
3054	<u>AGE RED USED, W OVER AGE 65 ON OBD</u> - If a widow annuitant has an age reduced rate (G-364.1), her DOB (G-364) must show that she was

	under age 65 on her OBD (G-364).
3055	<u>EE T2 EQUALS 0, BUT NO WF RED SHOWN</u> - If the type of computation (G-364.1) is "1981 Amends", then the OBD tier 2 (G-364.1) must be greater than zero unless the EE's WF (G-364.1) caused a VDB reduction.
3056	<u>TAKEBACK USED, ORIG T2 LESS THAN \$10</u> - When the OBD (G-364) is after 11/30/84, a takeback reduction (G-364.1) can not apply if the tier 2 before takeback (G-364.1) is less than \$10.00.
3057	<u>TAKEBACK CODE CONFLICTS WITH ABD/DOD</u> - When the type of computation (G-364.1) is "1981 Amends", the basis of takeback (G-364.1) must be "no takeback" if: (1) the EE's DOD (G-364.1) was after 12/83 (D case), or (2) his ABD (G-364.1) was after 12/83 (A case).
3058	<u>TAKEBACK CODE CONFLICTS WITH T/B AMT</u> - If the basis of takeback (G-364.1) is coded "No Takeback", then there should be no entries in 12-83 4(g) takeback amount (G-364.1) or 12-84 4(g) takeback amount (G-364.1). If the basis of takeback is coded "EE Actual T/B", "E/E Fictional T/B", or "Survivor", then there must be an entry in at least one of the takeback boxes on the G-364.1.
3059	<u>\$10 GUARANTY CODE CONFLICTS WITH AMT</u> - The \$10 guaranty in tier 2 (G-364.1) can only apply if the tier 2 amount before takeback (G-364.1) is \$10.00 or greater.
3060	<u>DISCREPANCY IN CALCULATION OF T2</u> - If the rate effective date is after 11-30-83, then the T2 rate after the 12/83 takeback (G-364.1) should equal the rate before the 12/83 takeback (G-364.1) less the 12/83 takeback amount (G-364.1).
3061	<u>DISCREPANCY IN CALCULATION OF T2</u> - If the rate effective date is before 12-1-83, then the T2 rate after the 12/83 takeback (G-364.1) should equal the rate before the 12/83 takeback (G-364.1).
3062	<u>DISCREPANCY IN CALCULATION OF T2</u> - If the rate effective date is after 11-30-84 and the OBD (G-364) is before 12-1-84, then the T2 rate after the 12/84 takeback (G-364.1) should equal the pre-12/84 COL T2 rate (G-364.1) increased for the 12/84 tier 2 COL, less the 12/84 takeback amount (G364.1).
3063	<u>DISCREPANCY IN CALCULATION OF T2</u> - If the rate effective date is after 11-30-84 and the OBD (G-364) is after 11-30-84, then the T2 rate after the 12/84 takeback (G-364.1) should equal the pre-12/84 COL T2 rate (G-364.1) less the 12/84 takeback amount (G-364.1)./
3064	<u>NET T2 NOT EQUAL TO ITS COMPONENTS</u> - The net tier 2 (G-364.1)

	must equal the tier 2 COL Increase rate plus the equalized amount, the spouse minimum additional amount and the EE restored amount.
3065	<u>EE T2 EQUALS 0, BUT NO WF RED. SHOWN</u> - If the type of computation (G-364.1) is "1981 Amends", then the OBD tier 2 (G-364.1) must be greater than zero unless the EE's WF (G-364.1) caused a VDB reduction.
3066	<u>T2 RATE THRU 6/83 COL INCORRECT</u> - The tier 2 rate thru 6/83 (G-364.1) must not be greater than the gross tier 2 increased by the maximum COL percentage increase through 6/83 (3.53%). If the OBD (G-364) is after 5/83, no COL should be applied through 6/83.
3067	<u>TAKEBACK CODE CONFLICTS WITH OBD/DOD</u> - When the type of computation (G-364.1) is "1974 Act" or "Conversion", the basis of takeback (G-364.1) must be "no takeback" if the OBD (G-364) is after 12/83 and the EE's DOD (G-364.1) is before 1/84.
3068	<u>TAKEBACK CODE CONFLICTS WITH ABD/DOD</u> - When the type of computation (G-364.1) is "1981 Amends", the basis of takeback (G-364.1) must be "No Takeback" if: (1) the EE's DOD (G-364.1) was after 12/83 (D case), or (2) his ABD (G-364.1) was after 12/83 (A case).
3069	<u>TAKEBACK CODE CONFLICTS WITH T/B AMT</u> - If the basis of takeback (G-364.1) is coded "No Takeback," then there should be no entries in 12/83 4(g) takeback amount (G-364.1) or 12/84(g) takeback amount (G-364.1). If the basis of takeback is coded "EE actual T/B," "EE Fictional T/B," or "Survivor", then there must be an entry in at least one of the takeback boxes on the G-364.1.
3070	<u>\$10 GUARANTY CODE CONFLICTS WITH AMT</u> - The \$10 guaranty in tier 2 (G-364.1) can only apply if the tier 2 amount before takeback (G-364.1) is \$10.00 or greater.
3071	<u>DISCREPANCY IN CALCULATION OF T2</u> - If the rate effective date is after 11-30-83, then the T2 rate after the 12/83 takeback (G-364.1) should equal the rate before the 12/83 takeback (G-364.1) less the 12/83 takeback amount (G-364.1).
3072	<u>DISCREPANCY IN CALCULATION OF T2</u> - If the rate effective date is before 12-1-83, then the T2 rate after the 12/83 takeback (G-364.1) should equal the rate before the 12/83 takeback (G-364.1).
3073	<u>DISCREPANCY IN CALCULATION OF T2</u> - If the rate effective date is after 11-30-84 and the OBD (G-364) is before 12-1-84, then the T2 rate after the 12/84 takeback (G-364.1) should equal the pre-12/84 COL T2 rate (G-364.1) increased for the 12/84 tier 2 COL, less the 12/84 takeback amount (G364.1).

3074	<u>DISCREPANCY IN CALCULATION OF T2</u> - If the rate effective date is after 11-30-84 and the OBD (G-364) is after 11-30-84, then the T2 rate after the 12/84 takeback (G-364.1) should equal the pre-12/84 COL T2 rate (G-364.1) less the 12/84 takeback amount (G-364.1).
3075	<u>ORIGINAL BEGINNING DATE MISSING</u> - The OBD (G-364) must be entered.
3076	<u>ORIGINAL BEGINNING DATE MISSING</u> - The OBD (G-364) must be entered.
3077	<u>TAKEBACK USED, ORIG T2 LESS THAN \$10</u> - When the OBD (G-364) is after 11/30/84, a takeback reduction (G-364.1) cannot apply if the tier 2 before takeback (G-364.1) is less than \$10.00.
3080	<u>T2 COL INC AMT AFTER 84 IS INCORRECT</u> - The amount of the tier 2 increase entered in tier 2 COL increase amt. after 12/84 (G-364.1) must be consistent with the percentage increase based on the OBD (G-364) and the effective date (G-364.1) of the date break being computed.
3082	<u>T2 COL INC AMT AFTER 84 IS INCORRECT</u> - The \$10 guaranty (G-364.1) does not apply if the tier 2 after the 12/84 4(g) takeback (G-364.1) plus the cumulative post '84 COL Increase (G-364.1) is greater than \$10.00.
3083	<u>T2 COL INC AMT AFTER 84 IS INCORRECT</u> - The amount of the tier 2 increase entered in tier 2 COL increase amt. after 12/84 (G-364.1) must be consistent with the percentage increase based on the OBD (G-364) and the effective date (G-364.1) of the date break being computed.
3085	<u>T2 PLUS POST COL CONFLICTS WITH \$10 CD.</u> - The \$10 guaranty (G-364.1) does not apply if the tier 2 after the 12/84 4 (g) takeback (G-364.1) plus the cumulative post '84 COL increase (G-364.1) is greater than \$10.00.

COMPARISON EDITS

5001-5048 Employee comparison edits

6001-6029 Spouse comparison edits

7001-7025 Survivor comparison edits

These edits generally indicate a systems problem that must be investigated by analysts in the bureau of research and employment accounts. They are produced when data fields that should be identical in the Research, CHICO, and Rate History portions of the activity record are not. Occasionally a comparison edit may be produced in conjunction with other rate history edit rejects. Correcting the reason for the rate history edit reject should clear up the comparison edit as well.

RETIREMENT AND SURVIVOR DATE AND RECORD ID EDITS

These edits detect one of several possible errors involving date entries or the award form record identification numbers. They are numbered from 9001-9168. Most of these edits cause a payment reject. Edits that are identified with "(REF)" below the edit number may require corrective action but do not, of themselves, prevent payment.

- Invalid date. A date entry is invalid because either the month and year were transposed, the month entered was greater than 12, or the day was inappropriate for the month.
- The message INVALID VOUCHER BATCH RECORD DATE means that erroneous dates are appearing in the record because the Form G-180 batch record that accompanies each batch of manual award forms contained an invalid voucher date. No correction is required other than to resubmit the award.
- Date missing. A date that should have been entered was missing. This generally applies to rate or tier effective and ending dates.
- Form ID missing. Each award form has a unique two-digit number that is keyed as part of the award record. The numbers correspond to the circled codes in the accompanying forms items on Form G-357 and G-364. This edit occurs when the form ID is not present in the record but the form was "X"d as an attached form on the G-357 or G-364.

If the edit occurs because the form was not attached or was not keyed, the form may be added using ONCORR. If the edit occurs because the form ID itself was not keyed or the accompanying form indicator was checked in error, no corrective action should be required since those errors would have been corrected when the case was loaded onto ONCORR.

9001	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The accounting date in the CHICO activity record is invalid (employee or spouse). The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9003	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The date of the employee's last activity in the Research activity record is invalid. The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9004	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The employee's voucher date in the Research activity record is invalid. The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.

9005	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The initial award date in the employee's Research Activity record is invalid. The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9006	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The initial award date in the spouse's Research activity record is invalid. The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9007	<u>INVALID SUSP/TERM EFFECTIVE DATE</u> - The effective date of the spouse's suspension/termination in the Research activity record is invalid. Correct the entry on Form G-357.
9008	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The accounting date of the spouse's termination/suspension in the Research activity record is invalid. The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9009	<u>INVALID REGULAR WORK DED EFF DATE</u> - The effective date of the employee's regular work deductions in the Research activity record is invalid. Correct the entry on Form G-357.
9010	<u>INVALID REGULAR WORK DED EFF DATE</u> - The effective date of the spouse's regular work deductions in the Research activity record is invalid. Correct the entry on Form G-357.
9011	<u>INVALID WH RECOVERY DATE</u> - The withholding recovery date in the employee's Research activity record is invalid. Correct the entry on Form G-357.
9012	<u>INVALID WH RECOVERY DATE</u> - The withholding recovery date in the spouse's Research activity record is invalid. Correct the entry on Form G-357.
9013	<u>INVALID G-90 DATE</u> - The employee's G-90 date in the Research activity record is invalid. Correct the entry on Form G-357.
9014	<u>INVALID ACTUARIAL ADJ EFFECTIVE DATE</u> - The effective date of the actuarial adjustment in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357.
9015	<u>INVALID WAIVER EFFECTIVE DATE</u> - The effective date of the annuity waiver in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357.
9016	<u>INVALID REGULAR WORK DED EFF DATE</u> - The effective date of regular

	work deductions in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357.
9017	<u>INVALID PARTIAL WH EFFECTIVE DATE</u> - The partial withholding effective date in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357.
9018	<u>INVALID WH RECOVERY DATE</u> - The withholding recovery date in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357.
9019	<u>INVALID RATE EFFECTIVE DATE</u> - The effective date for the Rate History Reduction Record is invalid (employee and spouse). Correct the entries for the latest, 2nd latest, and/or 3rd latest rate effective dates on Form G-357.
9020	<u>INVALID RATE EFFECTIVE DATE</u> - The effective date for the Rate History rate record is invalid (employee and spouse). Correct the entries for the latest, 2nd latest, and/or 3rd latest rate effective dates on Form G-357.
9021	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The accounting date of the last activity in the Rate History activity record is invalid (employee and spouse). The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9022	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The voucher date in the Rate History activity record is invalid (employee and spouse). The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9023	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The accounting date of the initial award in the Rate History activity record is invalid (employee and spouse). The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9024	<u>INVALID G-90 DATE</u> - The G-90 date in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357.
9025	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The initial accounting date for the Supplemental Annuity in the Rate History activity record is invalid (employee). The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9026	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The accounting date for the current Supplemental Annuity award in the Rate History activity record is invalid (employee). The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.

9030	<u>INVALID ABD</u> - The ABD in the CHICO activity record is
(REF)	invalid (employee and spouse). This referral generally occurs on RASI partial awards. If it occurs on a manual award, correct the entry on Form G-357.
9031	<u>INVALID WD INSURED STATUS EFF DATE</u> - The date the employee is insured for work deductions in the Research activity record is invalid. Correct the entry on Form G-357a.
9032	<u>INVALID ABD</u> - The employee's ABD in the Research activity record is invalid. Correct the entry on Form G-357.
9033	<u>INVALID ABD</u> - The spouse's ABD in the Research activity record is invalid. Correct the entry on Form G-357.
9034	<u>INVALID TIER 1 DOE</u> - The Tier 1 DOE in the employee's Research activity record is invalid. Correct the entry on Form G-357a.
9035	<u>INVALID TIER 1 DOE</u> - The Tier 1 DOE in the spouse's Research activity record is invalid. Correct the entry on Form G-357a.
9036	<u>INVALID FILING DATE</u> - The employee's filing date in the Research activity record is invalid. Correct the entry on Form G-357a.
9037	<u>INVALID FILING DATE</u> - The spouse's filing date in the Research activity record is invalid. Correct the entry on Form G-357a.
9038	<u>INVALID DATE LAST WORKED-RR</u> - The employee's date last worked for a railroad in the Research activity record is invalid. Correct the entry on Form G-357a.
9039	<u>INVALID DATE LAST WORKED-LPS</u> - The employee's date last worked for a non-railroad employer in the Research activity record is invalid. Correct the entry on Form G-357a.
9040	<u>INVALID DATE LAST WORKED-LPS</u> - The spouse's date last worked for a non-railroad employer in the Research activity record is invalid. Correct the entry on Form G-357a.
9041	<u>INVALID DRR</u> - The employee's date rights relinquished in the Research activity record is invalid. Correct the entry on Form G-357a.
9042	<u>INVALID ADMIN FINALITY EFF DATE</u> - The administrative finality effective date in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357a.
9043	<u>INVALID DATE LAST WORKED - LPS</u> - The date last worked for a non-

	railroad employer in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357a.
9044	<u>INVALID WD INSURED STATUS EFF DATE</u> - The date the employee is insured for work deductions in the Rate History activity record is invalid. Correct the entry on Form G-357a.
9045	<u>INVALID DATE LAST WORKED - RR</u> - The employee's date last worked for a railroad in the Rate History activity record is invalid. Correct the entry on Form G-357a.
9046	<u>INVALID DRR</u> - The employee's date rights relinquished in the Rate History activity record is invalid. Correct the entry on Form G-357a.
9048	<u>INVALID ABD</u> - The ABD in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357.
9049	<u>INVALID TIER 1 DOE</u> - The Tier 1 DOE in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357a.
9050	<u>INVALID FILING DATE</u> - The filing date in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357a.
9051 (REF)	<u>INVALID VDB DOE</u> - The vested dual benefit date in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-354WF or G-355WF.
9052	<u>INVALID SUPP ANN CLOSING DATE</u> - The supplemental annuity closing date in the Rate History activity record is invalid. Correct the entry on Form G-357a.
9053	<u>INVALID WORKER'S COMP EFFECTIVE DATE</u> - The effective date of the employee's worker's compensation reduction in the Research activity record is invalid. Correct the entry on Form G-354.
9054	<u>INVALID WORKER'S COMP EFFECTIVE DATE</u> - The effective date of the employee's compensation reduction in the Rate History activity record is invalid. Correct the entry on Form G-354.
9055	<u>INVALID WORKER'S COMP TERM DATE</u> - The termination date of the employee's worker's compensation reduction in the Rate History activity record is invalid. Correct the entry on Form G-354.
9056	<u>INVALID SS BENEFIT TERM DATE</u> - The date of the employee's SS benefit termination in the Rate History activity record is invalid. Correct the entry on Form G-354.

9057	<u>INVALID TIER 1 EFFECTIVE DATE</u> - The employee's Tier 1 effective date in the Rate History activity record is invalid. Correct the entry on Form G-354.
9058	<u>INVALID TIER 1 ENDING DATE</u> - The employee's Tier 1 ending date in the Rate History activity record is invalid. Correct the entry on Form G-354.
9059	<u>INVALID TIER 2 EFFECTIVE DATE</u> - The employee's Tier 2 effective date in the Research activity record is invalid. Correct the entry on Form G-354.1 or G-354.1A.
9060	<u>INVALID TIER 2 EFFECTIVE DATE</u> - The employee's Tier 2 effective date in the Rate History activity record is invalid. Correct the entry on Form G-354.1 or G-354.1A.
9061	<u>INVALID TIER 2 ENDING DATE</u> - The employee's Tier 2 ending date in the Rate History activity record is invalid. Correct the entry on Form G-354.1 or G-354.1A.
9062	<u>INVALID VDB DOE</u> - The employee's vested dual benefit entitlement date in the Research activity record is invalid. Correct the entry on Form G-354WF.
9063	<u>INVALID VDB DOE</u> - The employee's vested dual benefit entitlement date in the Rate History activity record is invalid. Correct the entry on Form G-354WF.
9064	<u>INVALID VDB EFFECTIVE DATE</u> - The employee's vested dual benefit effective date in the Rate History activity record is invalid. Correct the entry on Form G-354WF.
9065	<u>INVALID VDB ENDING DATE</u> - The employee's vested dual benefit ending date in the Rate History activity record is invalid. Correct the entry on Form G-354WF.
9066	<u>INVALID EMPLOYER TAX CREDIT TERM DATE</u> - The employer tax credit termination date in the CHICO activity record is invalid. Correct the entry on Form G-354Sup.
9067	<u>INVALID SUPP ANN EFFECTIVE DATE</u> - The supplemental annuity effective date in the CHICO activity record is invalid. Correct the entry on Form G-354Sup.
9068	<u>INVALID SUPP ANN BEGINNING DATE</u> - The supplemental annuity beginning date in the Rate History activity record is invalid. Correct the entry on Form G-354Sup.
9069	<u>INVALID EMPLOYER TAX CREDIT TERM DATE</u> - The employer tax credit termination date in the Rate History activity record is invalid. Correct the entry on Form G-354 Sup.

9070	<u>INVALID SUPP ANN EFFECTIVE DATE</u> - The supplemental annuity rate effective date in the Rate History activity record is invalid. Correct the entry on Form G-354Sup.
9071	<u>INVALID SUPP ANN ENDING DATE</u> - The supplemental annuity rate ending date in the Rate History activity record is invalid. Correct the entry on Form G-354Sup.
9072	<u>INVALID O/M SPOUSE DOB</u> - The spouse's date of birth in the employee's Research activity record is invalid. Correct the entry on Form G-354.3.
9073	<u>INVALID IPI DOB</u> - An IPI's DOB in the Research activity record is invalid. Correct the entry on Form G-354.3.
9074	<u>INVALID O/M RATE EFFECTIVE DATE</u> - The O/M rate effective date in the Rate History activity record is invalid. Correct the entry on Form G-354.3.
9075	<u>INVALID O/M RATE ENDING DATE</u> - The O/M rate ending date in the Rate History activity record is invalid. Correct the entry on Form G-354.3.
9076	<u>INVALID WORKER'S COMP EFFECTIVE DATE</u> - The spouse's effective date of worker's compensation reduction in the Research activity record is invalid. Correct the entry on Form G-355.
9077	<u>INVALID TIER 1 TERM EFFECTIVE DATE</u> - The effective date of the spouse's Tier 1 termination in the Rate History activity record is invalid. Correct the entry on Form G-355.
9078	<u>INVALID WORKER'S COMP EFFECTIVE DATE</u> - The effective date of the spouse's worker's compensation reduction in the Rate History activity record is invalid. Correct the entry on Form G-355.
9079	<u>INVALID WORKER'S COMP TERM DATE</u> - The termination date of the spouse's workers compensation reduction in the Rate History activity record is invalid. Correct the entry on Form G-355.
9080	<u>INVALID SS BENEFIT TERM DATE</u> - The date of the spouse's SS benefit termination in the Rate History activity record is invalid. Correct the entry on Form G-355.
9081	<u>INVALID TIER 1 EFFECTIVE DATE</u> - The spouse's Tier 1 effective date in the Rate History activity record is invalid. Correct the entry on Form G-355.
9082	<u>INVALID TIER 1 ENDING DATE</u> - The spouse's Tier 1 ending date in the Rate History activity record is invalid. Correct the entry on Form G-355.
9083	<u>INVALID TIER 2 RESTORATION EFF DATE</u> - The spouse's Tier 2 restoration

	date in the Research activity record is invalid. Correct the entry on Form G-355.1 or G-355.1B.
9084	<u>INVALID WAIVER EFFECTIVE DATE</u> - The spouse's waiver effective date in the Rate History activity record is invalid. Correct the entry on Form G-357.
9085	<u>INVALID TIER 2 RESTORATION EFF DATE</u> - The spouse's Tier 2 restoration date in the Rate History activity record is invalid. Correct the entry on Form G-355.1 or G-355.1B.
9086	<u>INVALID TIER 2 EFFECTIVE DATE</u> - The spouse's Tier 2 effective date in the Rate History record is invalid. Correct the entry on Form G-355.1 or G-355.1B.
9087	<u>INVALID TIER 2 ENDING DATE</u> - The spouse's Tier 2 ending date in the Rate History activity record is invalid. Correct the entry on Form G-355.1 or G-355.1B.
9088	<u>INVALID VDB DOE</u> - The spouse's vested dual benefit entitlement date in the Research activity record is invalid. Correct the entry on Form G-355WF.
9089	<u>INVALID VDB DOE</u> - The spouse's vested dual benefit entitlement date in the Rate History activity record is invalid. Correct the entry on Form G-355WF.
9091	<u>INVALID VDB EFFECTIVE DATE</u> - The spouse's vested dual benefit effective date in the Rate History activity record is invalid. Correct the entry on Form G-355WF.
9092	<u>INVALID VDB ENDING DATE</u> - The spouse's vested dual benefit ending date in the Rate History activity record is invalid. Correct the entry on Form G-355WF.
9093	<u>INVALID DATE OF BIRTH</u> - The survivor's DOB in the Rate History activity record is invalid. Correct the entry on Form G-364.
9094	<u>INVALID ADMIN FINALITY EFFECTIVE DATE</u> - The survivor's administrative finality effective date in the Rate History activity record is invalid. Correct the entry on Form G-364.
9095 (REF)	<u>INVALID SSA DOE</u> - The survivor's social security date of current entitlement in the Rate History activity record is invalid. This referral should not be produced.
9096	<u>INVALID PARTIAL WH EFFECTIVE DATE</u> - The survivor's effective date of the partial withholding in the Rate History activity record is invalid. Correct the entry on Form G-364.
9097	<u>INVALID RATE EFFECTIVE DATE</u> - The effective date of the survivor's

	reduction record in the Rate History activity record is invalid. Correct the entries for the latest, 2nd latest, and/or 3rd latest rate effective dates on Form G-364.1 or the entry on Form G-364 for cert codes 2 and 5.
9098	<u>INVALID WH RECOVERY DATE</u> - The survivor's partial withholding recovery date in the Rate History activity record is invalid. Correct the entry on Form G-364.
9099	<u>INVALID ACTUARIAL ADJ EFFECTIVE DATE</u> - The survivor's effective date of actuarial adjustment in the Rate History activity record is invalid. Correct the entry on Form G-364.
9100	<u>INVALID WAIVER EFFECTIVE DATE</u> - The survivor's effective date for annuity waiver in the Rate History activity record is invalid. Correct the entry on Form G-364.
9101	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The voucher date in the survivor's Rate History activity record is invalid. The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9102	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The activity accounting date in the survivor's Rate History activity record is invalid. The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9103	<u>INVALID OBD</u> - The survivor's OBD in the Rate History activity record is invalid. Correct the entry on Form G-364.
9104	<u>INVALID TIER 1 BEGINNING DATE</u> - The survivor Tier 1 beginning date in the Rate History activity record is invalid. Correct the entry on Form G-364.
9105	<u>INVALID SUSP/TERM EFFECTIVE DATE</u> - The survivor's termination/suspension effective date in the Rate History record is invalid. Correct the entry on Form G-364.
9106	<u>INVALID DATE OF DEATH</u> - The employee's DOD in the survivor's Rate History activity record is invalid. Correct the entry on Form G-364.
9107	<u>INVALID RATE EFFECTIVE DATE</u> - The survivor's Tier 1 effective date in the Rate History activity record is invalid. Correct the entry on Form G-364.1.
9108	<u>INVALID RATE ENDING DATE</u> - The survivor's Tier 1 ending date in the Rate History activity record is invalid. Correct the entry on Form G-364.1.
9109	<u>INVALID RATE EFFECTIVE DATE</u> - The survivor's Tier 2 effective date in the Rate History activity record is invalid. Correct the entry on Form G-364.1.

9110	<u>INVALID RATE ENDING DATE</u> - The survivor's Tier 2 ending date in the Rate History activity record is invalid. Correct the entry on Form G-364.1.
9111	<u>INVALID RATE EFFECTIVE DATE</u> - The survivor's vested dual benefit effective date in the Rate History activity record is invalid. Correct the entry on Form G-364.1.
9112	<u>INVALID RATE ENDING DATE</u> - The survivor's vested dual benefit ending date in the Rate History activity record is invalid. Correct the entry on Form G-364.1.
9113	<u>INVALID RATE EFFECTIVE DATE</u> - The survivor's rate effective date in the Rate History activity record is invalid. Correct the entries for the latest, 2nd latest, and/or 3rd latest rate effective dates on Form G-364.1 or the entry on Form G-364 for cert codes 2 and 5.
9114	<u>INVALID RATE ENDING DATE</u> - The survivor's rate ending date in the Rate History activity record is invalid. Correct the entry on Form G-364.1.
9115	<u>INVALID YEAR OF ELIGIBILITY</u> - The employee's year of eligibility in the survivor's Rate History activity record is invalid. Correct the entry on Form G-364.1.
9117	<u>INVALID RIB/DIB DOE</u> - The survivor's vested dual benefit entitlement date in the Rate History activity record is invalid. Correct the entry on Form G-364.1.
9118	<u>INVALID TIER 1 TERM EFF DATE</u> - The survivor's Tier 1 termination date in the Rate History activity record is invalid. Correct the entry on Form G-364.1.
9119	<u>INVALID SUPP ANN CLOSING DATE</u> - The supplemental annuity closing date in the Research activity record is invalid. Correct the entry on Form G-357a.
9120	<p><u>TIER 1 FORM ID NO. MISSING</u> - The employee's Tier 1 record ID for the Rate History activity record is missing. The Tier 1 form ID (03) or effective date is missing, but the G-354 was checked as an accompanying form on the G-357.</p> <p>If the message was produced because Form G-354 was not attached but should have been, or because the data from the form was not keyed, the form can be added using ONCORR. If the message was produced because the form ID itself was not keyed or the accompanying form indicator was checked in error, no corrective action should be required, since the errors would have been corrected when the case was loaded onto ONCORR.</p>
9121	<u>TIER 1 EFFECTIVE DATE MISSING</u> - The employee's Tier 1 effective date in

	the Rate History activity record is missing. Correct the entry on Form G-354.
9122	<u>TIER 1 ENDING DATE MISSING</u> - The employee's Tier 1 ending date in the Rate History activity record is missing. Correct the entry on Form G-354.
9123	<p><u>TIER 2 FORM ID NO MISSING</u> - The employee's Tier 2 record ID for the Rate History activity record is missing. The Tier 2 form ID (04 or 05) or effective date is missing, but Form G-354.1 or G-354.1A was checked as an accompanying form on the G-357.</p> <p>If the message was produced because Form G-354.1 or G-354.1A was not attached but should have been, or because the data from the form was not keyed, the form can be added using ONCORR. If the message was produced because the form ID itself was not keyed or the accompanying form indicator was checked in error, no corrective action should be required, since those errors would have been corrected when the case was loaded onto ONCORR.</p>
9124	<u>TIER 2 EFFECTIVE DATE MISSING</u> - The employee's Tier 2 effective date in the Rate History activity record is missing. Correct the Form G-354.1 or G-354.1A entry.
9125	<u>TIER 2 ENDING DATE MISSING</u> - The employee's Tier 2 ending date in the Rate History activity record is missing. Correct the entry on Form G-354.1 or G-354.1A.
9126	<p><u>VDB FORM ID NUMBER MISSING</u> - The employee's windfall record ID for the Rate History activity record is missing. The VDB form ID (06) or effective date is missing but the G-354WF was checked as an accompanying form on the G-357.</p> <p>If the message was produced because Form G-354WF was not attached but should have been, or because the data from the form was not keyed, the form can be added using ONCORR. If the message was produced because the form ID itself was not keyed or the accompanying form indicator was checked in error, no corrective action should be required, since those errors would have been corrected when the case was loaded onto ONCORR.</p>
9127	<u>VDB EFFECTIVE DATE MISSING</u> - The employee's vested dual benefit effective date in the Rate History activity record is missing. Correct the entry on Form G-354WF.
9128	<u>VDB ENDING DATE MISSING</u> - The employee's vested dual benefit ending date in the Rate History activity record is missing. Correct the entry on Form G-354WF.
9129	<u>SUPP ANN FORM ID NO MISSING</u> - The SUP history record ID for the Rate History activity record is missing. The SUP form ID (08) or effective date is

	<p>missing, but the G-354SUP was checked on the G-357.</p> <p>If the message was produced because Form G-354 Sup was not attached but should have been, or because the data from the form was not keyed, the form can be added using ONCORR. If the message was produced because the form ID itself was not keyed or the accompanying form indicator was checked in error, no corrective action should be required, since those errors would have been corrected when the case was loaded onto ONCORR.</p>
9130	<u>SUPP ANN EFFECTIVE DATE MISSING</u> - The supplemental annuity rate effective date in the Rate History activity record is missing. Correct the entry on Form G-354 Sup.
9131	<u>SUPP ANN ENDING DATE MISSING</u> - The supplemental annuity rate ending date in the Rate History activity record is missing. Correct the entry on Form G-354 Sup.
9132	<p><u>O/M FORM ID NO. MISSING</u> - The O/M record ID for the Rate History activity record is missing. The O/M form ID (07) is missing, but the G-354.3 was checked as an accompanying form on the G-357.</p> <p>If the message was produced because Form G-354.3 was not attached but should have been, or because the data from the form was not keyed, the form can be added using ONCORR. If the message was produced because the form ID itself was not keyed or the accompanying form indicator was checked in error, no corrective action should be required, since those errors would have been corrected when the case was loaded onto ONCORR.</p>
9134	<u>O/M RATE ENDING DATE MISSING</u> - The O/M rate ending date in the Rate History activity record is missing. Correct the entry on Form G-354.3.
9135	<p><u>TIER 1 FORM ID NO. MISSING</u> - The spouse's Tier 1 record ID for the Rate History activity record is missing. The Tier 1 form ID (10) or effective date is missing, but the G-355 was checked as an accompanying form on the G-357.</p> <p>If the message was produced because Form G-355 was not attached but should have been, or because the data from the form was not keyed, the form can be added using ONCORR. If the message was produced because the form ID itself was not keyed or the accompanying form indicator was checked in error, no corrective action should be required, since those errors would have been corrected when the case was loaded onto ONCORR.</p>
9136	<u>TIER 1 EFFECTIVE DATE MISSING</u> - The spouse's Tier 1 effective date in the Rate History activity record is missing. Correct the entry on Form G-355.
9137	<u>TIER 1 ENDING DATE MISSING</u> - The spouse's Tier 1 ending date in the Rate History activity record is missing. Correct the entry on Form G-355.

9138	<p><u>TIER 2 FORM ID NO. MISSING</u> - The spouse's Tier 2 record ID for the Rate History activity record is missing. The Tier 2 form ID (11 or 14) or effective date is missing, but either the G-355.1 or G-355.1B was checked as an accompanying form on the G-357(47).</p> <p>If the message was produced because Form G-355.1 or G-355.1B was not attached but should have been, or because the data from the form was not keyed, the form can be added using ONCORR. If the message was produced because the form ID itself was not keyed or the accompanying form indicator was checked in error, no corrective action should be required, since those errors would have been corrected when the case was loaded onto ONCORR.</p>
9139	<p><u>TIER 2 EFFECTIVE DATE MISSING</u> - The spouse's Tier 2 effective date in the Rate History record is missing. Correct the entry for Form G-355.1 or G-355.1B.</p>
9140	<p><u>TIER 2 ENDING DATE MISSING</u> - The spouse's Tier 2 ending date in the Rate History activity record is missing. Correct the entry on Form G-355.1 or G-355.1B.</p>
9141	<p><u>VDB FORM ID NUMBER MISSING</u> - The spouse's windfall record ID for the Rate History activity record is missing. The VDB form ID (12) or effective date is missing but the G-355WF was checked as an accompanying form on the G-357.</p> <p>If the message was produced because Form G-355WF was not attached but should have been, or because the data from the form was not keyed, the form can be added using ONCORR. If the message was produced because the form ID itself was not keyed or the accompanying form indicator was checked in error, no corrective action should be required, since these errors would have been corrected when the case was loaded onto ONCORR.</p>
9142	<p><u>VDB EFFECTIVE DATE MISSING</u> - The spouse's vested dual benefit effective date in the Rate History activity record is missing. Correct the entry on Form G-355WF.</p>
9143	<p><u>VDB ENDING DATE MISSING</u> - The spouse's vested dual benefit ending date in the Rate History activity record is missing. Correct the entry on Form G-355WF.</p>
9144	<p><u>RATE EFFECTIVE DATE MISSING</u> - The survivor's Tier 1 effective date in the Rate History activity record is missing. Correct the entry on Form G-364.1.</p>
9145	<p><u>RATE ENDING DATE MISSING</u> - The survivor's Tier 1 ending date in the Rate History activity record is missing. Correct the entry on Form G-364.1.</p>

9146	<u>RATE EFFECTIVE DATE MISSING</u> - The survivor's Tier 2 effective date in the Rate History activity record is missing. Correct the entry on Form G-364.1.
9147	<u>RATE ENDING DATE MISSING</u> - The survivor's Tier 2 ending date in the rate History activity record is missing. Correct the entry on Form G-364.1.
9148	<u>RATE EFFECTIVE DATE MISSING</u> - The survivor's vested dual benefit effective date in the Rate History activity record is missing. Correct the entry on Form G-364.1.
9149	<u>RATE ENDING DATE MISSING</u> - The survivor's vested dual benefit ending date in the Rate History activity record is missing. Correct the entry on Form G-364.1.
9150	<u>RATE EFFECTIVE DATE MISSING</u> - The survivor's rate effective date in the Rate History activity record is missing. Correct the entry on Form G-364.1.
9151	<u>RATE ENDING DATE MISSING</u> - The survivor's rate ending date in the Rate History activity record is missing. Correct the entry on Form G-364.1.
9152	<u>INVALID NCSP EFFECTIVE DATE</u> - The employee's effective date of noncovered service pension in the Research record is invalid. Correct the entry on Form G-354.
9153	<u>INVALID LPS WORK DED EFFECTIVE DATE</u> - The employee's effective date of LPS work deductions in the Research activity record is invalid. Correct the entry on Form G-357.
9154	<u>INVALID SUSP/TERM EFFECTIVE DATE</u> - The employee's effective date of termination/suspension in the Research activity record is invalid. Correct the entry on Form G-357.
9155	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The employee's accounting date of termination/suspension in the Research activity record is invalid. The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9156	<u>INVALID LPS WORK DED EFFECTIVE DATE</u> - The spouse's effective date of the work deductions in the Research activity record is invalid. Correct the entry on Form G-357.
9157	<u>INVALID LPS WORK DED EFFECTIVE DATE</u> - The effective date of LPS work deductions in the Rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357.
9158	<u>INVALID SUSP/TERM EFFECTIVE DATE</u> - The effective date of termination/suspension in the Rate History activity record is invalid (employee

	and spouse). Correct the entry on Form G-357.
9159	<u>INVALID VOUCHER BATCH RECORD DATE</u> - The accounting date of the termination/suspension in the Rate History activity record is invalid (employee and spouse). The Form G-180 batch record contained an invalid date. No corrective action is required other than to resubmit the award.
9160	<u>INVALID DATE LAST WORKED - RR</u> - The spouse's date last worked for a railroad in the Research activity record is invalid. Correct the entry on Form G-357a.
9161	<u>INVALID ADMIN FINALITY ORIGINAL DOB</u> - The administrative finality DOB in the rate History activity record is invalid (employee and spouse). Correct the entry on Form G-357a.
9162	<u>INVALID DATE LAST WORKED - RR</u> - The spouse's date last worked for a railroad in the Rate History activity record is invalid. Correct the entry on Form G-357a.
9163	<u>INVALID NCSP EFFECTIVE DATE</u> - The employee's effective date of non-covered service pension in the Rate History activity record is invalid. Correct the entry on Form G-354.
9164	<u>INVALID ADMIN FINALITY ORIGINAL DOB</u> - The survivor's administrative finality DOB in the Rate History activity record is invalid. Correct the entry on Form G-364.
9165	<u>INVALID REG WD TERM EFF DATE</u> - The employee's regular WD termination effective date in the Rate History Activity record is invalid. Correct the entry on Form G-357.
9166	<u>INVALID LPE WD TERM EFF DATE</u> - The employee's LPE WD termination effective date in the Rate History Activity record is invalid. Correct the entry on Form G-357.
9167	<u>INVALID SP PUB PEN EFF DATE</u> - The spouse's public pension effective date in the Rate History Activity record is invalid. Correct the entry on Form G-357.
9168	<u>INVALID SUR PUB PEN EFF DATE</u> - The survivor's public pension effective date in the Rate History Activity record is invalid. Correct the entry on Form G-364.

Appendix C - ONCORR Edit Messages

The following edit messages are displayed on the award form correction screens when an error is detected. (Error messages for other screens are explained in the text.) For

messages that contain variable data, the basic format of the message is shown below with the variable data in parentheses and an example following.

1. Individual item edits. These messages apply to the screen being updated. They may appear when the examiner attempts to update the screen by pressing ENTER, a PF key to go to another screen within the form, PF22 (FORM SELECT), PF23 (REJECT REASON) or PF24 (DONE). The erroneous data will be highlighted in red and the cursor positioned underneath it.

MESSAGES	MEANING
ADDRESS DOES NOT CONTAIN GROUP MARK	A group mark (SHIFT and "1" on the terminal keyboard) must be entered in the second line of the address.
INVALID DATA. MUST BE NUMERIC	Non-numeric data was entered in a field that should be numeric.
INVALID DATE ENTRY	The month entered is greater than 12 or the date is not appropriate for the month.
INVALID ENTRY. CODE SHOULD BE BLANK OR X	If the highlighted item applies, the appropriate entry is an "X". If it does not apply, it should be left blank.
INVALID ENTRY. CODE SHOULD BE BLANK, Y, or N	The appropriate entry for the highlighted item is a "Y" or "N". The item may also be left blank.
(ITEM NAME) CANNOT EXCEED (SOME NUMBER OR AMOUNT)	The item entry cannot exceed the number or amount specified.
EXAMPLE: SUP ANNUITY RATE CANNOT EXCEED \$70.00	
(ITEM NAME) INVALID	The code entered was not in the acceptable range of values for that item.
EXAMPLE: BIC CD INVALID	
(ITEM NAME) MAY NOT BE ZEROS	The item cannot be completed with zeros. If no entry is required leave the item blank.
EXAMPLE: OTHER RECOVERY CLAIM NO. MAY NOT BE ZEROS.	

(ITEM NAME) MUST BE (SOME VALUE)	The item entry must be one of the values shown.
EXAMPLE: PAYEE CODE MUST BE NUMERIC, 01 THRU 09	
(ITEM NAME) MUST NOT BE BLANK	The item must be completed.
EXAMPLE: PREFIX MUST NOT BE BLANK	

2. Relational edits. These messages apply to the screen being updated only if both items that are being edited are on that screen. In that case, the erroneous item(s) will be highlighted in red and corrections will not be updated to the screen until the error(s) are corrected.

If the error message appears after PF24 (DONE) is pressed, and the items involved are not both on the screen the examiner is on, the examiner may move to the item(s) that require correction and the corrections made to the screen he is leaving will be updated. To correct the error, the examiner may have to go to another screen within the form or another form within the award. The message will identify which form has the error.

For survivor awards, a payee code is displayed at the beginning of the error message. When PF24 is pressed, all payees paid with one award form set are edited at the same time and any resulting error messages may apply to any members of the family group, not just to the payee to which the screen applies.

MESSAGES	MEANING
ACCOMPANYING FORMS NOT CONSISTENT WITH AWARD	The accompanying forms "X"d on Form G-357 or G-364 do not agree with the forms that were keyed.
BENEFICIARY SYMBOL AND PAYEE CODE INCONSISTENT	The beneficiary symbol does not agree with the payee code, e.g., the beneficiary symbol is "M" and the payee code is "1.
BENEFICIARY'S OWN SSN MUST NOT BE THE SAME AS EE'S SSN	On a survivor award, the beneficiary's own social security number must be different from the employee's.
BOTH (ITEM NAME) AND (ITEM NAME) MUST HAVE ENTRIES OR BE BLANK	Both items must either be completed or left blank. One cannot be completed without the other being completed.

EXAMPLE: BOTH TAX REFUND CODE AND AMOUNT MUST HAVE ENTRIES OR BE BLANK	
CLAIM NO. OR EMPLOYEE SSA NO. MUST BE ENTERED	The claim number and the employee's social security number cannot be left blank. One or both must be completed.
EITHER (FORM NO.) OR(FORM NO.) MUST BE DELETED	More than one tier 2 input sheet cannot be attached to the award.
EXAMPLE: EITHER G-355.1B OR G-355.1 MUST BE DELETED	
FORM (NO.) CANNOT BE CREATED UNLESS FORM (NO.) IS DELETED	More than one tier 2 input sheet cannot be attached to the award.
EXAMPLE: FORM G-354.1A CANNOT BE CREATED UNLESS FORM G-354.1 IS DELETED.	
IF (ITEM NAME) IS (SOME VALUE), (ITEM NAME) MUST BE (SOME VALUE)	One item must have a certain value, if another item has a certain value.
EXAMPLE: IF THE ACC/OP AMOUNT IS NOT ZERO, THE ACC/OP CODE MUST BE 1 OR 2	
IF (ITEM NAME) IS (SOME VALUE), (ITEM NAME) MUST BE ENTERED	One item must be completed if another item has a certain value.
EXAMPLE: IF TYPE CERT IS NOT 1, LAST MONTHLY RATE SHOULD BE BLANK	
IF (ITEM NAME) IS (SOME VALUE), (ITEM NAME) SHOULD BE BLANK	One item must be blank if another item has a certain value.
EXAMPLE: IF TYPE CERTIS NOT 1, LAST MONTHLY RATE SHOULD BE BLANK	
(ITEM NAME) MUST BE (SOME RELATIONSHIP) TO (ITEM NAME)	The relationship of two item (e.g., same as, greater than) is specified.
EXAMPLE: G-364.1 CLAIM NO. MUST BE THE SAME AS G-364 CLAIM NO.	

(ITEM NAME) OR (ITEM NAME), BUT NOT BOTH, MAY BE ENTERED	Only one of the items named may be completed.
EXAMPLE: G-354.1 OR G-354.1A, BUT NOT BOTH, MAY BE ENTERED.	
NET AMOUNT PAID INCONSISTENT	ONCORR performs the same edit routine as DAISY (see reject message 0089). Depending on the source of the error the message will display either the net amount paid computed by ONCORR or state that non-numeric data was found on Form G-357 or G-364.
NET ANN RATE MUST EQUAL TOTAL RR OR O/M RATE LESS DEDUCTIONS	On Form G-357, the net annuity rate must equal the total RR rate, or O/M rate, if applicable, less any work deduction adjustment, legal process/partition deduction, assignment/nonpartition deduction, actuarial adjustment, waiver deduction, or partial withholding.
PAID THRU DATE ERROR	(See RCM 9.12.28 for an explanation of the "paid thru date" edits.)
TIER SUMMARY TOTAL INCONSISTENT	ONCORR performs the same edit routine as DAISY (see reject message 0088). Depending on the source of the error, the message will display either the tier summary total computed by ONCORR, or state that Form G-369 was not found or that non-numeric data was found on Forms G-357, G-364, or G-369.

Appendix D - Function Keys On Standard Terminals And PC Terminals

TERMINAL KEY	FUNCTION	PC KEY
PA1	Return to the REJECT SELECTION screen	PG UP
PA2	Exit Application	PG DN
PF3	Go to the REJECT/REFERRAL REASONS screen in the correction mode	F3

PF4	Delete an award (REJECT SELECTION screen)	F4
PF5	Go to the REJECT/REFERRAL REASONS screen in the view mode	F5
PF6	Go to the REJECT/REFERRAL REASONS screen in the authorization mode	F6
PF7	Page backward	F7
PF8	Page forward	F8
PF9	Reopen an award (REJECT SELECTION screen) or view balance control amounts (REJECT/REFERRAL REASONS screen)	F9
PF10	Go to the REASSIGN/EXAMINER AUTHORIZER NUMBER screen	F10
PF11	Go to the first screen of an award form	F11
PF12	Go to the second screen of an award form	F12
PF13	Go to the third screen of an award form	SHIFT and F1
PF14	Go to the fourth screen of an award form	SHIFT and F2
PF15	Go to the fifth screen of an award form	SHIFT and F3
PF16	Go to the sixth screen of an award form	SHIFT and F4
PF17	Go to the seventh screen of an award form	SHIFT and F5
PF18	Go to the eighth screen of an award form	SHIFT and F6
PF19	Go to the ninth screen of an award form	SHIFT and F7
PF20	Go to the tenth screen of an award form	SHIFT and F8
PF21	Go to the eleventh screen of an award form	SHIFT and F9

PF22	Go to the FORM SELECTION screen	SHIFT and F10
PF23	Go to the REJECT/REFERRAL REASONS screen	SHIFT and F11
PF24	Award correction or authorization is complete	SHIFT and F12
CLEAR	Return to previous record level	PAUSE
ENTER	Process selection	ENTER KEY on number pad
SHIFT AND 1	Bar character used as group / (right-hand mark in address bracket)	
PRINT	Make a print of the screen you are viewing	Hold down SHIFT plus ESC plus PRINT screen

9.13.1 General Information About KORFORMS

The Key Operating Report (KOR) manual activity KEY/MASTER screens "KORFORMS" replace the Form G-660, "Receipt Code Sheet" and Form G-661, "Disposition Code Sheet." These screens are used by Operations to manually enter "Receipt" and "Disposition" records into the monthly KOR run. A KORFORMS batch may include both "Receipt" and "Disposition" records.

Using KEY/MASTER, data can be edited for basic content accuracy at the time of input, thus preventing some input rejects. The KORFORMS batches are held on the KEY/MASTER facility until 5:30 p.m. on the last workday of each month. The batches are extracted at 5:30 p.m. on the last workday of the month for processing into the next KOR run, which is scheduled to run on the next business day.

Once the KORFORMS batches are extracted, they are reviewed by the Records Analysis and Systems section and deleted from KEY/MASTER. The KORFORMS batches are saved on tape in the event a KOR rerun is needed.

9.13.2 Accessing Key/Master

To access the system:

- A. Sign on to TPX as usual.
- B. Use your assigned PF key or type an "s" next to KEYPROD
- C. On the Keymaster screen, hit enter
- D. On the Operator Commands screen, type "ENT" on the the commands line and "KORFORMS" on the Application Name Line.
- E. Hit enter twice

9.13.3 KORFORMS Data Entry Screens

Access "KORFORMS" from the TPX menu by selecting "KEYPROD" with the PF key explained in RCM 9.13.2. The KEY/MASTER screen will appear.

- A. Creating a KORFORMS Batch - If you are creating or correcting a KORFORMS batch, go directly to the KORFORMS data entry operator (DEO) screen. To do this, leave the "Supervisor Code" and "Command" blank and press "Enter."

This will take you to the next screen. To create a new batch, on the command line, type "ENT." Enter the application name "KORFORMS" on the application name line, then press the ENTER key. The next screen will display the batch number and security code for that batch. Write them down as a future reference.

should you need to adjust the batch. Then press the ENTER key. The "Receipts" screen for KORFORMS will appear. If this is not the screen that you want, use PF-2 to select the other KORFORMS screen, "Dispositions." The menu is displayed at the bottom of the screen. Refer to RCM 9.13.10 for instructions on correcting data if you start on the wrong screen.

When all of the required items on the screen are completed, press ENTER. The ENTER key will cause the information to write off to your KORFORMS batch. The screen will refresh to allow a new record for that screen. If you need a different KORFORMS screen at any time, use the appropriate PF key to request the KORFORMS screen that you need.

Refer to the command line at the top of each KORFORMS screen. The number of records that have been entered into the batch are indicated after "E:" and the record number of the current screen for that batch is indicated after the "C:" symbol. Although there is no limit for the number of records in a batch, we suggest that you limit your batches to no more than 100 records.

- B. Accessing an Existing KORFORMS Batch - If you are accessing an existing KORFORMS batch to correct a record or to add new records to that batch, on the command line, type "ENT." Always TAB past the "Application Name" line to leave it blank. Type the batch number. Tab to the next line and type the security code. Then press the ENTER key. The last KORFORMS record entered for that batch will appear. Press the ENTER key. The screen will refresh to allow a new record entry for the same screen. If this is not the screen that you need, use the appropriate PF key to request the KORFORMS screen that you need. The KORFORMS menu is displayed at the bottom of each screen.

RCM 9.13.10 explains the commands to use to correct a record in the batch.

9.13.4 General Information About Receipts

The receipt of most employee and spouse applications is recorded through mechanical processing. Survivor AA-21 applications are coded in by APPLE. All initial survivor annuity applications and all reactivated applications (retirement and survivor) are manually coded in on KORFORMS. When an application is coded in as a receipt, either as an initial or as a reactivation, it is counted among the pending cases until it is coded out as being paid, denied or closed without award.

The receipt of SSA initial and reactivated awards is coded through SOLAR. However, when more than one SSA SOLAR award is received for the same payee, the system will only code in the first application. The other SSA SOLAR award must be coded in manually on KORFORMS. Any SSA payment set up by Operations must also be coded in on KORFORMS. When a SSA SOLAR award is coded in, it is counted among the pending cases until it has been paid or closed without award.

Do not code in "Supplemental" applications since they are only additions to the original application. When reactivating an application, code it in under the same application type code (APPL TYPE CD) and number or SSA benefit type code (BEN TYPE CD) and number previously assigned to it. Only the status code (APPL STAT CD) changes on a reactivated application. 3.

9.13.5 Folder Record Of Receipt Coding Action

You may print out a copy of any KORFORMS screen, other than the supervisor screen, with the EXTRA! "PRINT SCREEN" commands. A copy of the KORFORMS receipt coding is not on the annuity application. When necessary, use the KOR monthly pending list to verify the APPLE, RASI, or KORFORMS receipt coding

9.13.6 Coding Receipts On KORFORMS

The "Receipt Code Sheet" screen will appear when you begin a new KORFORMS batch. PF1 can also be used to move to this screen. The cursor moves automatically after each of your typed entries. If you leave an item blank, use the "Tab" key to move the cursor. The activity code will be entered into the record mechanically by KORFORMS when you complete your entries and press enter.

RECEIPT CODE SHEET		ACTIVITY CODE = 07	
1. PREFIX _	2. CLAIM # ____ - ____ - ____		
3. RECEIPT DTE ____	4. APPL\BEN TYPE CD ____		
5. APPL\BEN NUM ____	6. BEN SS NUM ____ - ____ - ____		
7. APPL STAT CD _	8. FO NUMBER ____	9. HOW FILED _	
10. APPL ENTR DTE ____	11. APPL REL DTE ____		
12. DOB DTE ____	13. ABD\OBD DTE ____		

INSTRUCTIONS FOR DATA ENTRY:

1. PREFIX - Type the alphabetical prefix "A," or "D".
2. CLAIM NUMBER - Enter the RRB claim number. If the claim number is six digits or less, enter zeros in the first three spaces.
3. RECEIPT DATE (MM/DD/CC/YY) – Always complete this item. Use preceding zeroes in any unused boxes. The receipt date is:

- a. New Applications - Enter the application filing date.
 - b. Reactivated Application - Enter the coding date.
 - c. SSA application for survivor benefits - Enter date received in the RRB mailroom.
 - d. Disabled IPI or Medicare Only Child - Enter the date of the Form AA-19A for the disabled retirement child.
 - e. SSA PAM or SOLAR award - Enter the date the SSA award was transmitted to the RRB (SSA Run Date).
4. APPL/BEN TYPE CD - Always complete this item. A comparison to the old KOR Type of Application code is at the end of this document (Appendix A).

APPL/BEN TYPE CD	RRB Application or SSA Benefit
11	AA-1: Employee Full Age and Service Annuity
12	AA-1: Employee Reduced Age and Service Annuity
13	AA-1: Employee 60/30 Age and Service Annuity
16	AA-1D: Employee T & P Disability Annuity
17	AA-1D: Employee Occupational Disability Annuity
21	AA-3: Spouse Annuity Based on Age
22	AA-3: Female Spouse Annuity Based on Minor Child/Grandchild
27	AA-3 with AA-19A: Female Spouse Annuity Based on Disabled Child/Grandchild
31	G-319: Retirement Overall Minimum Annuity- IPI spouse or IPI minor child/grandchild
32	G-320: IPI Student
36	AA-19A: Application For Determination Of Child/Grandchild Disability
37	AA-19A: Medicare Only for Retirement Child/Grandchild Disability
41	AA-3: Divorced Spouse Annuity

APPL/BEN TYPE CD	RRB Application or SSA Benefit
42	AA-3: Male Spouse Annuity Based on Minor Child/Grandchild
47	AA-3 with AA-19A: Male Spouse Annuity Based on Disabled Child/Grandchild
50	Spouse-to-Widow(er) Conversion (old AA-17A)
51	AA-17: Application For Widow(er)'s Annuity
52	AA-18: Application For Surviving Young Mother's/Father Annuity
53	AA-19: Application For Surviving Child's/Grandchild's Annuity
54	G-315: Full-Time Student Annuity
55	G-315: Child's Annuity Converted to FTS Annuity
56	AA-17B: Application For Determination Of Widow(er) Disability
57	AA-19A: Application For Determination Of Surviving Child/Grandchild Disability Annuity
58	AA-20: Application For Surviving Parent's Annuity
61	RASI or Map: Employee Supplemental Annuity
62	SALSA
63	Tax Refund
64	AA-21: Application For Lump-Sum Death Payment
65	AA-21: Application For Annuities Unpaid At Death
68	Residual Lump Sum
71	AA-6: Employee Medicare Only Application
72	AA-7: Spouse Medicare Only Application
73	SMIB Refund
76	AA-17B: Determination of Widow(er) Disability For Medicare Only

APPL/BEN TYPE CD	RRB Application or SSA Benefit
77	AA-1D: Determination of Employee Disability For Medicare Only (D/F only)
81	AA-17: Application for Remarried Widow(er) Annuity
82	AA-17: Application for Surviving Divorced Spouse Annuity
83	AA-18: Application For Remarried Surviving Young Mother's/Father's Annuity
84	AA-18: Application For Surviving Divorced Young Mother's/Father Annuity
86	AA-17B: Application for Disabled Remarried Widow(er) Annuity
87	AA-17B: Application for Disabled Surviving Divorced Spouse Annuity
93	Retirement Initial or Post SSA Award (PAM/SOLAR)
94	Survivor Initial or Post SSA Award (PAM/SOLAR)
95	Retirement SSA Aero
98	Survivor SSA Aero

5. APPL\BEN NUM - Always complete this item. When the code entered in item 4 is less than 90, this item is used to complete the KOR-SURV-APPL-NUM field in the KOR Master Record. When the code entered in item 4 is more than 90, this item is used to complete the KOR-SURV-APPL-NUM and the KOR-SSA-BENE-TYP-CD field in the KOR Master Record.

- a. RRB Applications - Complete this item with the two-digit application number (use preceding zero when applicable) so the system can identify the correct application when the disposition is entered. For applications coded in by RASI, enter "00" in this item. For applications coded in by APPLE, use the number that APPLE assigned to the application. APPLE assigns numbers to applications consecutively as the applications are entered into APPLE. Thus the first application on the Application Menu Screen has the number 01, the second application is 02, etc. Note that FNODs are not assigned a number and should not be counted when determining the assigned application number.

For example, the young mother's AA-18 would be "01," the child's AA-19 would be "02," etc.

b. Solar Awards - The correct codes for SOLAR awards are shown below:

- Code 01: Initial award where the beneficiary's SSN is the same as the RR EE's SSN.
- Code 02: Initial award where the SSA beneficiary's SSN with BIC other than C, B6 or B9 is not the RR EE's SSN.
- Code 11: Initial award where the BIC of the SS claim number is C1.
- Code 12, etc.: Initial award where the BIC of the SS claim number is C2, etc.
- Code 30: Initial award where the BIC of the SS claim number is B6 or B9.

6. BEN SS NUM - Always complete this item, even if it is the same as item 2. Enter the applicants own social security number. If the applicant does not have a social security number, enter "000000000".

7. STATUS OF APPLICATION - Always complete this item The codes are:

0 = New Retirement Application, SUP ANN, Medicare only, or PAM/SOLAR award.

1 = Reactivated RRB application, SUP ANN, or PAM/SOLAR award 2 = Recertified

3 = SSA AERO Calc (PAM, SOLAR, STAZA)

4 = Survivor "Spouse to Widow Conversion"

5 = Aged Widow or RLS (with Application AA-21)

6 = Survivor Accrued Annuity (with Application AA-21)

7 = Spouse Accrued Annuity (with Application AA-3)

8. FIELD OFFICE NUMBER - When item 7 above is has a status code of zero, enter the number of the RRB field office or, if applicable, the Headquarters code.

Region 1 - Atlanta	Region 2 - Philadelphia	Region 3 - Denver
101 = Atlanta, GA	211 = Albany, NY	370 = Albuquerque, NM
111 = Birmingham, AL	243 = Altoona, PA	371 = Bellevue, WA
117 = Charlotte, NC	221 = Baltimore, MD	372 = Billing, MT

182 = Ft. Worth, TX	231 = Boston, MA	373 = Denver, CO
183 = Houston, TX	217 = Buffalo, NY	374 = Des Moines, IA
153 = Huntington, WV	296 = Chicago, IL	375 = Duluth, MN
121 = Jacksonville, FL	282 = Cincinnati, OH	376 = Fargo, ND
184 = Kansas City, MO	283 = Cleveland, OH	377 = Oakland, CA
161 = Little Rock, AR	285 = Decatur, IL	381 = Sacramento, CA BO
155 = Louisville, KY	286 = Detroit, MI	378 = Omaha, NE
131 = Nashville, TN	241 = Harrisburg, PA	379 = Phoenix, AZ
181 = New Orleans, LA	289 = Indianapolis, IN	380 = Portland, OR
145 = Roanoke, VA	290 = Joliet, IL	384 = Spokane, WA BO
141 = Richmond, VA BO	291 = Milwaukee, WI	383 = Salt Lake City, UT
186 = St. Louis, MO	251 = Newark, NJ	382 = St. Paul, MN
125 = Tampa, FL	201 = New York, NY	386 = Covina, CA
	205 = Westbury, NY	387 = Wichita, KS
	261 = Philadelphia, PA	
	293 = Pittsburgh, PA	
	271 = Scranton, PA	
401 = A Social Security Administration application which was transferred to RRB or an application that was filed at Headquarters (i.e. foreign survivor student application)		
402 = An RR Cert case coded in by PAM/SOLAR.		
430 = A SUP ANN initial (reg ann and sup) from RASI		
431 = A SUP ANN attainment from MAP.		
999 = Miscellaneous or Field Office Number Missing		

9. HOW FILED - This information for applications processed by APPLE can be found on the APPLICATION ENTRY Screen APMOO2 in item "Dev CD." Enter the appropriate code.

1 = In person - This corresponds to the code "P" on APPLE. Use this code if the application is taken on APPLE and the summary/certification is mailed to the applicant for signature.

2 = By mail - This corresponds to the code "M" on APPLE. Use this code, If a RRAILS paper application (i.e. AA-17, AA-18, AA-19 or AA-20) is used to obtain the information for the APPLE screens.

3 = By employer

4 = Record from PAM/SOLAR

5 = SUP ANN Age Attainment

6 = Internet (Future Use)

Leave this item blank for RRA application reactivations (Recon cases).

10. APPL ENTR DTE - This item is for future use. For now, leave this item blank.

11. APPL REL DTE - This item is for future use. For now, leave this item blank.

12. DOB DTE - Complete this item only for RRB monthly annuity applications or a SUP ANN. Enter the applicant's date of birth. If unknown, leave this item blank. If you are not coding an RRB annuity application or SUP ANN, leave this item blank.

13. ABD/OBD DTE - Complete this item with the ABD/OBD only for new RRB annuity applications (status code = 0). For survivor cases, you can use the estimated OBD from the APPLE Summary Screen. For retirement cases, the estimated ABD is on RASI request. For an RRB SUP ANN, enter the SUP ANN Begin Date.

Note: KOR will correct this date if the disposition record closes out the application with a different ABD, OBD, or SUP ANN Begin Date.

If you are not coding a new RRB annuity application or SUP ANN, leave this item blank.

Always press ENTER after coding each Receipt record. Otherwise, the record will not be written off to the KORFORMS batch.

Refer to RCM 9.13.11 for instructions for closing your KORFORMS batch.

9.13.7 General Information About Dispositions

Award disposition coding is done mechanically.

The following disposition actions must be coded out manually using KORFORMS:

- A. Denial or closed without award (CWOA) not coded out by APPLE
- B. DBD KOR cases for retirement disabled children.
- C. Disability Medicare only cases
- D. SSA Awards coded in mechanically by PAM and paid with different disposition coding on SOLAR (SSA Unmatched Disposition).
- E. Survivor Accrued Annuity-at-Death applications not coded out by DAISY.

9.13.8 Folder Record Of Disposition Coding Action

You may print out a copy of any KORFORMS screen with the EXTRA "PRINT SCREEN" commands. However, a copy of the KORFORMS disposition coding is not on the annuity application. When necessary, use the KOR monthly final disposition listings to verify the disposition coding.

9.13.9 Coding Dispositions On KORFORMS

When you open a new batch, the "Receipt Code Sheet" screen will appear. Use PF2 to move to the "Disposition Code Sheet" screen. The cursor moves automatically after each of your typed entries. If you leave an item blank, use the "Tab" key to move the cursor. The activity code will be entered into the record mechanically by KORFORMS when you complete your entries and press enter.

DISPOSITION CODE SHEET ACTIVITY CODE = 08

1. PREFIX _ 2. CLAIM # ____ - ____ - ____ 3. APPL\BEN TYPE CD ____

4. APPL\BEN NUM ____ 5. BEN SS NUM ____ - ____ - ____

6. APPL STAT CD _ 7. PRTIAL PD DTE ____ _ ____

8. FINAL DISP DTE ____ _ ____ 9. TYPE OF DISP ____

10. DOB DTE ____ _ ____ 11. ABD\OBD DTE ____ _ ____

12. EXAMINER NUM ____ 13. AUTHORIZATION NUM ____

14. MED EVID COMPL DTE ____ _ ____

INSTRUCTIONS FOR DATA ENTRY:

1. PREFIX - Type the alphabetical prefix "A," or "D." 2. CLAIM NUMBER - Enter the RRB claim number. If the claim number is six digits or less, enter zeros in the first three spaces.

3. APPL\BEN TYPE CD - Always complete this item. The code should be the same as number on the KORFORMS Receipt record for this record. (See 9.13.6 item 4.)
4. APPL\BEN NUM - Always complete this item. The code should be the same as number on the Receipt record for this record. (See 9.13.6 item 5.)
5. BEN SS NUM - Always complete this item, even if it is the same as item 2. This number should be the same as their own SSA number on the KORFORMS Receipt record for this record. (See 9.13.6 item 6.)
6. STATUS OF APPLICATION - This should be the same as the status code for the receipt of this record. (See 9.13.6 item 7.)
7. PTIAL PD DTE - Complete this item with the final disposition record if the applicant was paid a partial award before the final disposition date. Otherwise, leave this item blank.
8. FINAL DISP DTE - Always complete this item. Enter the final disposition date.
9. TYPE OF DISPOSITION – Always complete this item. Enter the appropriate code:

00= Final Award or Allowance for AA-6 or AA-7

01= Closed Without Award or Denial

06= Supplemental Annuity Reduced to Zero

Note that code “03 - OLDDS rating information” and code “05 - Partial Award” are used in the KOR program, but are never entered on KORFORMS.

10. DOB DTE – Always complete this item. This should be the same as the DOB on the receipt of this record. (See RCM 9.13.6 item 12.)
11. ABD/OBD DTE - Complete this item with the ABD/OBD only for new RRB annuity applications (status code = 0). For an RRB SUP ANN, enter the SUP ANN Begin Date.

Note: KOR will correct the ABD, OBD or SUP ANN Begin Date when the disposition record closes out the application with the correct ABD, OBD, or SUP ANN Begin Date.
12. EXAMINER NUMBER - Enter the appropriate examiner number in this item. If this item is left blank, KOR will enter the exam number “999.”
13. AUTHORIZER NUMBER - Enter the appropriate authorizer number in this item. If this item is left blank, KOR will enter the exam number “999.”

14. MED EVID COMPL DTE - This item is for future use. For now, leave this item blank.

Always press ENTER after coding each disposition record. Otherwise, the record will not be written off to the KORFORMS batch.

Refer to RCM 9.13.11 for instructions for closing your KORFORMS batch.

9.13.10 Correcting Your KORFORMS Entries

There are several ways the examiner or clerk can correct their own KORFORMS entries in a batch that has not yet been extracted to the monthly KOR run.

Use the PAGE DOWN (or the PA-2 key on the CRT terminal) to page back through the records as they were entered into your batch. Use the PAGE UP (or the PA-1 key on the CRT terminal) to page forward through the records as they were entered into your batch.

The "Command Line" for your batch is at the top of each KORFORMS screen. Use the HOME key (or the keys ALT-RULE on a CRT terminal) or the TAB key to move the cursor up to the command line.

- A. Started Entry on Wrong Screen - If you begin to enter data on the wrong KORFORMS screen, do not press the ENTER key. Use the PAUSE key (the CLEAR key on the CRT terminal) to prevent the data from being forwarded on to KEY/MASTER. Then use the appropriate PF key to request the correct KORFORMS screen and type your entries.
- B. Entry Has Typo or Incorrect Data - To correct a record in a batch that has not yet been extracted for the KOR run, type the correct information on the screen. Then tab up to the command line and type "REP" for "Replace." Then press ENTER. The message "RECORD MODIFIED" should appear at the top left corner of the screen.
- C. Need to Delete One Record from the Batch - To delete a record in a batch that has not yet been extracted for the KOR run, page to that record. Tab up to the command line and type "DEL" for "Delete." Then press ENTER. The message "RECORD DELETED" should appear at the top left corner of the screen.
- D. Need to Cancel Entire Batch - To cancel an entire batch that has not yet been extracted for the KOR run, tab up to the command line of any KORFORMS screen and type "CAN" for "Cancel." Then press ENTER. The message "CANCELLED" should appear when you close out the batch.

NOTE: A batch can also be cancelled from the supervisor screen by a person with a valid supervisor code.

- E. Batch Seems to be Locked Up - When you press ENTER, the message MUST RESUME may appear in the upper left corner of the screen. This means that you must exit the paging mode PAGE UP or PAGE DOWN (PA-1/PA-2) before you can add new records to the batch. To do this, page forward to the last record in the batch. Tab up to the command line at the top of the screen and type "RES" for "Resume." Then press ENTER. A blank KORFORMS screen should appear to allow new entries to the batch or allow you to close the batch.

9.13.11 Closing KORFORMS Batches

When your entries for the batch are completed, close the batch. Close your batch by pressing the PF-24 key (Shift/PF12).

You may later add records to a closed batch, as explained in RCM 9.13.3(B).

KEY/MASTER will hold a "closed" batch until it is extracted to the monthly KOR run.

9.13.12 Signing Off Key/Master

After you close the batch, you will go to a screen that indicates whether your batch is "closed." Then press PF-12. The screen should say you are logged off. Press PF-12 again. You will be at the SYSTEM/FUNCTION screen. Type 1 at the cursor and press ENTER. You will be logged off the KEY/MASTER system.

9.13.13 KORFORMS Supervisory Functions

Access "KORFORMS" from the TPX menu by selecting "KEYPROD" with the PF key explained in RCM 9.13.2. The KEY/MASTER screen will appear.

If you have supervisory access to KORFORMS, type your KORFORMS supervisor code on the supervisor code line. Press the ENTER key. Then type the command "STA" and "KORFORMS" next to PARM 1. DO NOT REQUEST A PRINT SCREEN FOR THE SUPERVISOR SCREEN.

The supervisor screen will help you find a batch number and security code for a batch. The supervisor screen may be used to reinstate a cancelled batch on the same workday as the day of the cancellation. However, if the batch is not reinstated, the KEY/MASTER reallocation program may drop all cancelled batches for that day at the close of business.

The data on the supervisor screen is displayed as follows:

CMD = Command Column. Use the command "C" to cancel a batch or "R" to reinstate a batch. Then press ENTER. The program will ask you to verify this request. Press ENTER again.

Batch = Batch number

E = Current Status of batch. This must be "C" = "Closed" for the batch to be extracted to the monthly KOR run.

S/C = Security Code

ENT = Number of records in batch

CDATE = Date batch was created (year/Julian date)

H M S = Time of day batch was created

EDATE = Date batch was extracted by Data Processing (year/Julian date)

E OPER = KEYPROD LOGON ID of the person who created the batch

You can view the entire list of KORFORMS batches by continuing to press "Enter". After you reach the end of the list, you will be taken back to the command screen.

The PF-1 through PF-8 keys for the KORFORMS menu work only from the Data Entry Operator (DEO) mode (see RCM 9.13.3). You cannot view a KORFORMS batch from the supervisor mode. To view a KORFORMS batch, go from the "Supervisor" mode to the "Data Entry Operator" (DEO) mode by typing the command "DEO". Leave all other items blank and press ENTER. Then follow the instructions for correcting a KORFORMS batch in RCM 9.13.3(B).

Appendices

Appendix A - COMPARISON OF OLD AND NEW KOR CODES

Old KOR Type of Application Codes	New KOR RRB APPL TYPE CD	RRB Application
Employee (Male or Female)		
0_0	11	AA-1: Employee Full Age and Service Annuity
0_0	12	AA-1: Employee Reduced Age and Service Annuity
0_0	13	AA-1: Employee 60/30 Age and Service Annuity
2_0	16	AA-1D: Employee T & P Disability Annuity
2_0	17	AA-1D: Employee Occupational Disability Annuity

Old KOR Type of Application Codes	New KOR RRB APPL TYPE CD	RRB Application
Spouse (Tier 1 and Tier 2)		
1_0	21	AA-3: Spouse Annuity Based on Age
1_0	22	AA-3: Female Spouse Annuity Based on Minor Child/Grandchild
1_0	27	AA-3 with AA-19A: Female Spouse Annuity Based on Disabled Child/Grandchild
Retirement O/M		
No Code	31	G-319: Retirement Overall Minimum Annuity- IPI spouse or IPI minor child/grandchild
No Code	32	G-320: IPI Student
W_4	36	AA-19A: Application For Determination Of Child/Grandchild Disability
Y_4	37	AA-19A: Medicare Only for Retirement Child/Grandchild Disability
Survivor		
341	50	Spouse-to-Widow(er) Conversion (old AA-17A)
301	51	AA-17: Application For Widow(er)'s Annuity
3_2	52	AA-18: Application For Surviving Young Mother's/Father Annuity
3_3	53	AA-19: Application For Surviving Child's/Grandchild's Annuity
3_7	54	G-315: Full-Time Student Annuity
3_7	55	G-315: Child's Annuity Converted to FTS Annuity
3_5	58	AA-20: Application For Surviving Parent's Annuity

Old KOR Type of Application Codes	New KOR RRB APPL TYPE CD	RRB Application
3_8	56	AA-17B: Application For Determination Of Widow(er) Disability
3_4	57	AA-19A: Application For Determination Of Surviving Child/Grandchild Disability Annuity
Lump Sum or Supplemental Payments		
6_1	61	RASI or Map: Employee Supplemental Annuity
No Code	62	SALSA
No Code	63	Tax Refund
3_6	64	AA-21: Application For Lump-Sum Death Payment
3_6	65	AA-21: Application For Annuities Unpaid At Death
3_6	68	Residual Lump Sum
Medicare Only		
4_0	71	AA-6: Employee Medicare Only Application
5_0	72	AA-7: Spouse Medicare Only Application
No Code	73	SMIB Refund
8_8	76	AA-17B: Determination of Widow(er) Disability For Medicare Only
7_0	77	AA-1D: Determination of Employee Disability For Medicare Only (D/F only)
Tier 1 Only		
1_0	41	AA-3: Divorced Spouse Annuity
1_0	42	AA-3: Male Spouse Annuity Based on Minor Child/Grandchild
1_0	47	AA-3 with AA-19A: Male Spouse Annuity Based on

Old KOR Type of Application Codes	New KOR RRB APPL TYPE CD	RRB Application
		Disabled Child/Grandchild
3_1	81	AA-17: Application for Remarried Widow(er) Annuity
3_1	82	AA-17: Application for Surviving Divorced Spouse Annuity
3_2	83	AA-18: Application For Remarried Surviving Young Mother's/Father's Annuity
3_2	84	AA-18: Application For Surviving Divorced Young Mother's/Father Annuity
3_8	86	AA-17B: Application for Disabled Remarried Widow(er) Annuity
3_8	87	AA-17B: Application for Disabled Surviving Divorced Spouse Annuity
Current KOR Type of Appl Codes	New SSA BEN TYPE Codes	SSA BEN TYPE
903, 913	93	Retirement Initial or Post SSA Award (PAM/SOLAR)
904, 914	94	Survivor Initial or Post SSA Award (PAM/SOLAR)
933	95	Retirement SSA Aero (wit KOR-APPL-STATS-CD of "1")
934	98	Survivor SSA Aero (wit KOR-APPL-STATS-CD of "1")

9.14.05 Background

Effective September 14, 2001, the paper G-90 has been replaced with an online version. An online database has been created to store and display the results of SEARCH calculations. Previously, SEARCH results were printed on paper G-90's, sorted, distributed to the requesting units and filed in the employee's claim folder. More recently, a temporary file replaced the conventional claim folder and the G-90 was manually scanned onto the imaging system. These functions are no longer required.

The online G-90 was developed to address two primary needs: expanded SEARCH calculations; and support a paper and folder free work environment. The results of expanded SEARCH calculations, such as providing true PIA history for up to 20 effective dates, would have required the paper G-90 to be three pages. This in turn would require the three pages to be printed, sorted, distributed and then physically scanned onto the imaging system.

9.14.10 What's on the database?

The database will house all mechanically produced employee retirement and survivor reentry G-90's and all final employee retirement G-90's. This includes all special mass adjustment G-90's such as RAIL and AERO and RESCUE. SURPASS will continue to store final survivor G-90's. Spouse and auxiliary spouse G-90's are not available on the database. The RR90 will temporarily be printed pending SSA procedural changes.

Note: You must continue to manually scan the G-90a onto the imaging system.

9.14.15 Effective date

The following provides the location of G-90's based on the date the G-90 was produced.

If the G-90 was produced before 9/14/2001, then the G-90 is a paper G-90.

- Effective 10/2/00 - all initial G-90's were physically scanned and are available on the imaging system.
- After 9/13/2001 - On the G-90 Online database - no longer printed.

Note: The SEARCH results of the 2001 RAIL are on the database.

9.14.20 How to locate a G-90

In order to locate a G-90, you must access the SQL G-90 database on the intranet. Below are various alternatives.

1. Through Internet Explorer - Type the following address:
<http://internalappsprd.usrrb.ad.local/WebApps/GOLDMenu/GoldMenu.aspx>

2. Create a desk top short cut - see T-01-58.
3. Through Boardwalk, under 'Applications Associated Link' and click 'G-90 Online'.

Note: Multiple sessions on the database are allowed.

9.14.25 Database location

The database (DB) is located on the production server RRBSQLP01. It is accessed through Boardwalk on the intranet:
<http://internalappsprd.usrrb.ad.local/WebApps/GOLDMenu/GoldMenu.aspx>

9.14.30 Access

Since the DB is located via the intranet, field office personnel as well as headquarters personnel have access to G-90's online. Multiple users may view the same G-90 at the same time. You may also have multiple sessions open in order to compare G-90's if necessary.

9.14.35 Frequency

The G-90 Online DB is run nightly as part of the SEARCH stream. A mechanical process loads the daily SEARCH activity to the G-90 Online DB. This includes MAP (age 62 recalc G-90's) & DF Attainments. Special SEARCH output such as the RAIL and AERO and RESCUE are loaded upon request.

9.14.40 Relationship to imaging

A special file is created as part of the SEARCH stream that is loaded to the imaging DB. The file contains specific information about the G-90 that is used to create an index within workdesk. This index allows you to verify if the G-90 is available online. You can access the G-90 as specified in 9.14.20. It is not accessible through workdesk.

9.14.45 Purge erroneous G-90

If a G-90 has been generated based on erroneous information, the G-90 should be removed from the DB. You should send an email to ~~Barry-Fredrick~~ or Stewart Kusterski requesting the G-90 to be deleted as well as the imaging team. You must include the reason and the G-90 ID number.

9.14.50 HSL report

The reports providing SEARCH counts, rejects and pending reentry G-90's are located on Boardwalk, Applications under System Reports. The link is \\share\\hsl_reports\\Production.

9.14.51 G-90 Rejects

G-90 rejects are listed in the SEARCH Counts daily report that is posted on Boardwalk, Applications, System Reports, SEARCH Counts (refer to link above in 9.14.50). A referral is also loaded to USTAR under categories SISG90 for survivor and RBDG9R for retirement. As you handle the case, these USTAR referrals must be closed upon concluding your action just as any other referral that is on USTAR.

9.14.55 G-90 Online Log

An online log is produced after each load to the G-90 Online DB has been completed. It provides counts of records processed, stored, deleted, and when the job started and ended. It also provides counts by the type of G-90 processed, e.g., RASI. Some fields that may be important to you:

- G-90's Processed - total number of G-90's produced from SEARCH.
- G-90's Deleted - total number of reentry G-90's purged because SEARCH provided a final G-90. Match based on G-90 ID number.
- GEN - number of G-90's stored on the DB.

The log is located at <http://internalappsprd.usrrb.ad.local/ClassicASP/Gold/G90Log.asp>

9.14.60 Retention period

The G-90 Online DB has an unlimited retention period.

9.14.65 Location

The PC database (DB) is located through the intranet at:

<http://internalappsprd.usrrb.ad.local/WebApps/GOLDMenu/GoldMenu.aspx>

<http://internalappsprd.usrrb.ad.local/WebApps/GOLDMenu/GoldMenu.aspx>

9.14.70 Inquiry screen

The inquiry screen is displayed below. You may locate a G-90 by claim number, type of G-90, by the date the G-90 was loaded onto the DB or by the G-90 ID number. The search process will begin after you click the icon labeled 'List G-90s For Claim' or by pressing 'enter.'

G-90s For Given Claim

Please enter the search criteria below and click the button. The screen will display a list of G-90s matching the criteria. Please note that you can enter as much criteria as you would like.

Claim Number (X999999999 format)

Requestor

Loaded After Date (yyyymmdd - no slashes)

Loaded Before Date (yyyymmdd - no slashes)

G-90 ID

Submit	Reset
--------	-------

Warning: Please narrow your search criteria. Please enter a claim number if you set 'Requestor' to 'ANY'. If you set 'Requestor' to 'ANY' without a claim number and search a wide range of dates, your PC could be tied up for a very long time and it could disrupt other users.

9.14.75 Inquiry screen definition

The fields on the inquiry screen are defined as follows:

- Claim Number - claim number as provided on G-90 request. The format is prefix (A, D or H) followed by nine digits. A six digit claim number must include zeroes in the first three digits of the claim number following the prefix, e.g., A000123456.
- Requestor - type of G-90. The categories are as follows:
 - Any
 - Survivor Reentry B
 - Survivor Reentry A
 - RESCUE – (RAIL or AERO G-90)
 - Retirement Reentry A
 - Retirement Reentry B
 - SPEED
 - SPARC (MAP age 62 recalc)

- DF
- RASI
- Manual G60
- Financial Interchange
- MS ACCT
- Loaded After Date - search for all G-90's loaded onto the DB after specified date. The format is YYYYMMDD without any spaces.
- Loaded Before Date - search for all G-90's loaded onto the DB before specified date. The format is YYYYMMDD without any spaces.
- G-90 ID - search for a specific G-90 based on the G-90 ID number.

9.14.80 Search result

The following information is a sample reply based on 'Manual G60.'

G-90's Which Meet Criteria - To display the G-90, click its G-90 ID.

G-90 ID	Surname	Date Loaded	Unit Type	Req	Req Desc	SSNumber	Reqtr Assign	Compl Reason
123456	SMITH	09/13/2001	RPS	RET	123-45-6789	ManualG60		

9.14.85 Description of result

The labels for the search result are explained below.

- G-90 ID - unique number assigned to each G-90 request. Since more than one G-90 may be available for any given claim number, a unique number for each G-90 request is necessary.
- Surname - employee's last name.
- Date Loaded - the date the G-90 was loaded onto the DB, (what was the G-90 print date).
- Requesting Unit - the specific unit that made the G-90 request.
- Request Type - type of SEARCH calculation.

- Description - more detailed request type (AGE 62 and ALT PIA).
- SS No - social security number on request.
- Requestor - type of G-90.
- Assigned - date entered by CCU supervisor for survivor reentry B G-90's that require additional manual calculations.
- Completed - date survivor reentry B G-90 was completed by CCU examiner.
- Reason - only displays cause for survivor reentry B and only if manual calculations are required.

9.14.90 G-90 display

You must click on a specific G-90 ID number to view the G-90.

9.14.95 Navigation

The following are guides to navigating through the DB.

- Get out - click on the icon 'Back' until you're home.
- New search - click on the icon 'Back' until you're at the search screen.
- Views - use scroll bar for up, down and side to side.

9.14.100 Request Data

Field Name	Description
Claim Number	RRB Claim number for which the G-90 was requested.
SSN	The social security account number on which the G-90 was requested.
Surname	The last name of the employee for whom the G-90 was requested. <ul style="list-style-type: none"> • First 10 letters if mechanical or G60 request • First five letters if survivor request
Init	First initial of first name and middle initial.
Sex	M = male; F = female

DOB	Employee's date of birth, MM/DD/CCYY.
DOD	Employee's date of death, MM/DD/CCYY. Only on survivor G-90.
DOF	Employee's date of filing an annuity application, MM/DD/CCYY.
DLW	Employee's date last worked in the railroad industry, MM/DD/CCYY.
Prior SVC MOS	Employee's prior service months as provided on request.
Prior SVC Ave	Employee's prior service average as provided on request.
ABD	Employee's retirement annuity beginning date, MM/DD/CCYY.
Req Unit	Unit/section which requested the G-90.
Type Req	Type of request made
Date Into System	The G-90 request date, MM/DD/YY.
G-90 date	Final G-90 date, MM/DD/CCYY.
SS Reply	Date of reply from SSA, MM/DD/CCYY.
Reent A	Date re-entry A data received, MM/DD/CCYY.
Reent B	Date re-entry B data received, MM/DD/CCYY.
BA#	Railroad employer code for which the employee last worked.
Prev BA#	The second to last railroad employer code for which the employee worked.
Comp Alloc	A 'Y' indicates compensation after the ABD was allocated back.
CC	Employee current connection code: Y = CC on his ABD or DOD. N = Does not have a CC on his ABD nor DOD. V = CC on 12/31/74 (ABD CC unknown).
NCSP Eff Dt	For future use. Initial effective date to apply the non-covered service pension, MM/DD/CCYY
NCSP Pension	Employee's non-covered service pension amount. For future use.

Amt	
NCSP Guaranty Amt Eff Dt	For future use.
NCSP Guaranty Amt	For future use.
Type Annuity	Employee annuity type: 1 = Full age 65 or pre-1983 60/30 2 = Reduced age 62 or Recalc age 62 3 = Disability 4 = 60/30 with a DF 5 = 1983 Amendment 60/30
Dis Onset	Employee's disability onset date, <u>MM/DD/CCYY</u> .
DF Beg Dt ^{4st} Period	Employee's disability freeze date, <u>MM/DD/CCYY</u> .
NCSP Post 1956 MthsDF End Dt 1st Period	The total number of post 1956 non-covered service months. For future use.
NCSP Total MthsDF Beg Dt 2nd Period	The total number of non-covered service months. For future use.
DF End Dt 2nd Period	For future use.
G-90 ID No	A unique number assigned to each G-90 request.

9.14.105 Messages

Field Name	Description
Messages	<ul style="list-style-type: none"> G-60 REQUEST - indicates G-90 produced from manual G60 request

	<ul style="list-style-type: none"> • G-90 M/S DATA FROM EDM - MS stored on EDM was used • G-90 M/S FROM DCC DETERM - M/S data from G-90 request and creditability determination by Claims Certification Unit • SEARCH M/S CRED. DET. - MS creditaability determined mechanically by SEARCH • MAP REQUEST - G-90 from monthly attainment program, age 62 recalc • (CCYY) AERO ASSOCIATE AND FILE DOWN - result of a mechanical AERO recomputation operation • RAIL (CCYY) - result of a mechanical lag operation • 1973 NOT INCLUDED IN GROSS RESIDUAL - The 'GROSS RLS' does not include 1973 compensation. • 1974 NOT INCLUDED IN GROSS RESIDUAL - The 'GROSS RLS' does not include 1974 compensation. • 1973 AND 1974 NOT INCLUDED IN GROSS RESIDUAL - The 'GROSS RLS' does not include 1973 NOR 1974 compensation. • RR COMP MAY HAVE BEEN CREDITED AS WAGES - RR compensation for one or more years has also been credited as wages. Refer to 'Possible Duplicate Earnings' in RCM 9.3.13. • G-90 IS FOR M/S ACCT ONLY- The calculations are for the annual military service accounting project.
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9.14.110 Remarks

Field Name	Description
Remark	<p>This field displays re-entry A, re-entry B, and final G-90 messages that are either informational or which require further action by an examiner.</p> <p>RE-ENTRY A MESSAGES</p> <ol style="list-style-type: none"> 1) Re-entry A Data Required - Military Service Creditability 2) Re-entry A Data Required - Lag Data 3) Re-entry A Data Required - Lag Data and Military Service

Creditability

- 4) Re-entry A Data Required - Lag Data and Date of Death
- 5) Re-entry A Data Required - Lag Data and Annuity Beginning Date
- 6) Re-entry A Data Required - Annuity Beginning Date
- 7) Re-entry A Data Required - Military Service Creditability and Annuity Beginning Date
- 8) Re-entry A Data Required - Date of Death
- 9) Re-entry A Data Required - Date of Death and Military Service Creditability

RE-ENTRY B MESSAGES

Message 1: Out of Balance Indication RRB/SSA: USTAR code RBOG9R

Detail wages and/or compensation do not equal total. Possible causes: SSA wage info is outstanding, specifically 1953-1955 wages/QCs. When RRB's request is made to SSA, SSA initiates corrective action. SSA typically resolves the issue within 30 days - new G-90 request should be made to verify no change in PIAs.

Message 2: Incorrect Account Number Indication: USTAR code RBOG9R

Total compensation does not equal cumulative compensation. Possible causes are:

- Multiple A/N - Send an email to CESC to consolidate comp records, once notified of resolution, request new G-90; or
- incorrect SCORE record - Possible discrepancy in surname and/or DOB from request and SCORE FILE DATA displayed on GOLD. If SCORE error, send an email to CESC to correct error; request new G-90 once EDM has been updated. If error on request, correct and request new G-90.

Message 3: Service After ABD: USTAR code RBOG9R

Referral produced when there are more than 3 months reported after the ABD.

For cases identified thru RESCUE - refer to Final G-90 messages below for more detail

Message 4: More than 4 Periods of M/S

Message 5: Military Service after 1956

Message 6: SSA 794 Pending: USTAR code CCUG9F

SSA has action pending on the case - request new G-90 in 30 days and compare to earlier G-90.

Message 7: Eligibility Prior to 1941

Message 8: Military Service after 1974: obsolete - NAN

Message 9: 2 Vesting Years, One or Both Prior to 1951

Message 10: Vesting Year 2 Required

Message 11: Questionable Compensation

Message 12: Lag Not Used: obsolete - NAN

Message 13: Two M/S Creditability Codes in Year after 1950: obsolete - NAN

Message 14: Determine QC's through Vesting Year

Message 15: M/S After 1956 Not Corroborated by QC Pattern: obsolete - NAN

Message 16: Excess of Overlapping M/S Months. Determine QCs through Vesting Yr

Message 17: Manual Computation Required for PIAs, AIME PIAs, AMCs, Basic Amt

Message 18: Determine Month & Year 360 Months Established

Message 19: 60/30 Determination Not Made

Message 20: Possible Deeming Required: obsolete - NAN

Message 21: Vesting Year is Questionable

Message 22: Vesting Year is Required: USTAR code RBOG9R

SEARCH is unable to make vesting determination because the vesting year is prior to 1951. If vested, complete g60 with vesting year

Message 23: Review Creditable Service Months: obsolete - NAN

FINAL G-90 MESSAGES

ADDITIONAL QC'S MAY APPLY 1937-1950

This message is displayed when insufficient QC's are established for a 5 year vesting case and there are wages greater than \$49.99 in the period 1937-1950. Secure a QBD to verify the QC's – you may NOT use the \$400 rule to establish QC's.

ASSUMED NOT VESTED

This message will appear on an employee RASI requested initial G-90 for a 60/30 annuitant if TRIC did not make a vesting determination before the G-90 was displayed. The G-90 was processed as if the employee was not vested, the PIA 4 is shown on this G-90 as "9999."

A second G-90 (and possibly G-90a) will be produced to furnish the vested status. (See Section 7.4.40.)

CHECK CHILD CARE D/O

This message will appear in retirement case if the employee is a disability annuitant under age 37 in the earlier of his ABD year or DF year and his ABD is 7-1-80 or later or his DF date is 2-1980 or later.

This message will appear in survivor cases if the employee was under age 37 in the earlier of his ABD year or DF year and his ABD was 7-1-80 or later, or his DF year was 1980 or later, and the DOD is 8-1-81 or later.

If the employee has 1 or more years with no earnings after the year he attains age 21 and before the earlier of his ABD or DF onset year, develop for possible child care drop-out years as explained in RCM 4.7.120ff.

ESTIMATED AIME PIA 9 FURNISHED

The AIME PIA 9 furnished on the Form G-90 for the 60/30 annuitant is an estimated PIA based on an estimated average annual earnings amount for the AIME PIA 9 indexing year. The estimated AIME PIA 9 should not be used to award the O/M. If the O/M applies, obtain the correct AIME PIA 9 based on the actual average earnings amount for the indexing year.

LAG NOT USED, MAY BE A FACTOR IN COMPUTATIONS

This message is displayed on mechanical DF G-90's to indicate that lag compensation was not included in the PIA computations on the DF G-90. If the employee has lag compensation which would affect the PIA computations, release Forms G-60 to obtain correct PIA computations which include the DF.

LESS THAN 120 SERVICE MONTHS BEFORE 1975

This message is displayed on employee survivor G-90's if the employee does not have 120 months of railroad service before 1975. This message indicates that the maximum lump sum death payment is 3 times the PIA or \$225, whichever is less. The maximum LSDP for this case cannot be based on ten times the basic amount.

LESS THAN 120 TOTAL SERVICE MONTHS

This message is displayed on employee G-90's if the employee does not have 120 months of railroad service. In retirement G-90's no computations are provided. In survivor G-90's, the computations are provided.

(L) LAG COMPENSATION REPORTED FOR (YEAR)

This message is displayed on the employee G-90 if the employee has lag compensation. The message indicates what years in item 4 are considered lag.

MATCH AND FORWARD TO RM

This message is displayed on mechanical DF G-90's to indicate that the DF G-90 should be matched to the claim folder and forwarded to the appropriate Modular Unit.

MBR DISAGREES ON (NAME) (DOB) (NAME AND DOB) (SEX) (NAME AND SEX) (DOB AND SEX) (NAME, DOB AND SEX)

A discrepancy exists in name, DOB, or sex. MBR data is furnished but the message is displayed to point out the discrepant item.

Resolve the discrepancy.

MBR MAY BE INCORRECT

This message is displayed on COL reject G-90's if the BIC code is not A and SSA transmitted a code indicating that the MBR date may be incorrect.

If the MBR data is incorrect or if you are unable to determine if the MBR data is incorrect, secure an MBR print-out to verify the MBR data.

MS CONSIDERED IN COMPUTATION

This legend will appear if the G-90 is the result of a G-60 request for RECOMP PIA data and M/S was considered in the computations.

M/S INVOLVED - 37 ACT CASE

This message is displayed on AERO G-90's to indicate that the employee's military service was not included in the computations.

If inclusion of the employee's military service would affect the computations, request manual computations from the Claims Certification Section.

M/S NOT INCLUDED IN GROSS RESIDUAL

The employee's military service after 1950 has not been included in the gross residual. If the gross residual with M/S must be obtained, return the Form G-90 to the Claims Certification Section and ask that M/S be included.

MS NOT USED IN COMPUTATION

This legend will appear in RECOMP G-90 cases where the M/S was not used in the computations.

Review the G-90 to determine if the M/S will increase the PIA amounts. Generally, if the M/S is prior to 1951 and the AMW is over \$250.00, the "OLD START" is not applicable. In such cases, the RECOMP PIA's on the G-90 will be correct. However, you must also consider if the M/S will provide an additional year of coverage for cases where the special minimum PIA may be applicable.

If there is a possibility that the M/S will increase the PIA data, request a manual PIA calculation.

MS QUESTIONABLE - NOT USED IN COMPUTATION

This legend will appear if the G-90 is the result of a G-60 request for RECOMP PIA data and M/S was shown on the G-60 but was not used in the computations. Usually this will happen in cases where the M/S period is erroneous, i.e., keypunch error or examiner error.

Review the file copy of the G-60 to see if the correct M/S period was

furnished. If the M/S period is correct, request a manual PIA calculation. If the M/S period shown on the G-60 is incorrect, submit a new G-60 with the correct M/S period.

NO EFFECTIVE PIA 1 RECOMP

This message is displayed on 1937 Act recomp requests if no PIA 1 recomputation is payable.

NO SS INSURED STATUS FOR SSEB

This message is shown on survivor G-90's in which the employee does not have enough quarters of coverage to have an SS insured status. The SS insured status determination for SSEB is based on combined wages and compensation. The SSEB acquired quarters are shown in item 10F.

NOTICE OF RRB JURISDICTION RELEASED (TO BIRMINGHAM PAYMENT CENTER) (TO CHICAGO PAYMENT CENTER) (TO KANSAS CITY PAYMENT CENTER) (TO NEW YORK PAYMENT CENTER) (TO PHILADELPHIA PAYMENT CENTER) (TO SAN FRANCISCO PAYMENT CENTER)

This message is shown on survivor G-90's in "D" cases if an entry was made in the RSI block of item 3L and the employee died in the current year or last year. This message indicates that the Claims Certification Section released a notification to be appropriate SSA payment center that RRB has jurisdiction of survivor benefits in this case.

NUMBER OF OVERLAPPING M/S MONTHS QUESTIONABLE

The examiner should review the proof(s) of active military service in file to determine if they match the period(s) of creditable military service shown in item 1T of page 1 of the G-90.

If the military service period(s) shown are correct, refer the folder to the Claims Certification Section for verification of the correct number of overlapping military service months shown on the G-90.

% - DUE TO PRIOR YEAR ADJUSTMENT

The PIA 1 which should have been in effect immediately prior to the AERO recomputation does not equal the PIA 1 in the PREH/Rate History database record for that period. Therefore, an annuity adjustment may be due for the period prior to the current recomputation.

Return the G-90 to the Claims Certification Section via Form G-563 and

request all applicable PIA computations prior to the current recomputation.

POSSIBLE DF INVOLVED

A disability freeze appears to have been included in the computation of the beneficiary's SS benefit, but has not been included in the computation of PIA 21 or PIA 4.

This message will appear when:

- 1) The beneficiary is receiving a benefit on his own account, and
- 2) The SS DOE is prior to age 62, and
- 3) A DF prior to age 62 has not been entered on the TRIC request.

If the DF onset date is not available in the folder (e.g., from an RR-1e or SSA-3103), release a teletype or RR-6a to SS to request the DF onset date. If the DF date furnished by SSA affects the PIA computation (refer to RCM 8.11.15), request a manual PIA computation from the Claims Certification Section per RCM 8.11.122.

-POSSIBLE DUPLICATE EARNINGS BA 9999

This message is displayed if the employee has earnings reported by an employer listed on a table of known duplicate earnings problems see RCM 9.3 Appendix E). Duplicate earnings are defined as earnings that have been reported by an employer both as compensation AND as wages for a year or years after 1977.

If this message appears on a G-90 and the compensation and wages posted for the year(s) in question are equal (plus or minus \$1), no action is necessary for the year(s). SEARCH is programmed to not use the wages in the computation when the compensation and wages are equal.

If the message appears on a G-90 and the compensation and wages posted for the year(s) in question are not equal (difference is greater than plus or minus \$1), take the following action:

- 1) Request a DEQY for the year(s) in question.
- 2) Check the DEQY to see if the wages are from a railroad employer. If they are not, there are no duplicate earnings and the calculations shown on the G-90 can be used. However, if the wages are from a railroad employer, duplicate earnings are involved.

- 3) If there are duplicate earnings, send a copy of the G-90 and the DEQY printout to the Certification Compensation Unit (CCU) for manual calculations, using Form G-563. Advise CCU to provide the necessary calculations using the duplicate earnings as compensation only. If the calculations change, manual award action is required.

PRIOR SERVICE MAY INCREASE AMC

The employee has less than 30 years of service and at least one of the months of compensation used in the computation of the employee's AMC is less than \$250. If higher, the prior service average may be substituted for the compensation of any subsequent service month(s) used in the computation of the employee's AMC.

Obtain the employee's prior service average. Attach Form G-26 to the G-73a/G-90 and send to the Claims Certification Section. In the "COMMENTS" section of the G-26 enter the following:

"Determine if prior service increases the AMC. If so, please furnish the increased AMC and Tier II amounts."

REENTRY A OUTSTANDING 240 DAYS CASE DELETED FROM PENDING FILE

The case was referred out for reentry A handling 240 days or more ago but the reentry A data has not been received by the system. The Claims Certification Section has dumped the request off the system.

If Form G-90 is needed, submit Form G-60.

RRSIA: EE HAS LESS THEN 60 MONTHS AFTER 1995.

This is displayed if the employee meets the 5 year vesting criteria but has less than 60 months after 1995.

RRSIA: INSUFFICIENT QC'S – PIA's N/A

This is displayed when the employee meets the 5 year vesting criteria but has insufficient QC's based on earnings from 1951 to the latest year indicated in field, RRSIA, Through

SERV. AFT. ABD.;CHK. ABD.; SERV. NOT USED

The above message is displayed when the reported service

months/compensation are after the annuity beginning date.

A) G-90 Calculations

1. PIA #1 - compensation posted is allocated to the year last worked up to the maximum for that year.
 - prior to 1993, the remaining compensation is not used.
 - after 1992, the remaining compensation is used to compute a recomputation if applicable.
2. Tier 2 - service months/compensation posted after the ABD are allocated to the year last worked up to the maximum for that year. If the ABD is in the year last worked, the maximum number of service months and compensation is limited to the number of months prior to the ABD for that year.

B) Possible Actions:

- ABD entered incorrectly on the G-90 – request new G-90 – adjust annuity accordingly.
 - Information in the file does not indicate return to service or is inconclusive
1. Less than 4 months reported - no action necessary, G-90 calculations are correct.
 2. 4 or more months reported - follow succeeding directions.
 - Appears the employee worked, carried on payroll, or received a settlement or any type of payment for which service and compensation were credited after the ABD
 - a) Request CESC to investigate by contacting the railroad that reported the service months. This is done by sending an e-mail message to the QRSC mailbox with the following information: 1) "RR service After ABD" in the e-mail subject line, 2) the claim number, employee name, and BA# of the railroad employer, and 3) a statement requesting CESC to investigate the service after ABD, along with a mention of any pertinent information available from the folder, imaging, etc...
 - b) Do not use the G-90 until the investigation is completed.

- c) Upon notification from CESC, verify corrections on EDM
 - 1) If appropriate, request a new G-90 or complete Form G-563 for referral to CCU to obtain updated tier computations - adjust the annuity accordingly.
 - 2) Otherwise use the original G-90 for any necessary annuity adjustment.
- d) If a response has not been received within 90 days, trace with CESC.

C) RAIL reject 66 - Service after the ABD

The Calculation Analysis and Systems unit will provide a list (in place of manual G-563's), consisting of the employee's claim number and ABD, to:

- CESC to initiate the investigation
- Operations in order to track and trace open requests.

Once EDM is updated, CESC will notify Operations with a copy of the modified EDM screen. Operations will then request a new G-90 and adjust the case accordingly.

- D) Employee returned to railroad service after retirement and has again quit working.
 - 1. Send form G-563/G-90 to the Claims Certification Unit requesting tier 2 recomputations with effective dates corresponding to the ABD and the month after the last reported service month.
 - 2. Correct tier 1 recomputation can be obtained via a G-90 request, but the service months will be cutback in calculating tier 2.

SICK PAY NOT USED DUE TO REJECT

The Sick Pay master file indicates that sick pay activity was rejected. If sick pay affects a year for which Tier I compensation is not posted at the maximum, forward the G-90 via Form G-563 to the Claims Certification Section requesting resolution of the rejected sick pay and recalculation of PIAs 1, 3 and 9.

SSA BENEFICIARY IND

A benefit is not being paid on this A/N; however, the SS W/R indicates that the account holder has filed for benefits on another A/N.

Prepare a G-60 on the other account number if known. If unknown, refer the case to the SSA on-site representative to contact the reviewing office holding jurisdiction over the WE's account number.

SSA INDICATES MULTIPLE ACCOUNT NUMBER

This message is displayed on COL reject G-90's if SSA has indicated the beneficiary has multiple SS account numbers.

SSA INDICATES WRONG ACCOUNT NUMBER

The name, DOB, and/or sex from the request data do not match the name, DOB and/or sex from SSA's wage tape. Wage and MBR data are provided, and computations have been made.

Reconcile the discrepancy. If our request data was incorrect, prepare a G-60 with the correct data. If the SS account number was incorrect for a mechanical RASI generated request, RASI will request TRIC if the correct SS account number is entered into RASI.

SSA WAGE REPLY OUTSTANDING 30 DAYS

SSA has not replied within 30 days of our tape request; the Claims Certification Section has deleted the tape request from the TRIC system.

Some reasons for SSA's failure to reply are No Match on Request Data (check the identifying data and claim numbers for accuracy), Wages in Suspense or Out of Balance. If the problem cannot be determined from the G-90, attach it to a G-563 and request the Claims Certification Unit to obtain the SS benefit and wage information manually.

If the G-90 does indicate what the problem is, correct the data on the PC G-60 request and resubmit. For a RASI case, correct the data on the system with a 996. When a new TRIC request is compiled, it will contain the corrected data.

SSEB INSURED STATUS DETERMINATION NOT MADE

This message appears on survivor G-90's in which an SSEB insured status determination was not made mechanically. An SSEB insured status determination may be requested from the Claims Certification

Section, if necessary.

360 MONTHS NOT ESTABLISHED

This message is displayed when TRIC cannot establish 360 months of service for an employee filing for a 60/30 annuity. This takes into account all creditable service months through the last non-lag year, any lag months (including Title VII months) included on the G-60 or passed by RASI in the TRIC request and any creditable military service months established. Because the system must know the month in which 360 was attained, nothing further can be done at this point. A RASI case will not process further unless some change can be made in the total months available for crediting. The TRIC call-up will remain active. If no change is possible, the case must be dumped for manual handling.

A manual case should be re-examined for error in the reported data or the type of eligibility.

TIER 2 LAG COMP. NOT USED IN AMC AND TIER 2 CALCULATIONS

The employee's lag service and compensation was not included in the mechanical computation of the AMC and Tier II amounts on the survivor G-90. In these cases, the Claims Certification Section will manually compute the AMC and/or Tier II amounts including the lag. They will also usually cross out the message. If this message is displayed and a manual computation of the AMC and/or Tier II amounts including lag is not in file, return the G-90 to the Claims Certification Section and request a manual computation of the AMC and/or Tier II amounts including lag.

UI - 87 STOP: UNEMPLOYMENT OR SICKNESS BENEFITS CLEARANCE REQD

See RCM Sec. 5.9.41.

UNVERIFIED ACCOUNT

The account was established on the master record due solely to the receipt of a service and compensation report. Since employee Registration Form CER-1 was not executed, the master record is incomplete.

Attach a G-26 to a photocopy of the G-90. In the "Comments" section of the G-26 print "VERIFY ACCOUNT NUMBER" and the employee's full name. Route to the Claims Certification Section.

YEARS OF SERVICE ROUNDING MAY APPLY

The message will be displayed when:

- 1) The employee filed before April 1, 1982; and
- 2) The employee's date last worked was between September 30, 1981 and April 1, 1982; and
- 3) 1981 railroad lag service is involved; and
- 4) The G-88A shows the employee did not work in every month through the earlier of 12-31-81 or his date last worked.

The employee's rounded years of service through September 30, 1981 may be higher than his total years of service. However, the Tier II amount on the G-90 was computed using the employee's unrounded total years of service.

Develop for the number of service months worked in 1981 through September by requesting this information on Form G-115x from the district office which services the lag employer.

When the breakdown is secured, determine if the rounding provision applies. If it does, use the rounded years of service through September 30, 1981 to compute the annuity rates.

9.14.115 Subsequent Service and Compensation Date

Field Name	Description
Total Reported	The total subsequent service months and compensation (without M/S) through the date last worked. This includes months reported after the ABD.
Total Deemed	The total deemed service months credited to the employee's account.
Total R & D	The total of reported and deemed service months and compensation, excluding M/S.
Cred MS	The total M/S months and compensation credited under the RRA.
Total w/MS	The total subsequent service months (reported and deemed) and compensation including M/S.
Total MS Overlap	The total number of M/S months not credited as service months because railroad service has already been credited for those

	months.
37-50 MS Overlap	The total number of 1937-1950 M/S months which are not creditable as service months (since railroad service already has been credited for those months).
37-46 Comp	The total number of service months and compensation from 1937 through 1946.
Gross RLS	The gross residual without M/S.
Gross RLS w/MS	The gross residual with M/S.
SALSA	Separation allowance lump sum award amount.
Excess Tax	The amount of the 1974 Act tax refund.
360 Acquired	<p>Date employee attained 360 months of railroad service (MM/CCYY). This date (including M/S and lag) is used to determine the Amendment status of the PIA computation.</p> <ul style="list-style-type: none"> • 07/1984 indicates 60/30 attained after 6/1984 • 01/1986 indicates 60/30 attained after 12/1985 • 99/9999 indicates TRIC cannot determine date • 00/0000 indicates 1983 Amendments N/A
Tier 2 Contribution	The amount of RRA taxes paid that would have exceeded FICA taxes if the railroad service been covered by SSA.
1959 Gross Amt	Amount of compensation used in 1959.

9.14.120 SA Data

Field Name	Description
Name	Name shown on the Master Earnings File (MEF).
DOB	Date of birth shown on the Master Earnings File (MEF).
Sex Code	<p>Values indicating gender</p> <ul style="list-style-type: none"> • M - male

	<ul style="list-style-type: none"> • F - female
Mult A/N	An 'X' is displayed if a multiple SS account number was found and SS earnings have been consolidated.
Wages to Date	Total earnings credited under the SS Act to date.

9.14.125 MS Data

Field Name	Description
Beg Dt	The beginning date of the M/S period.
End Dt	The ending date of the M/S period for the corresponding M/S beginning date.
Cred/Use	Codes used to show how the period of M/S is creditable as follows: C = creditable as compensation W = creditable as wages only N = not creditable
MS Voluntary Code	Codes used to show the means of entry for the M/S period: V = voluntary entry I = involuntary entry
Ovlp	Number of months not creditable as service months because railroad service credited with same period.
Intv cd	Code used to indicate applicability of intervening wages.

9.14.130 Score File Data

Field Name	Description
Surname	Last name in the SCORE file data for the account number on which the G-90 has been requested.
Init	First (and second) initial, if any for the employee on this account number.

Acct No	Social security account number in the Claim Certification Section master record.
Clm No	If an "A" or "D" claim folder was established before 4/1/64, the claim number is printed here.
DOB	The month and year of birth in the Claims Certification Section master record.
LYS	Year of last railroad service, if after 1954.
DOD	The year of death shown for the railroad employee in the Claims Certification Section master record.
DOD Source	This item displays the source code of the death notification.
Inact Incor Ind	INACT = inactive; and INCOR = incorrect.
SS	
RSI	The year is entered if a claim has been filed with SSA based on the employee's earnings under the SS Act.
GF	RRB has or had a general file folder for the employee. An "H" indicates HIB filing.
DF	A disability freeze period has been established for the employee at SSA.
UI 87	An indication that there are recoverable RUIA benefits.
CC	An "X" in this box indicates a current connection. This block is completed in survivor cases only.
SSA Trans Dt	This item displays a "T" if there has been an SSA transfer or inquiry.
SSA Inq Dt	The date of the transfer or inquiry is shown in this item.

9.14.135 Compensation Data

Field Name	Description
YR	The years where the employee has reported earnings are shown here. If the employee has no reported earnings for any year, those years will not be displayed. If the employee has any earnings in

	the 1937-1950 period, the earnings totals for that block of years will be displayed.
SM	The number of compensation service months credited to the employee for each year.
DSM	The number of deemed service months credited. This began in 1985.
SM PAT	<p>This item displays a code indicating the employee's railroad service months employment pattern for each calendar quarter of the year as follows:</p> <p>0 = no service 1 = 1st month 2 = 2nd month</p> <p>3 = 1st and 2nd month 4 = 3rd month 5 = 1st and 3rd months</p> <p>6 = 2nd and 3rd months 7 = 1st, 2nd, and 3rd months</p>
DEEM PAT	The pattern of deemed months using the same 0 through 7 code used above.
WG QC	The total number of SS QC's earned for the year.
WGQC PAT	<p>A code for each calendar quarter to indicate the SS QC pattern. Due to SSA's change from quarterly wage reporting to annual wage reporting effective with 1978 earnings, the QC data printed for 1978 and later years differs from the data printed for 1977 and earlier years.</p> <p>For years prior to 1978, the wage QC pattern codes and their meaning are as follows:</p> <p>N = No QC</p> <p>C = Wage QC</p> <p>S = Self-employment QC</p> <p>A = Agriculture QC</p> <p>M = Military QC</p> <p>D = Military QC after 1974</p> <p>G = Gift QC</p> <p>F = Medicare qualified government employment QC</p>

	<p>R = Railroad employment QC (this code means the EE has 120 RR service months and SSA has combined FICA wages with RR compensation to determine a SSA insured status to compute a SSA PIA.</p> <p>X = FICA wage QC (same as "C" above)</p> <p>& = <\$50 in earnings, not a QC</p> <p>* = Type of work unidentifiable, but a credited QC</p> <p>< = <\$50 earnings, no QC</p> <p># = questionable QC</p> <p>For year 1978 and later, codes are as follows:</p> <p>C = QC</p> <p>N = No QC</p>
WG SE	<p>For years before 1978, this item displays the total self-employment wage QCs (0, 4, or &) for each year.</p> <p>For years 1978 and later, a self-employment indicator code will be printed for all wages earners who have wages posted after 1977. The codes and their meanings for G-90s with SSA Reply Date prior to 7/21/88 are as follows:</p> <p>A, B, or C = All earnings are SEI.</p> <p>N or S = No SEI has been reported.</p> <p>Q = Amounts posted are wages for an employer or agricultural earnings.</p> <p>R or T = Amounts posted are a combination of wages for an employer, agricultural earnings and SEI.</p> <p>For G-90s with an SS Reply Date of 7/21/88 or later, the codes and their meanings are as follows:</p> <p>B, C, or Y = All earnings reported are SEI.</p> <p>N or S = No SEI has been reported.</p> <p>Q = Amounts posted are wages for an employer or agricultural wages.</p>

	<p>T = Amounts posted are a combination of wages for an employer, agricultural earnings and SEI.</p> <p>For purposes of making a current connection determination, when a code Q, R or T is displayed, it will be necessary to release a teletype to SSA to ascertain which portion of the earnings posted after 1977 are wages for an employer and which are SEI.</p>
WG AG	<p>For years prior to 1978, this item displays the total number of agricultural wage QCs credited for each year.</p> <p>For years 1978 and later, this item displays a code which indicates whether or not agricultural wages have been reported for each year. The codes and their meanings are:</p> <p>Y = Agricultural wages have been reported</p> <p>N = No agricultural wages have been reported.</p>
WGMS PATTN	<p>A code is displayed for each calendar quarter to indicate whether deemed M/S has been credited for M/S after 1967. The codes are as follows:</p> <p>N = No deemed M/S for this quarter.</p> <p>& = Deemed M/S but not updated for this quarter.</p> <p>1, 2, or 3 = \$100, \$200 or \$300 respectively deemed M/S updated for this quarter.</p>
TIER 1 COMP	Total tier 1 compensation up to the maximum allowable for each year. Sick pay is not included in this amount. Lag compensation is not shown for any lag year.
MISC COMP	Miscellaneous compensation earned for years 1982 - current.
TIER 2 COMP	Total tier 2 compensation reported for each year after 1978, up to the maximum allowable for each year. Lag compensation is not shown for any lag year.
WAGES	Total SS earnings credited for each year.
Comb Tier 1 + WG	Total tier 1 compensation and SS earnings credited for each year up to the allowable maximum for each year. Sick pay is not included in this amount.
*Indexed Tier 1	Indexed tier 1 compensation used to compute AIME PIA #3 for

Comp for PIA3	G90 with date into system prior to 10/14/2011.
Indexed wage tier1 comp nonexcl	Indexed tier 1 wage/comp based on non exclusion eligibility year (EY). The column will display zero earnings if non disability case for G90 with date into system 10/14/2011 or later.
Indexed Wages & Tier 1 Comp for PIA1	Indexed SS earnings and Tier I compensation used to compute AIME PIA's 1 and 9 and the frozen minimum PIA. Miscellaneous pay is included.
DM/LAG	<p>May display one of three possible values.</p> <ul style="list-style-type: none"> • 'P' indicates a deemed service month manual determination is pending • 'R' indicates manual deeming has been resolved • 'L' indicates lag service months have been included

9.14.140 Tier 2 and Basic Amount Computations

Field Name	Description
AMC Computations	<p>Computations based on the employee's prior and subsequent service. Prior service will be used in these computations if the employee has less than 30 years of subsequent service. This item is not completed on recomp G-90's.</p> <p>Information displayed is dependent on the type of computation requested. If the retirement G-90 was requested under the pre-1981 amendment provisions (see Exhibit #2), this item will show the employee's total pre-1975 and post-1974 compensation (up to the applicable maximum), AMC's #1 through #5, optional AMC's #1, #2 and #5, and the FAMC. If the regular and optional AMC's are the same, the same figure will be shown in both places. If the Employee attains age 65 after 1974, optional AMC #1 will be left blank. If the employee attained age 65 before 1951, the word "MAN" will be displayed in the spaces for optional AMC's #1 and #5. When this occurs, examiners would get a manual computation based on the yearly breakdown of earnings that the Claims Certification Section has on microfilm. If creditable M/S has been included in the computations, the service months, compensation, and AMC's 1 & 5 will be shown with and without M/S.</p> <p>If the G-90 (retirement or certain survivor cases) was requested under the 1981 amendment provisions (see Exhibit #3), this item</p>

	<p>will show the employee's pre-1975 service months and compensation, the total service months, the compensation from the employee's highest 60 months of service, and AMC, the employee's Tier II amounts, the FAMC, and in some cases, the employee's rounded months of service. If creditable M/S has been included in the computations, the service months, compensation, AMC, and tier 2 amount(s) will be shown with and without M/S.</p> <p>Prior to the 1981 amendments, this item was always blank on survivor G-90's. Effective with the 1981 amendments, this item is completed if the employee died after September 30, 1981. The entries in this item should be used to compute current annuity rates only if the employee's ABD was after September 30, 1981, or if the employee died after September 30, 1981 and before becoming entitled to an annuity.</p>
Pre-1981 amendment	<p>The entries in this item for pre-1981 amendment cases are as follows:</p> <ul style="list-style-type: none"> • Pre 1975 - creditable service months, compensation, AMC and optional AMC based on the employee's railroad service through 12-31-74. • With M/S - contains the above computations with M/S included. • Post 1974 - creditable service months, compensation, AMC and optional AMC based on the employee's railroad service after 1974. • 1976 Maximum - AMC 3 amount based on the 1976 compensation maximum. • 1980 Maximum - AMC 4 amount based on the 1980 compensation maximum. • Thru RR DLW - employee's service months, compensation, AMC and optional AMC based on his service through the last year in which he worked in the railroad industry (for grandfather computation). • With M/S - computations immediately above with M/S included. • FAMC - final average monthly compensation amount.
1981 amendment cases	<p>The entries in this item for 1981 amendment cases are shown as follows:</p> <ul style="list-style-type: none"> • Pre-75 - pre-75 service months and compensation (without

M/S).

- Total Months - total creditable service months to date (with and without M/S).
- Rounded Months - If the employee filed for an annuity prior to 4-1-82, the rounded service months (with and without M/S) will be shown on employee retirement G-90's.

(Rounded service months through 9-30-81, even if applicable (certain survivor "A" cases), are not reflected on employee survivor G-90's.

- High 60 Compensation - compensation (with and without M/S) from the employee's high 60 months.
- AMC - AMC (with and without M/S).
- Tier 2 - employee's basic tier II amount (with and without M/S) before any WF reduction or COL increases.

Since rounded service months through 9-30-81 are not reflected on employee survivor G-90's, the tier II calculation for an affected case will be understated.

- COL Tier 2 - In survivor "A" cases where the employee died after 9-30-81, the employee's tier II amount (with and without M/S) with COL increases from the employee's ABD through the employee's date of death will be shown. This tier II will be understated if rounded service months through 9-30-81 are applicable. If the employee died after 1981 and on the first of the month in which a COL increase is due, the tier II amount(s) with COL increases will include the COL increase effective in the month of death.

In retirement cases and initial "D" survivor cases, a Tier II amount with COL increases will not be printed. Therefore, any COL increase that applies must be included.

NOTE: The employee's tier II amount with COL increases should not be used as the basis for the survivor tier II amount if:

- the vested employee annuitant was entitled to a WF before (s)he died; or
- the vested employee annuitant died before entitlement to a WF and would have been age 62 on the survivor OBD; or

	<ul style="list-style-type: none"> the vested employee died before entitlement to an annuity. <p>In the situations described above, a WF reduction must be applied to the employee's Tier II amount before including any COL increases. Therefore, the employee's basic tier II amount should be used for any case described above.</p> <ul style="list-style-type: none"> FAMC - This line displays the final average monthly compensation (FAMC) amount. See RCM 8.6, G-354.4 instructions, item 12 for information on the computation of the FAMC amount. RAILROAD SERVICE BEGIN DATE IS MM/CCYY <p>This date is acquired from EDM and is displayed as follows:</p> <ul style="list-style-type: none"> If the service beginning date is in the period before 1951, "99/1950" is displayed; If the service beginning date is in the period 1951 through 1959, "99/CCYY" is displayed. The "99" is constant and CCYY is the actual century and year; If the service beginning date is later than 1959, the actual month, century and year are displayed
Basic Amount	The employee's increment years, and AMR and basic amount to be used to compute the widow's employee restored amount, and the AMR and basic amount to be used to compute the lump sum death payment. This item is completed on employee retirement G-90's when the employee has a current connection and on employee survivor G-90's
RRSIA: EE Attained 60 Months	The month and year the employee acquires the 60 th month of service after 1995.

9.14.145 Old Start/Trans PIA Data

Field Name	Description
Type	"TRANS" will be shown if the eligibility year is between 1979 and 1983. "77 OS" will be if the eligibility year is prior to 1979.

AMW	The starting TRANS or 1977 OS PIA 's are from the June, 1978 AMW PIA table.
PIA Amt	The applicable PIA based on the employee's average monthly earnings.
YOC	Total years of coverage.
COL Amt	The PIA amount including applicable cost-of-living increases.

9.14.150 PIA 1 Data

Field Name	Description		
Eff Dt	If request type is	Then 1st eff date is	Followed by
	'01' for red 60/30	ABD	N/A
	'62' for red 60/30	1 st full month age 62	Latest 19 recomps
	All others	Later of ABD or SSA Insured Status(SSA I/S)	Latest 19 recomps
Type	"AMW" will be shown if the eligibility year is prior to 1979. "AIME" will be shown if the eligibility year is after 1978.		
AMW/AIME	The actual average monthly earnings if the AMW applies. The average indexed monthly earnings if the AIME applies.		
PIA Amt	The Primary Insurance Amount (PIA #1) derived from the AMW/AIME based on bend points for the Year of Eligibility. <u>If NCSP reduction applies, the higher of the NCSP guaranty amount or NCSP reduced PIA will be shown.</u>		
YOC	Total years of coverage <u>(YOC) based on NCSP if applicable. Otherwise displays YOC without NCSP consideration.-</u>		
Spec Min	An alternative PIA based on YOCs and earnings amounts for each year.		

ELG Yr	The eligibility year that this PIA #1 is based upon.
COL Amt	The PIA amount including applicable cost-of-living increases.
COL Spec Min	The alternative PIA including applicable cost-of-living increases.

9.14.155 SSEB/PIA9 Data

The SSEB/PIA9 is now a shared field for both the SSEB PIA and PIA9. Paper G-90s have separate sections for each of these calculations. The calculations have always been performed the same way.

Field Name	Description
Eff Dt	The earlier of first full month age 62 or disability freeze but not earlier than the later of ABD or SSA Insured Status (SSA I/S) followed by the latest 19 recomps.
Type	“AMW” will be shown if the eligibility year is prior to 1979. “AIME” will be shown if the eligibility year is after 1978.
AMW/AIME	The actual average monthly earnings if the AMW applies. The average indexed monthly earnings if the AIME applies.
PIA Amt	The Primary Insurance Amount (PIA #9 or SSEB) derived from the AMW/AIME based on bend points for the Year of Eligibility. <u>If NCSP reduction applies, the higher of the NCSP guaranty amount or NCSP reduced PIA will be shown.</u>
YOC	Total years of coverage. <u>(YOC) based on NCSP if applicable. Otherwise displays YOC without NCSP consideration.</u>
Spec Min	An alternative PIA Based on YOCs and earnings amounts for each year.
ELG Yr	The eligibility year that this SSEB PIA/PIA #9 is based upon.
COL Amt	The PIA amount including applicable cost-of-living increases.
COL Spec Min	The alternative PIA including applicable cost-of-living increases.

9.14.160 PIA 3 Data

The data below is no longer provided on G90 with date into system 10/12/2011 or later.

Field Name	Description
Eff Dt	The Year of Eligibility used for the PIA #3 computation.
Type	“AMW” will be shown if the eligibility year is prior to 1979. “AIME” will be shown if the eligibility year is after 1978.
AMW/AIME	The actual average monthly earnings if the AMW applies. The average indexed monthly earnings if the AIME applies..
PIA Amt	The Primary Insurance Amount (PIA #3) derived from the AMW/AIME based on bend points for the Year of Eligibility.
YOC	Total years of coverage.
Spec Min	An alternative PIA based on YOCs and earnings amounts for each year.
ELG Yr	The eligibility year that this PIA #3 is based upon.
COL Amt	The PIA amount including applicable cost-of-living increases.
COL Spec Min	The alternative PIA including applicable cost-of-living increases.

9.14.165 PIA 17 Data

The calculation of PIA 17 has been expanded as of 3/1/2002 as follows.

If the MS is cred as	And the MS end date is	then
wages	N/A	PIA 17 w/o MS
comp	Before 1957	PIA 17 w/ & w/o MS
comp	After 1956	PIA 17 w/ MS

Field Name	Description
AIME	The average indexed monthly earnings.
PIA Amt	The Primary Insurance Amount (PIA #17) derived from the AIME

	based on bend points for the Year of Eligibility. <u>If NCSP reduction applies, the higher of the NCSP guaranty amount or NCSP reduced PIA will be shown.</u>
YOC	Total years of coverage- <u>(YOC) based on NCSP if applicable. Otherwise displays YOC without NCSP consideration.</u>
Spec Min	An alternative PIA based on YOCs and earnings amounts for each year.
COL Amt	The PIA amount including applicable cost-of-living increases.
COL Spec Min	The alternative PIA including applicable cost-of-living increases.

9.14.170 PIA 4 - 8D Data

Field Name	Description
PIA	The label for each of PIAs 4, 5, 6, 7, 8, 8D.
AMW	The average monthly earnings amount used to determine the PIA amount.
Amt	The Primary Insurance Amount for each PIA. These are all AMW based PIAs at the 6/74 level.
YOC	Total years of coverage.
Spec Min	An alternative PIA based on YOCs and earnings amounts for each year.

9.14.175 Quarters of Coverage

Field Name	Description
Required	The number of QCs required for an insured status under SSA rules are shown here.
MS as	If M/S is involved, either “comp” or “wages” will be printed to show how the military service was used for determining total QCs.
Acquired through	The acquired quarters of coverage using different computation methods will be shown. The year in which the QC total shown is

	based.
Wages Only	Number of QCs using only wages through a specific year will be shown.
To Date	Number of QCs to date are shown.
Wages & Post 1974 Comp to date	Acquired quarters based on “wages and post-1974 compensation” are shown.
QTR I/S Acquired	<p>The quarter in which an insured status was acquired for work deduction purposes is shown here. If the employee does not have a work deduction insured status, “9-99” will be shown here.</p> <p>If it is possible that the annuitant might have a W/D insured status but the program was unable to make a determination because SSA did not furnish the wage QC pattern for 1937-1952, a dash (-) will be printed here. If unable to make a determination on the basis of information in file, release a teletype to SSA to obtain the annuitant’s total QCs, and determine the work deduction insured status per RCM 5.7.41.</p>
SSEB Acquired QTRs	The quarter in which an insured status was acquired for SSEB purposes is shown here. The number of QCs shown will be the same as the number of quarters based on wages only to date or the number of quarters based on wages and post-1974 compensation, if either of those are enough to earn an insured status. If the employee does not have enough QCs for an insured status based on wages and compensation in the 1937-1950 period (one QC is credited for each \$50 of earnings) and/or wages and compensation for the period after 1950; in that case, the number of quarters of coverage acquired using these additional earnings will be shown.
FMB Eff Dt	The effective date for the Family Maximum Benefit will be shown here.
Amt	The amount of the Family Maximum Benefit. It will be based on AIME PIA #9 for retirement G-90s. The FMB will be based on PIA #1 for survivor G-90s. <u>If NCSP reduction applies, the higher of the NCSP guaranty amount or NCSP reduced PIA will be shown.</u>
COL thru	The amount of the Family Maximum Benefit including cost-of-living increases through current.
FRZN MIN	The Frozen Minimum PIA will be shown here, but only if the employee was initially eligible before 1982. On retirement G-90s,

	the minimum AIME PIA of \$122.00 will be printed. On survivor G-90s, the minimum AIME PIA with COL increases from the employee's ABD through the date the G-90 is dated will be shown here. If the employee is initially eligible after 1981, the Frozen Minimum does not apply.
Amt	The Frozen Minimum PIA amount is shown here.
COL Amt	The amount of the Frozen Minimum including cost-of-living increases through current.

9.14.180 RRSIA

Field Name	Description
SSA I/S REQ QC's	The number of required QC's to be insured at SSA.
SSA I/S ACQ QC's	The number of acquired QC's from 1951 to the Through date.
Through	The last year of earnings considered by SEARCH to derive the number of acquired QC's.
_SSA I/S	The month and year the number of required QC's is met.

9.14.190 G-90 Online - Survivor Reentry B

FOM 1 - Manual G-90 Listing will no longer be supported on TextBook. The section provides a list of all current survivor reentry B G-90's. It provides the claim number, date the G-90 was entered onto the FOM, the date the examiner cleared the G-90, and the cause of the reentry B. This information is now available on the G-90 Online Database (GOLD).

9.14.195 Effective Date

The new process for the survivor reentry B G-90's was placed into production effective October 3, 2001. Any open items on the FOM listing have been resolved. The Manual G-90 Listing in the FOM will be purged on November 1, 2001.

9.14.200 New Process

The following describes the survivor reentry B G-90 process.

1. Each business day GOLD is updated with SEARCH output.

2. The CCU supervisor will identify all survivor reentry B G-90's that require a manual calculation. She will enter and update the 'Assignment' date daily.
3. CCU examiners are responsible for reviewing GOLD and reacting to any survivor reentry B G-90 containing an 'Assignment' date. Upon completing a G-90a, they will enter the 'Completed' date.

9.14.205 CCU Action

The following three types of survivor reentry G-90's are reacted to by the CCU examiners.

1. Service after date of death
2. Military service after 1956
3. MS TR2 questionable - 37-50 overlap

If a manual computation is required for any other survivor reentry B, a G-563 is to be completed.

9.14.210 Tracing

Please send an e-G-115 to RIS Supervisor's attention:

- If a survivor reentry B G-90 does not contain an "Assigned" date within three business days of the date the G-90 was loaded to GOLD; or
- If the 'Completed' date has not been entered within 10 business days from the date the G-90 was 'assigned' on GOLD.

9.14.215 Access

All users with access to 'rrbwebp01' have access to GOLD. Please refer to RCM 9.14.20 for instructions how to access GOLD.

9.15.1 Datasets from Mainframe Programs

Monthly activity counts are mechanically created into datasets by the mainframe programs listed below for the STATS Reports. A copy of each of the datasets remains on TSO for at least 12 generations. The generations are numbered progressively, as they are created (i.e. 1, 2, 3, 4, etc.).

The line of data for each field office is considered to be “a record.” The KOR program P2678901 will pull in the first 53 records received from each dataset. This means that the records at the end of datasets with numbers, such as “810” or “999” are bypassed.

If any of the datasets for the month are not ready, the KOR program P2678901, which creates the Field Office Workload Master dataset (P.BRC.#2789DD9), willabend. This happens because the latest generation of the dataset has a “Month of Activity” that does not match the “Month of Activity” for the KOR run. An exception is made for the monitoring dataset (see RCM 9.15.9). Since the monitoring dataset is only created once a year, the KOR program P2678901 will bypass it, unless BIS is notified that a dataset has been created for that month.

9.15.2 RRA Application Counts from KOR

P.BRC.#2454DD2 is a dataset of counts from the monthly KOR run with records in the following format:

Source Code	Month of Activity	Field Office	Counts of Applications by Type
K	(MMCCYY)	(D/O Number)	AA-1, AA-1D, AA-3, S to W, AA-17, AA-17B, AA-18, AA-19, AA-19A, G-315, AA-20, AA-21, AA-6, AA-7, and EE Dis Med

9.15.3 Change of Address Counts from FAST

P.BRC.R26889.DD4 is a dataset of monthly counts from FAST/COA with records in the following format:

Source Code	Month of Activity	Field Office	Code “R” COA	Other COA
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F (MMCCYY) (D/O Number) 99999 99999

9.15.4 First Notice of Death Counts From APPLE

P.BSB.RAPB20.DD1 is a dataset of monthly counts from APPLE with records in the following format:

Source Code	Month of Activity	Field Office	First Notice of Death Initially Entered in Month
A	(MMCCYY)	(D/O Number)	9999

9.15.5 Non-Receipt Counts from Check Issue

P.BRC.#2029DD5 is a dataset of monthly non-receipt counts from check issue with records in the following format:

Source Code	Month of Activity	Field Office	Non-Receipt Cases Entered in Month
N	(MMCCYY)	(D/O Number)	9999

9.15.6 SPEED Monthly Counts

This is for future use. KOR program P2678901 will not abend if the SPEED dataset is not yet ready. This will be a dataset of monthly counts of work deduction cases from the Speed program with records in the following format:

Source Code	Month of Activity	Field Office	SPEED Records Entered in Month
S	(MMCCYY)	(D/O Number)	9999

9.15.7 W-4P Monthly Counts from TAS

P.BRC.#2271DD4.Y2K is a dataset of monthly W-4P counts from the TAS program with records in the following format:

Source Code	Month of Activity	Field Office	W-4P Records Entered in Month
T	(MMCCYY)	(D/O Number)	9999

9.15.8 RUIA Monthly Field Office Activity Counts from RUCS

P.BUS.#5141SD2 is a dataset of monthly RUIA counts for activity entered into RUCS by field offices. The records are in the following format:

Source Code	Month of Activity	Field Office	UI Apps	UI Clms	SI Clms	UI Intv
R	(mmddccyy)	(D/O No)	9999	9999	9999	9999

9.15.9 Monitoring Counts

P.BRC.#2789DD7 is a monthly dataset of counts for monitoring activity created in the month. Remind BIS whenever there is an updated monitoring dataset for the “Month of Activity” of the KOR run.

For months in which the monitoring program is not run, a new generation of this dataset is not created. KOR program P2678901 will not abend if a monitoring dataset is not created for the “Month of Activity” of the KOR run. For those months, when KOR creates the Field Office Workload Master dataset, KOR will enter zero as the monitoring counts for that month.

The records are in the following format:

Source Code	Month of Activity	Field Office	Rep Pay	Aged	Parent for Child
M	(MMCCYY)	(D/O No)	9999	9999	9999

9.15.10 Field Office Workload Master (Combined Counts)

P.BRC.#2789DD9 is the monthly Field Office Workload Master dataset of the combined counts from the datasets listed above. This dataset is created by the KOR program P2678901. This program pulls in the “last created” dataset from those listed above. If the “Month of Activity” on the “last created” and the month of activity for the KOR P2678901 run to not match, the KOR P2678901 run will abend.

The format of the Field Office Workload Master dataset is as follows:

Source Code	Month of Activity	Field Office	Counts From Datasets Listed Above
WM	(MMCCYY)	(D/O No)	

This dataset is downloaded mechanically each month to a PC server as part of the KOR P2678901 run. A copy of the mainframe dataset P.BRC.#2789DD9 remains on TSO for 12 generations.

Once the data from the dataset is appended to the PC STATS database of field office activity, the dataset can be deleted from the PC server.

9.15.11 Verifying the Monthly KOR Program P2678901 Run

A. A&T Duties Before Running P2678901

A & T will verify that the regular monthly KOR run is correct. A&T will also verify that all the “last created” datasets describe in RCM 9.15.2-RCM 9.15.9 are for the correct “Month of Activity” and the datasets have valid field office numbers in the first 53 records.

There are two steps for checking each dataset.

First - View each dataset on TSO by typing in the dataset name and browsing the last generation created. Check to make sure that the last generation created has the correct “Month of Activity” and the correct RRB field office numbers in the first 53 records.

Second - Use the EXTRA! /Tools/Transfer File utility to download the datasets to your PC “H\.” If you save the dataset names (including the generation number) as a group on the Transfer File utility, you can simply edit those names to adjust the “generation count” by 1 each month before downloading the files to your PC.

If everything is okay, prepare Form G-569, *Job Request/Control /Status Sheet* and walk the form to the second floor incoming tray for job requests to authorize the monthly KOR program P2678901 run to create the Field Office Workload Master dataset (P.BRC.#2789DD9).

B. A&T Duties After Running P2678901

If all of the syslist condition codes are “000,” check to make sure the counts on

dataset "P.BRC.#2789DD9. (generation for the month of activity)" agree with the counts on the individual datasets described in RCM 9.15.2-9.15.9 for the generation for the same month of activity. One way to do this is to use "EXTRA!/Tools/ Transfer File" to download the dataset P.BRC.#2789DD9 to your PC "H\:" with the other STATS datasets discussed in Section (A) above. Then open each one with Microsoft Excel and copy the counts to the Microsoft Excel workbook for checking STATS (currently STATSFISYEAR2004.xls).

Note: The STATFISYEAR2004.xls is simply a tool to use to check the datasets. It is not part of the STATS Microsoft Access program.

The files are downloaded to your PC as text files.

1. Open Microsoft Excel.
2. Then use File-Open and select the dataset from your PC "H:" that you want to open.
3. Microsoft Excel will convert that file to an Excel format by asking a few questions. Indicate that the datasets are "delimited" by "comma." You can then click on finish.
4. The Microsoft Excel version of the counts can then be copied to the appropriate month on STATSFISYEAR2004.xls using Edit-Copy-Edit-Paste. Copy the counts from the individual datasets to the area with the yellow headings. Copy the counts from the P.BRC.#2789DD9 dataset to the area with the blue headings.
5. Then use Excel Auto Sum to total the counts in each column and compare the totals in the columns from the individual datasets to the totals in the columns from the P.BRC.#2789DD9 dataset. Also compare the totals for that month to the totals for previous months in that fiscal year or totals for previous fiscal years.

If everything looks okay, advise BFS that the dataset that was downloaded by KOR mechanically into the STATS input folder for that month is okay to import into the STATS Microsoft Access program.

C. When a Rerun of P2678901 is Needed

If a problem with the counts on the P.BRC.#2789DD9 dataset is not found until after the counts are added to the STATS Microsoft Access program, advise BFS to use the STATS function that purges that month's counts from the STATS PC database. Then, request the Control Desk to rerun KOR program P2678901. When requesting a rerun of the KOR program P2678901, you must give the Control Desk the actual generation numbers of each dataset they should use as input to the program. Follow the same instructions explained in Sections A and B above to

verify the new generation of dataset P.BRC.#2789DD9 created from the rerun.

9.15.12 Basic PC STATS Reports

The PC based STATS program is a Microsoft Access program. It stores the monthly counts from the Field Office Workload Master datasets (P.BRC.#2789DD9) for at least three fiscal years. The STATS menu page allows the user to select several types of predefined detailed or summary reports with the click of a button.

9.15.13 Regional and National Totals

The mainframe datasets only include counts by field office number. The STATS PC program computes the totals by region and the national totals. The valid field office numbers for each region are stored in a table in the PC program. The authorized user may correct the field office number table by choosing the FTE reports button on the menu screen.

9.15.14 Field Office FTE Counts

The PC based STATS program allows the authorized user to update or correct the FTE counts for each field office. A PC table stores these counts for the STATS Consolidated Maintenance reports.

9.15.15 Field Office Error Counts and Accuracy Reports

The PC based STATS program allows A&T to update or correct the monthly error count for each field office.

The authorized user clicks on the Accuracy Reports button on the menu screen. A screen then appears with the error counts that have been entered into the program. The user may correct a previously entered count by typing over it with the correct count for that field office and corresponding month or may enter new counts for the month just ended.

A PC table stores these counts for the monthly STATS Field Service Accuracy reports, which are produced by the BFS.

9.15.16 Automated Distribution of Monthly STATS Reports

The PC based STATS program allows the BFS to create monthly fiscal year-to-date STATS reports. Part of the "Print" process allows BFS to electronically distribute the reports to established field office STATS folders that have been set-up on the RRB Network. A Form G-590 to STD is required to add a new user to this automatic distribution.

The reports can also be printed on paper or saved to a file.

9.15.17 Correction of Monthly STATS Reports

The PC based STATS program does not allow the correction of activity for an individual field office. Instead, when a correction is required, the counts for the entire “Month of Activity” are deleted from the PC database by BFS. The KOR program P2678901 must be rerun with the corrected data for that “Month of Activity” and the new generation of dataset P.BRC.#2789DD9 must be downloaded to the PC server.

9.15.18 Optional STATS Reports

The PC based STATS program allows BFS to create special reports that compare up to four different fiscal years for field offices, regions or national totals. These reports may be printed on paper, printed to a file or electronically mailed to field office STATS folders that have been set-up on the RRB Network.

9.15.19 OP-STATS Reports

The PC based STATS program also creates reports of monthly RRA application receipt counts by application type for RBD, SBD and DSUBD. These reports use the same table of activity counts as the regular monthly field office reports. However, they are formatted to show only the RRA application counts of interest to RBD, SBD and DSUBD.

9.15.20 Field Office Consolidated Maintenance With FTE’s Report

The Bureau of Field Service also can create a report titled Consolidated Maintenance With FTEs. This report includes the number of items processed along with an item processed/FTE calculation.

The FTE counts by field office number are included in a table in the program. This table is maintained by BFS.

9.15.21 Field Office Consolidated Maintenance With FTE’s/Weighted Scores Report

A. General

The Bureau of Field Service also can create a report titled Consolidated Maintenance w/FTEs-Weighted Score. This report has the same work categories as the Consolidated Maintenance With FTE Report described in RCM 9.15.20. But, instead of the actual number of items processed, this report assigns weights to the different types of work activities.

The score is calculated by multiplying the weight value by the number of work items processed and then dividing by the actual FTE. The FTE counts by field office and the assigned weights by activity type are included in tables in the program. These tables are maintained by BFS. The current weights are shown below.

Activity	Weight Value
Regular Ret Apps (AA-1, AA-3, AA-6, AA-7))	32
EE and Survivor Dis APP (AA-1d, AA-17b, AA-19a, EE Dis Med)	60
Regular Recurring Survivor (AA-17, S to W, AA-18, AA-19, G-315, AA-20)	32
LSDP APP (AA -21)	20
FNOD	4
COA	1
Rep Payee Appts	16
W-4p Input	2
RRA Monitoring (Rep Payee, Aged, Parent for Child)	5
RRA Non-Receipt Non - Receipt (PI Entry)	4
Speed	3
UI Application	2
UI Claim	1
SI Benefit Activity	1
UI Interviews	4

B. Weighted RRA Applications

For RRA applications, an additional calculation is done (adding the weighted totals for each type of application to arrive at the total score):

Step 1 - Multiplying each RRA application type by the BFS weighted value for that type of application; and,

Step 2 - Adding the results of step 1 together for the total BFS weighted value of the RRA Apps.

C. Weighted RRA Maintenance

For RRA maintenance activity, an additional calculation is done (adding the weighted totals for each type of activity to arrive at the total score):

Step 1 - Multiplying each RRA maintenance activity by the BFS weighted value for that type of activity; and,

Step 2 - Adding the results of step 1 together for the total weighted value of the RRA maintenance activity.

9.15.22 Purging the STATS Database

The PC based STATS program will not automatically purge any records. It will remind BFS to purge records that are more than three years old. It will only allow records less than three years old to be deleted when all the data for the “Month of Activity” is being corrected and rerun.

9.16.1 Create an Overpayment Letter Through the Overpayment Recovery Correspondence System (ORCS)

Accessing ORCS through Boardwalk

The ORCS program is located on Boardwalk under Applications. Go to Associated Links and click on ORCS.

NOTE: If this is the first time accessing ORCS, contact the Manager/Supervisor or ORCS Administrator for assistance.

The blue info button is located at the top of the main menu screen. This button is found throughout the ORCS program providing hints and reminders.

Click the show hide button to view the Main Menu screen. The Main Menu will pre-fill with the logon name, division, subunit, examiner number, phone extension, access level and title. A comment line is provided for user entry. Press the Update button to save the comments. To change personal information, use Misc on the menu bar or click on Edit Personal Profile. Update first name, last name, examiner number, authorizer (auth) number, phone extension and preferred number grid items. (Preferred number grid allows the user to select the amount of items shown per page. Depending on the screens resolution, the user may want to change the amount. The default is 25 items.) Inform the supervisor if the division, subunit, access level and/or access title needs to be changed. Press the Submit button to update data.

Click this link to view the Edit Personal Profile screen.

View Manager List – Current list of managers and supervisors.

What's New? – A new notification feature that will provide updates to the ORCS program.

Work Packages Assigned to You – Allows the user to view their assigned work, delete a case that is PE (Pending Exam) or ResetToPE if case is PA (Pending Auth).

Click this link to view the Main Menu screen.

Actions Menu

The actions menu consists of a variety of ORCS functions. Based on the unit designation, access will vary between users.

RRA: Prepare New Overpayment Letter, Prepare PAR Action Only (G-205/G-206), Authorize, View My Cases, or Recall Case from Closed or OIG Status. (RRA includes Retirement and Survivor examiners.)

DRD: Prepare New Non-Entitlement Overpayment Letter, Authorize, View My Cases and Recall Case from Closed or OIG Status.

CSU: Prepare PAR Action Only (G-205/G-206), View My Cases, Recall Case from Closed or OIG Status.

RUIA: Prepare New Overpayment Letter, Prepare RUIA G-205R, Authorize or View My Cases. (FUTURE ENHANCEMENT)

MEDICARE: Prepare New Overpayment Letter, Prepare PAR Action Only, Authorize or View My Cases. (FUTURE ENHANCEMENT)

Click this link to view the Actions Menu screen.

Prepare Overpayment Letter

NOTE: It is recommended that all PAR actions be completed before preparing an overpayment letter. Before beginning an overpayment letter, ROC/SURPASS awards should be pending auth.

Select Prepare New Overpayment Letter from Actions Menu. The Debtor Selection screen will appear.

This screen is used to process RRA, DRD, RUIA and Medicare overpayment letters. The user can enter an RRB claim number or SS number (SSN). When the RRB or SSN is submitted, ORCS will retrieve the data from the mainframe. It may take a few seconds to retrieve this data. ORCS will provide the annuitant history under that claim number.

NOTE: If an RRB claim number is entered, ORCS will upload all annuitants associated with that number. If entering an SSN, leave the RRB claim number blank. ORCS will only upload that specific annuitant. If an incorrect annuitant or the wrong claim number was selected, go back to the top of the Debtor Selection screen and select a new annuitant or enter a new claim number.

ORCS alerts the user if an existing case matching the entered claim number or SSN is found. If so, check with the user before continuing so no duplicate case is created.

Click this link to view the Debtor Selection screen.

The Alternative Case Preparation buttons only appear when the user enters a claim/social security number and a matching mainframe record is not found. This would be used to send overpayment letters to debtors that have not been entered into PREH (Examples: an annuitant cancels their annuity or third party/legal partition cases). This functionality will also be used in the later phases of ORCS to send overpayment letters for RUIA and MEDICARE because many of their debtors are not in the PREH database.

A. Create OP Letter to Other Claimant – This will allow the user to enter the employee and annuitant/claimant information when no mainframe data is found.
Click this link to view the Alternative Case Preparation screen.

B. Create Cancel (No Debt) Letter to Annuitant – This allows the user to create a **RL-31A** to the annuitant when no mainframe data is found.

Click this link to view the Alternative Case Preparation No Debt screen.

The “copy” button will enter the SSN if it is the same as the claim number. If the claim number is a six-digit number (Example: A 123456), the user will be required to enter the SSN. The “copy” button will also enter the annuitant/claimant information if it is the same as the employee. Choose a check symbol and payee code. Select “Begin” to continue.

After reviewing the data, select the appropriate payee. ORCS will retrieve the Pay Summary, if entered.

Click this link to view the Pay Summary screen.

ORCS will retrieve the mainframe data from PREH and ROC/SURPASS. Review the retrieved data, select Debtor Type (Current Pay, Non-Entitlement, Zero Annuity, Cancel with Debt) and then select “Use PREH” (for One Pay Only cases) or “Use ROC/SURPASS” (for Recert Cases) to continue. Dashes will be shown when no data is available.

Click this link to view the PREH/ROC/SURPASS screen.

The Work Package Confirmation screen will appear. The user will be asked to confirm the annuitant’s name and address. This is **required** because there can be some inconsistencies in the parsing of the name and address when data is retrieved from the mainframe.

Click this link to view the Confirm Name screen.

Click this link to view the Confirm Address screen.

The PAR table is uploaded each day with current data. If ORCS discovers an existing debt, a window will appear allowing the user to select this debt or establish a new debt.

1. Select an existing debt and click “Submit”, the Bill Doc ID and amount of the chosen debt will be displayed.
2. Select “Cancel”, the existing debt or debts associated with the claim number will be ignored and a new overpayment will be established.

3. Select "Make 10a Letter", choose an existing debt and click "Make 10a Letter," the Bill Doc ID and amount of the chosen debt will be displayed.
Click this link to view the Section 10a screen.

Click this link to view the Existing PAR Debt screen.

NOTE: If this is an 1856 case, see RCM 9.16.13.

Click this link to view the Work Package Confirmation screen.

The Work Package Confirmation screen provides the user with the Employee, Annuitant and Benefit Information that has been retrieved from the mainframe. Each of these items can be opened or closed by pressing the show/ hide buttons on the left side of the screen.

If a debt is found, a red-colored box appears at the top of the screen. Click on that box and details of the debt will be shown.

Click this link to view the Current Debt screen.

In some cases the payment summary may be missing or incomplete. The user will have the opportunity to complete these entries after selecting Begin Work Package.

The Work Package Confirmation screen allows the user to confirm that the data entered is correct, if not, the user can go back to the Debtor Selection screen and choose another claim number.

At the bottom of the screen, ORCS asks if this is a RRAILS RL-483 letter. This form letter is rarely used and it does not need any PAR action. If this form is selected, ORCS will by-pass the PAR information.

Select Begin Work Package. This will **establish an ORCS record** and the Work Package Preparation screen will appear.

Click this link to view the Work Package Preparation screen.

NOTE: Not all the entries below will be shown on the Work Package Preparation screen. It will depend on the type of letter that is created.

The Work Package Preparation screen provides the following information:

1. Overpayment Type (current pay, non-entitlement, zero annuity, etc)
2. Status History – Date and time for each status.
Click this link to see Status History.
 - PE – Pending Exam

- PA – Pending Auth
 - P2 – Pending 2nd Auth (Any OP over the threshold amount. Currently, the retirement and survivor 2nd Auth threshold is \$15,000.)
 - PD – Pending DRD Review
 - PG – Pending OIG
 - PR – Pending Reminder Call-up
 - CN – Cancelled
 - CL – Closed, Action Completed (Letter and/or PAR Action)
3. Created – Date and time
 4. Updated – Date and time
 5. Mainframe Compare *– Date and time mainframe was compared.
 6. Mainframe Update *– Date and time mainframe was updated. **NOTE:** If the date is different, ORCS will compare and update the mainframe. This assures that the most current data is being used.
 7. Update Reminder – This feature is used when an examiner needs to set a date for completion of a case. ORCS allows a future date to be 90 days or less and will release a notification email to the examiner. Select a date and press “Update Reminder”. The status of the case will be Pending Reminder (PR). An examiner can work on a case in PR status but they cannot change the status until they remove the reminder date.
 8. Change Status – Shows the type and status of a case.
 9. View Events – Another way to view the status changes.
 10. Reload Mainframe – When the Reload Mainframe button is pressed, the user is directing the ORCS program to check the mainframe data in PREH, ROC, SURPASS, PAR, etc. for any changes since the last time the user entered information for that claim number. **NOTE:** ORCS checks the mainframe once a day. If a change occurs in the same day, press “Reload Mainframe” to include any new updates. An Alert – Mainframe Automatic Update screen will appear when an update is made. Click this link to see Alert – Mainframe Automatic Update screen.
 11. View and Add Remarks – Users can view or add remarks to a case. Click this link to see View and Add Remarks screen.

The **Benefit Information** screen will be prefilled with PREH data. This data cannot be modified by the user.

1. New Actuarial Amt – Actuarial amount will be shown, if applicable.
2. Entitlement End Date – Entitlement End Date will be shown, if applicable. In certain cases ORCS will ask for an entitlement end date. **Example:** Annuity is based on minor child and entitlement will end in less than 48 months. Enter the month and year the entitlement will end. This will allow ORCS to set recovery options based on the remaining months of entitlement. If a date is not entered, ORCS will not let the user proceed.
3. Actuarial Table – Actuarial Table information will be displayed, but will only be used when actuarial adjustment is offered.

The **Overpayment Information** screen will be prefilled with PREH data. This data cannot be modified by the user.

1. OP Source – Payment Summary, Manual or Undefined will be shown. If manual or undefined is entered, the authorizer is required to verify data entered.
2. Pay Sum OP – This is the overpayment found on the Payment Summary.
3. Pay Sum Accrual – This is the accrual found on the Payment Summary.
4. Pay Sum Accrual on G-206 – This is the accrual amount shown on the G-206.
5. G-206 Offset Amt – This is the offset amount shown on the G-206.
6. Gross OP Amt – Total gross overpayment.
7. OP Amt for Letter – This is the overpayment amount shown on the letter.
8. OP Amt for PARS G-205 – This is the overpayment amount shown on the G-205.
9. 1856 OP Amt – This is the overpayment amount shown on an 1856 letter.
10. Penalty Amt – This amount is assessed for annuitants who fail to notify the RRB about their earnings in a timely manner. This penalty can be assessed for all annuitants including those receiving disability annuities.
11. Penalty Included – Verify that the penalty amount was included in the Payment Summary, if not ORCS will include it in its calculation.
12. OP Amt – Total overpayment after penalty deduction.
13. 1856 Balance – This is the projected balance of the overpayment in PARS. This amount will always need to be verified by the user for accuracy.

14. Action Out Amt – This amount represents all accruals applied to the current overpayment. This entry requires an action out code.
15. Net OP Amt – Net OP Amt will be pre-filled if an existing debt or a payment summary is completed.
16. Enter OP Amount – If no OP amount is shown, ORCS will prompt the user to establish an overpayment. Click this link to see the OP Amount screen.
17. Existing PWH – Pre-filled
18. Previous OP Amt – Pre-filled
19. PWH Start Date – Pre-filled
20. OP Letter Date – Pre-filled
21. OP Recovery Date – Pre-filled
22. Bill Doc ID – Pre-filled.
23. Adjustments – Pre-filled
24. Accruals – Pre-filled
25. Months PWH – Pre-filled
26. Recovered Amount – Pre-filled
27. Remaining Amount – Pre-filled
28. 1856 – Choose “Yes”, to add the new debt to the existing debt.
29. Modify 1856 Entries
30. View Payment Summary – If a payment summary (ROC, SURPASS or ORCS version) has been established the user can view the screen.
31. Update Payment Summary – The user can make updates to the payment summary screen. The data will be recalculated through ORCS. See RCM 9.16.3 for payment summary instructions.
32. Edit Penalty Amount – User can edit the penalty amount.
33. Edit OM Amount – User can edit the O/M amount.
34. G-221 – When an overpayment is over the threshold amount, a prompt will ask if a G-221 is needed. Select “Yes” or “No”. If yes, the user will be prompted on the

PAR screen to complete the G-221.

Click this link to view the Work Package G-221 screen.

- 35. Process PAR – Select this button to go to the PAR Action Preparation screen.
- 36. Letter Only No PAR – Select this button when only a letter needs to be processed.
- 37. Process Letter – Select this button to go to the Letter Preparation screen.

The PAR data must be completed first. ORCS will direct the user to the PAR Action Preparation screen. PAR instructions are found in RCM 9.16.2.

Select “Process Letter” button to continue.

The Letter Preparation screen provides the user with Work Package, Employee, Annuitant, and Letter information that has been retrieved from the mainframe. Each of these items can be seen by pressing the show/hide button on the left side of the screen.

Click this link to view the Letter Preparation screen.

The Letter Preparation screen appears only **once**. It primarily provides the user with the recovery options available and the letter selections. If the user selects the wrong recovery option or letter selection, the case must be deleted. Return to the Action Menu screen and reenter the case.

ORCS provides two types of letters:

1. ORCS OP letters – includes a list of commonly used code paragraphs and the option of adding custom paragraphs. The user can view the code paragraphs by number or category.

The Letter Edit screen allows the user to view all available paragraphs and assigned paragraphs by number or category. To view paragraphs by category, press the down arrow under Filter by Category. The drop down menu will allow the user to view all the categories. Click on a category and only those paragraphs will be shown.

Click this link to view the Letter Edit screen.

Paragraphs that are considered “required” will be labeled with an “R”. These paragraphs cannot be deleted or moved. Other assigned paragraphs, not labeled with an “R”, can be moved back to the available paragraphs column if not needed. Users can move any available paragraphs to the assigned paragraph column by selecting the paragraph and using the “>” key. Move an assigned paragraph back to the available paragraph column by selecting the paragraph and using the “<” key.

Custom paragraphs can be added to the assigned paragraph column. Click “Add Custom” button and a box will appear. Enter the custom paragraph in that box. There is a maximum of four custom paragraphs available for each letter. If a custom paragraph is not needed, use the “<” key to remove it.

Paragraphs can be moved within the assigned paragraph column. Select the paragraph and move the up or down buttons, located on the right, to the appropriate position. The user can preview the letter by selecting the Show/Hide letter button.

Inserts that are required in paragraphs have been labeled “U” for user and “S” for system. All inserts labeled “S” will be pre-filled by ORCS. All others will be completed by the user.

Paragraphs that require inserts will be shown under “Enter Insert Values”. The paragraph number, title and insert will be shown. The user will fill in the insert and then view the completed paragraph by pressing insert or format (FMT). To see the completed letter, press Show/Hide Letter. The letter is automatically saved.

2. RRAILS OP letters – includes 16 commonly used RRAILS letters with the option to add a custom paragraph. This enhancement allows the user to request RRAILS letters within the ORCS program.

The Letter Edit screen provides the user with all available RRAILS letters. Instructions on how to navigate through the letter edit screen are explained in Regular OP Letters, above.

Click this link to view the Letter Edit RRAILS screen.

Many of the RRAILS letters have variations to them that cannot be replicated in ORCS, so different versions were made to handle these situations. See the explanations below:

1. RL31A – Select ORCS RL31A and move to the Assigned Paragraphs column.
2. RL104 Series – ORCS RL-104 consists of 2 letters: With and Without Rights.

With Rights – Select ORCS RL104.1 and RL104.2 and move to the Assigned Paragraphs column. Add a custom paragraph and move it under RL104.1. Enter the reason for the overpayment in the custom paragraph.

Without Rights – Select ORCS RL104A.1 and RL104A.2 and move to the Assigned Paragraphs column. Add a custom paragraph and move it under RL104A.1. Enter the reason for the overpayment in the custom paragraph.

3. RL140 Series– ORCS RL140 consists of 4 letters:

RL140A – Attained Age 19

RL140B – Ceased FTS Attendance

RL140C – Changed Your Intent

RL140D – Completed Requirements

Select the appropriate letter and move to the Assigned Paragraphs column. Enter Insert Values.

4. RL166B Series– ORCS RL166B consists of 2 letters: Reinstate and Suspend.

Reinstate – Select RL166B1.a and RL166B1.b (Reinstate) and move to the Assigned Paragraphs column. Add a custom paragraph and move it under RL166B1.a. Enter the reason for the overpayment in the custom paragraph box.

Suspend – Select RL166B2.a and RL166B2.b (Suspend) and move to the Assigned Paragraphs column. Add a custom paragraph and move it under RL166B2.a. Enter the reason for the overpayment in the custom paragraph box. Enter Insert Values.

5. RL483 – Select ORCS RL483 and move to the Assigned Paragraphs column. Enter Insert Values.
6. RL484 – Select ORCS RL484 and move to the Assigned Paragraphs column. Enter Insert Values.
7. RL1855A – Select ORCS RL1855A and move to the Assigned Paragraphs column. Enter Insert Values.
8. RL1855B – Select ORCS RL1855B and move to the Assigned Paragraphs column. Enter Insert Values.
9. RL1855C – Select ORCS RL1855C and move to the Assigned Paragraphs column. Enter Insert Values.
10. RL8000 Series – ORCS RL8000 consists of 2 letters: Entitlement and Non-Entitlement.

Entitlement – Select RL8000A.1 and RL8000A.2 (Entitlement) and move to the Assigned Paragraphs column. Add a custom paragraph and move it under RL8000A.1. Enter the reason for the overpayment in the custom paragraph box. Enter Insert Values.

Non-Entitlement – Select RL8000B.1 and RL8000B.2 (Non-Entitlement) and move to the Assigned Paragraphs column. Add a custom paragraph and

move it under RL8000B.1. Enter the reason for the overpayment in the custom paragraph box. Enter Insert Values.

Select the Show/Hide button and preview the letter.

Select the appropriate ORCS letter option (Regular or RRAILS) and press Start Letter. The Letter Edit and Recovery Option screen will appear.

Click this link to view the Recovery Option screen.

The user is able to verify the recovery options available or request a G-422 to the Bureau of Actuary, if applicable. To hide this box, press Show/Hide Recovery Opt.

A G-422, Request for Actuarial Adjustment, is requested when the actuarial tables cannot be used to calculate an actuarial amount. ORCS will alert the user to print a G-422.

Click this link to view the Print G-422 screen.

Complete the Form G-422 and remit to the Bureau of Actuary. The case will return to PE status.

When the actuarial amount is received from the Actuary, click on the case and enter the amount, submit and a new Recovery Option screen will appear.

Click this link to view the Actuarial Adjustment screen.

Click this link to view the Recovery Option Actuarial Amount Results screen.

After completing the Letter Edit screen and any PAR action, go to the top right corner and select Status. The Change Status screen will appear.

Click this link to see the Change Status screen.

The Change Status screen provides the following:

1. Status – Pre-filled
2. Start – Pre-filled (Date/Time)
3. End – Will be pre-filled with a date and time when case is completed.
4. Status By – Pre-filled with user name
5. Select Next Status – User entry – PA = Authorization; DL = Delete Case
6. Remarks – Enter Remarks if applicable.
7. Submit Status – Case will be sent to Authorization or Deleted

8. Cancel – Returns to the previous page.

When a case is ready for Authorization, select PA and press Submit Status. If a case needs to be deleted, select DL and press Submit Status. If a case is incomplete, the user can return to the Main Menu. This case will be shown as PE under Work Packages Assigned to You.

9.16.2 PAR (G-205/G-206) Instructions

The PAR Action Preparation screen can be accessed through the overpayment letter process or by selecting Prepare PAR Action Only from the Actions Menu.

A. Accessing PAR (G-205) Through the Letter Process

1. **ESTABLISH** – When establishing a new debt the user has the option to enter a G-205 and one G-206. Click this link to view the G-205 G-206 screen. Select “Process PAR” the PAR Action - Establish screen will appear. This screen includes the Work Package, Employee, Annuitant and PAR Action Information screens. Click on Show/Hide to view these screens. In cases where the overpayment is over the threshold and the case requires OIG handling, select “Create G-221”.
Click this link to view the PAR Action G-221 screen.

Click this link to view the PAR Action – Establish screen.

The PAR Action Information screen consists of the following:

1. Bill Doc ID – Pre-filled
2. Action Code – Pre-filled
3. Bill Print Flag – Pre-filled
4. Transaction Type – Pre-filled
5. Waiver Flag – Pre-filled
6. Cash Receipt No – Pre-filled
7. Dunning Flag – Pre-filled
8. Text Type Code – Pre-filled
9. Counter – User selects from drop down menu.
10. Cause Code – User selects from drop down menu.
11. Source Code – User selects from drop down menu.

12. Type Code – User selects from drop down menu.
13. ASTRO Code – User selects from drop down menu.
14. Gross OP Amount – Pre-filled
15. RR OP Amount – Enter OP amount
16. SUP OP Amount – Enter OP amount
17. Remarks – Enter Remarks, if applicable.
18. Save G-205 – Press this key to save G-205 data.
19. Preview G-205 – This allows the user to view the G-205. Scroll up and down to view the full screen. Press the “Close” button to return to the PAR Action – Establish screen.
20. Create G-221 – Press this key to create a G-221. Items 1-7 are prefilled. Complete the applicable items, submit and close. Click this link to view the PAR Action G-221 screen.
21. Preview G-221 – Allows the user to preview a completed G-221. Click this link to view the G-221screen.
22. Delete G-221 – Press this key to delete a G-221.
23. Add G-206 – Press this key to access a G-206. Multiple G-206 can be entered. See below for G-206 instructions.

When the PAR Action is complete, go to the top right corner and select Letter. The Letter Preparation screen will appear.

2. **Modify** – When modifying an existing debt, the user has the option to enter a G-205 or a G-206. Select “Process PAR” the PAR Action Preparation – Modify screen will appear. This screen includes the Work Package, Employee, Annuitant and PAR Action Information screens. Click on Show/Hide to view these screens.

Click this link to view the PAR Action Preparation – Modify screen.

The PAR Action Information screen consists of the following:

1. Bill Doc ID – Pre-filled
2. Action Type – Pre-filled
3. Previous OP Amount – Pre-filled

4. Previous RR OP Amount – Pre-filled
5. Previous SUP OP Amount – Pre-filled
6. Action Out Code – User selects Action Out Codes only when decreasing the debt.
7. Adjusted OP Amount – Pre-filled
8. RR OP Amount – Enter OP amount, select increase or decrease
9. SUP OP Amount – Enter SUP OP amount, select increase or decrease
10. Remarks – Enter Remarks, if applicable.
11. Save G-205 – Press this key to save G-205 data.
12. Preview G-205 – This allows the user to view the G-205. Scroll up and down to view the full screen. Press the “Close” button to return to the PAR Action Preparation screen.

Click this link to view the View G-205 screen.

When the PAR Action is complete, go to the top right corner and select Letter. The Letter Preparation screen will appear.

B. Accessing Prepare PAR Only Action (G-205)

On the Actions Menu, select “Prepare PAR Action Only (G-205/G-206)”. The Debtor Selection screen will appear. Enter a claim number or SSN.

On the Debtor Selection screen the user has the option to:

1. **Select an Annuitant** – Review and press “Use PREH”.

The Work Package Confirmation screen will appear. Review and select “Begin Work Package”. Confirm name and address. If an existing debt is found, the user can select the debt and press “Submit” or create a new debt by pressing “Cancel”.

Click this link to view the Existing PAR Debt screen.

2. **Select Establish G-205 PAR Action, (Creates a PAR record for someone other than the annuitant(s) shown on the Debtor Selection screen.)** – follow prompts and then select “Begin”.

Click this link to view the PAR Alternative Case Preparation screen.

The Work Package Preparation screen will appear. A prompt will alert the user if any entries are missing or incorrect. Select "Process PAR".

The following prompts will appear:

Annuity Entitlement – Select Entitlement or Non-Entitlement to determine the correct Flags.

Click this link to view the Annuity Entitlement screen.

PARS Category – Select OIG Referral, Reclamation, Estate Handling or N/A. Your selection will be shown in the Remarks Section of the G-205.

Click this link to view the PARS Category screen.

The PAR Action Information screen consists of the following:

1. Bill Doc ID – Pre-filled
2. Action Code – Pre-filled
3. Bill Print Flag – Pre-filled
4. Transaction Type – Pre-filled
5. Waiver Flag – Pre-filled
6. Cash Receipt No – Pre-filled
7. Dunning Flag – Pre-filled
8. Text Type Code – Pre-filled
9. Counter – User selects from drop down menu.
10. Cause Code – User selects from drop down menu. Certain Non-Entitlement cause codes with text type require a payment summary because in these situations a mechanical letter is generated and will be released by DRD.
Click this link to view the Non-Entitlement Cause codes screen.
11. Source Code – User selects from drop down menu.
12. Type Code – User selects from drop down menu.
13. OP Amount – Pre-filled
14. RR OP Amount – Enter OP amount.

15. SUP OP Amount – Enter SUP OP amount.
16. Remarks – Enter Remarks, if applicable.
17. Save G-205 – Press this key to save G-205 data.
18. Preview G-205 – This allows the user to view the G-205. Scroll up and down to view the full screen. Press the “Close” button to return to the PAR Action preparation screen.

Click this link to view the Preview G-205 screen.

19. Add G-206 – Press this key to access a G-206. Multiple G-206 can be entered. See below for G-206 instructions.

When the PAR Action is complete, go to the top right corner and select Status. Change the status to PA (Auth), CL (Close) or DL (Delete).

3. **Select an Existing Debt** – If an Existing Debt is shown on the Debtor Selection screen, click on the Bill Doc ID.

Click this link to view the PAR Existing Debt screen.

The Modify G-205 – Add G-206(s) screen will appear. Choose a check symbol, payee code and/or make a change to the annuitant's SS number. Select a G-205 or a G-206.

Click this link to view the Modify PAR screen.

A consolidated Work Package Preparation screen will appear. Select “Process PAR “.

Click this link to view the Work Package Preparation screen.

Complete the PAR Action Preparation screen, go to the top right corner and select Status. Change the status to PA (Auth), CL (Close) or DL (Delete).

C. Accessing PAR (G-206) Through the Letter Process

A G-206 can be created through the letter process when the user is establishing a debt or from the Actions Menu, Prepare Overpayment letter.

1. **Letter Process** – Follow the G-205 instructions above. The user can request one G-206 to post an accrual, select “Prepare G-206”.
2. **Prepare PAR Action Only** – On the PAR Action Preparation screen, select “Prepare G-206”.

Click here to view the View G-206 screen.

Instructions for the G-206 are as follows:

1. Action – Select from the following items: E – Initial Entry; M – Modify Increase; M – Modify Decrease; R – RECUR (Based on the selection, ORCS will determine the other fields to be completed.)
2. Account Identification – ORCS will pre-fill most items. The Cash Receipt DOC ID may be pre-filled. If not, ORCS will alert the user to enter that number.
3. Transaction Type – Select from the following items: AW (one time only); WO Waiver, Tolerance, Comp; CC Cash; NA Cancelled Payments.
4. Payment Information – Payment Amount – Amount filled in by user; Deposit Number – Pre-filled; Action Out Code – User can select from drop down menu.
5. Withholding Action – This section is used when RECUR has been selected. Select from: Start Full Withholding (date/amount); Start Partial Withholding (date/amount); Stop Withholding (date) and Withholding Action Completed (Full Recovery). Any withholding action requires a date and amount.
6. Remarks – Enter remarks, if applicable.
7. Adjudication Section Sign Off – Pre-filled.
8. DRD Sign Off – Pre-filled, if applicable.
9. Submit G-206 – Press this button to enter the data to PAR.
10. Cancel – Press this button to cancel the data entered.

The PAR Action Preparation screen will show all the G-206 entries. The user will be able to view and edit each screen.

[Click here to view the PAR Action screen.](#)

When the PAR Action is complete, go to the top right corner and select Status. Change the status to PA (Auth), PD (DRD), CL (Close) or DL (Delete).

9.16.3 Payment Summary

The user will complete the payment summary on ROC or SURPASS. ORCS will retrieve the payment summary from the mainframe. If the user needs to make a change to the payment summary, it must be done on ROC or SURPASS. Once the change has been made, select the button “Reload Mainframe” from the Work Package Preparation screen. ORCS will retrieve the new data.

Click this link to view the Reload Mainframe screen.

If no payment summary was completed, the user will be allowed to create a payment summary within ORCS. Click the "Update Payment Summary" button on the Work Package Preparation screen. The Payment Summary Edit screen will appear.

Click this link to view the Payment Summary Screen.

A. ACCRUALS

1. Click the Accruals Calendar
2. Navigate to current month and year; click "<" arrow to go back a month or ">" arrow to go forward a month; to see all the months in the year, click on the month. To navigate to another year, click on the year. Clicking again on the year will show a 10 year period. The arrow keys can take the user 10 years in the past and future.
3. Select the appropriate Adjustment Effective Date.
4. Select the Accrued Through Date. Enter the amount of the monthly payment; navigate to the From Date.
5. Click calendar and select date.
6. Click "Insert", the amount and date of the entry will be shown. If this information is incorrect, the user can delete the entry.
7. To add another accrual amount and date, follow the above instructions.

B. PREVIOUS

1. Click the Previous calendar.
2. Select the appropriate Previous Adjustment Effective Date.
3. Select the Accrued through Date.
4. Enter the amount of the monthly payment; navigate to the From Date.
5. Click calendar and select date.
6. Click "Insert", the amount and date of the entry will be shown. If this information is incorrect, the user can delete the entry.
7. To add another previous amount and date, follow the above instructions.

C. ACCRUALS WITHHELD

1. Enter "Accrual Withheld" amount.
2. Enter a description.
3. Click calendar and select date.
4. Click "Insert", the amount and date of the entry will be shown. If this information is incorrect, the user can delete the entry.
5. To add another accrual withheld amount and date, follow the above instructions.

D. OPO AMOUNTS

1. Enter "OPO Amount".
2. Enter a description.
3. Click calendar and select date.
4. Click "Insert", the amount and date of the entry will be shown. If this information is incorrect, the user can delete the entry.
5. To add another OPO amount, follow the above instructions.

E. PREVIEW

Select "Preview" to view the payment summary.

9.16.4 Authorize

When a user is assigned a case for authorization, go to the Actions Menu and select Authorize. Enter the RRB claim number and press "Search", the Auth Assign screen will appear.

Click this link to see Authorize screen.

Place a check under "Chg Chk" and press **Assign**. Go the Main Menu and the case will be added to the user's Work Assignments. Select the case and begin authorization.

Click this link to see Authorize Assign screen.

9.16.5 Authorization

From the Main Menu, under Work Package Assigned to You, search for cases Pending Auth (PA) status. Click the annuitant's name to retrieve this case. The Work Package Review screen will appear. The tabs at the top of the screen allow the authorizer to review the following items:

Click this link to view Work Package Review screen.

1. Summary - Provides the Work Package, Employee, Annuitant, and Benefit Information.
2. Change Status – Provides the status of each case.
Click this link to view the Auth Change Status screen.
3. Payment Summary – Provides the current payment summary for the case.
4. Status History – Provides the history of the case.
5. Remarks – Provides all remarks made for this case.
6. Events – Provides the event (chronological work package action of interest), name, date, and time for this case.
7. Letter – Provides a preview of the letter, including the enclosures and the paragraphs used. Click this link to view the Letter Review screen.
8. Recovery Options – Provides recovery options available.
9. PAR Action – Provides a preview of the G-205/G-206 and the G-221, if applicable.
Click this link to view the Auth PAR Action screen.

After reviewing all the data, select the change status tab.

PE – The case needs to be returned. Enter comments and submit.

P2 – Second Auth

PD – DRD Handling

PG – OIG Handling

CL – The case is ready for upload, printing and imaging.

Click this link to view Auth Change Status screen.

After changing the status to CL, the letter and attachments will be automatically printed and imaged. ORCS will return the user to the main menu.

After the letter and necessary attachments have been printed, release the letter package to the Mailroom for delivery.

9.16.6 View My Cases

This screen allows users to view all their closed cases and pending authorization cases.

Click this link to View My Cases screen.

This screen allows the user to view the last 30 calendar days of cases. The user can change the date fields by using the calendar icons and then pressing Apply Dates.

This screen provides the following information:

1. Annuitant Name – Pre-filled.
2. Claim Number – Pre-filled.
3. Status – PA = Pending Auth; CL – Closed Case
4. Days to Close – The number of calendar days it took to close the case.
5. SSN – Pre-filled.
6. Type – CPS = Current Pay; Zero = Zero Annuity ; PAR-O = PAR Only; CAN-D = Cancel Delete; NON = Non-Entitlement
7. Status Date - Date entered into ORCS
8. Status By – Pre-filled.
9. Created – Date case created
10. Examiner Name – Pre-filled.
11. Auth 1 – Pre-filled.
12. Auth 2 – Pre-filled.
13. DRD – Pre-filled.
14. OIG – Pre-filled.
15. Reprint – Allows user to Reprint a closed letter and attachments.

9.16.7 Reports

ORCS provides a variety of reports. These reports are only available to the ORCS Administrator, Managers and Supervisors. Contact the ORCS Administrator if a new report is needed or changes to current reports are recommended.

9.16.8 UtilityTables

The Utility Tables contain pertinent data that is used by ORCS to process the overpayment letters. Utility Tables are maintained by the ORCS Administrator.

9.16.9 PAR LOOKUP – B2, B5, B8, UNC

The PAR LOOKUP screen allows the user to search for a PAR record (B2, B5, B8 and Uncollectible). The Search can be done by RRB claim number, Bill Doc ID or Bill Type

and Digit Range. The user can also Reactivate Uncollectible and Remove Charges from this screen.

Click this link to view the PAR Lookup screen.

Enter a claim number, press Search. All data pertaining to that number will be shown.

Click this link to view the PAR Lookup Result screen.

This screen provides the following information:

1. Source – PAR or UNCL will be pre-filled.
2. Prefix – Prefilled.
3. Claim Number – Pre-filled.
4. Counter – Pre-filled.
5. BillDocID – Pre-filled.
6. Debt Total – Pre-filled.
7. Charges – Pre-filled, if appropriate.
8. Name – Pre-filled.

A. Reactivate Uncollectible (UNCL)

When an accrual is found for an uncollectible debt, enter the claim number on the PAR LookUp screen and click on the highlighted UNCL under the Source Code. The Request to Reactivate UNCL Debt screen will appear.

Click this link to view the Request to Reactivate UNCL Debt screen.

Enter the name, address, city, state and zip code of the claimant. Check the box if entering a foreign address. Enter the accrual amount and Remarks. Submit the request and an email will be sent to the DRD, ORCS mailboxes and to the remitter. When DRD action is complete, the user will be notified by email. Take appropriate PAR action to complete the case.

Click this link to view UNCL Email.

B. Remove Charges

If charges are included in the debt, the source PAR will be highlighted, click on PAR. The Request to Remove Charges screen will appear.

Click this link to view the Request to Remove Charges screen.

Enter the accrual amount and Remarks. Submit the request and an email will be sent to the DRD and ORCS mailboxes and to the remitter. When DRD action is complete, the user will be notified by email. Take appropriate PAR action to complete the case.

Click this link to view Remove Charges Email.

DRD will release an email to the remitter, DRD and ORCS mailboxes when action is completed.

9.16.10 Library

The Library consists of all the RRA code paragraphs, RRAILS, and DRD letters. It also holds future RUIA and Medicare Letters. The Library is maintained by the ORCS Administrator.

9.16.11 Management Utilities

Management Utilities are maintained by the ORCS Administrator.

Managers have access to the following Utilities:

1. **Assign Work** – This screen allows the managers to select the division, subunit, view the cases in the division and subunit.

Click this link to view the Assign Work screen.

Select the Assignee – The drop down menu provides a list of examiners available. Select an examiner. Check the box next to the case you are assigning. Press “Assign Checked Cases”. The case(s) will be sent to that examiner.

Click this link to view the Select Assignee screen.

2. **OIG Case Return** – Managers can check the status of an OIG case by using this menu selection. It will provide the OIG determination and what action should be taken. Click this link to view the OIG Case Return screen.

3. **Reassign Work** – This option is available for managers to reassign work. Select division and current assignee.

Click this link to view the Reassign Work screen.

Select the subunit and new assignee. Place a check mark next to the case(s) to be reassigned.

Click this link to view the New Assignee screen,

Click the box "Reassigned Checked Cases". The cases will be sent to the new assignee.

Click this link to view the Reassignment screen.

9.16.12 MISC

The Misc screen brings the user to the Self-Maintenance screen. This screen allows the user to make any changes in their own profile. This was explained in RCM 9.16.1.

9.16.13 1856 Paragraph

In cases where an overpayment is being recovered by partial withholding and the annuitant incurs another overpayment, ORCS will provide an option to include the 1856 paragraph in the overpayment letter. This paragraph provides details of the previous overpayment.

The 1856 paragraph details will be found on the Work Package Confirmation screen. The user will have the option to include this paragraph by selecting "Yes" or "No".

Click this link to view 1856 Entries screen.

Click this link to view the Package Confirmation 1856 screen.

The Work Package Preparation screen will show the 1856 paragraph information. It will also allow the user to modify the 1856 amount and the partial withholding start date. This is also where adjustments and accruals can be added.

Click this link to view the Modify 1856 screen.

Click this link to view the Package Preparation 1856 screen.

On the PAR Action Preparation screen, enter the RR or SUP overpayment amount and indicate increase or decrease. If decrease is selected an action out code is necessary.

The Letter Edit screen will notate that the 1856 paragraph was included.

Click this link to view the 1856 Letter Edit screen.

To view the completed letter, select show/hide letter. Insert paragraphs will follow 1856 paragraph.

Click this link to view Sample 1856 Paragraph screen.

When the PAR Action is complete, go to the top right corner and select Status. Change the status to PA (Auth) or DL (Delete).

9.16.14 10A Letter

A 10A letter is used when a debt needs to be collected from another individual receiving a benefit on the same RRB claim number. (Example: Collecting the employee's overpayment from a spouse accrual.) Begin by entering a claim number and select the appropriate annuitant from the Debtor Selection screen. Select "debtor choice" and press "PREH". (ROC and SURPASS cannot be selected when 10A is chosen.) Select the correct existing debt and then press "Make 10A Letter". A screen will appear requesting the debtor's name and gender (male or female). Select "Submit 10A Letter".

Click this link to view Section 10A Letter screen.

Continue through the letter process. On the Work Package Preparation screen select the appropriate billing document ID and press "Process Letter".

The Letter Preparation screen will verify that a 10A letter is being processed. Select Regular or RRAILS letter, and Start Letter.

Add any custom or code paragraphs. Press "Show/Hide Letter" to view the 10A letter. No PAR action is needed. Select "Change Status". The user can send the letter to auth, delete or return to the Main Menu if the case is incomplete.

9.16.15 OIG Handling

Overpayments that are over the threshold amount and with a possibility of fraud require Office of Inspector General (OIG) Handling.

After the letter and PAR action is completed, the authorizer will review and close the case. An OIG package will be produced (includes a draft of the overpayment letter, factsheets (OIG and PEMS) and G-221) and will be printed. The authorizer will release the printed package to OIG following established procedures. The PAR and ASTRO file will be uploaded later that day.

After the OIG makes their determination, they will notify RBD/SBD via email. The managers will be able to follow the status via Management Utilities – OIG Case Return. After receipt of the OIG's determination, the manager will change the status to Pending Exam (PE). The examiner will review the case and send to Pending Auth (PA). The authorizer will review and then close the case. The letter and necessary attachments will be printed and automatically sent to imaging. The authorizer will release the letter and necessary attachments to the Mailroom.

9.16.16 PAR Non-Entitlement Handling

Operations (RBD or SBD) prepare non-entitlement PAR action cases that are submitted to DRD for handling.

The PAR cause code will determine the type of mechanical letter for Operations to release to DRD. When the authorizer changes the status, the PD (pending DRD review) code will be shown. The PAR file will be uploaded. DRD will review the case on the Work Package Review screen. If acceptable, DRD will change the status to closed (CL). The mechanical letter and necessary attachments will be printed and released by DRD. The letter and attachments will be sent to Imaging. However, if DRD notices an error in the case, it will be returned to pending exam (PE). The work package will not be complete until DRD changes the status to CL.

Click this link to view the DRD Change Status screen.

9.16.17 DRD Processing

Accessing ORCS

See RCM 9.16.1.

Click this link to view the DRD Main Menu screen.

Actions Menu

The following functions are available to DRD:

1. Prepare Overpayment Letter
2. View My Cases
3. Recall Case from Closed or OIG Status

Click this link to view the DRD Actions Menu.

Prepare Overpayment Letter

Select Prepare New Overpayment Letter from Actions Menu. The DRD Debtor Selection screen will appear.

NOTE: DRD requires an existing debt. If ORCS does not find an existing debt, it will alert the user. Return to the Debtor Selection screen and enter a new claim number.

Enter a RRB claim number or SSN. When submitted, ORCS will retrieve the data from the mainframe. It may take a few seconds to retrieve this data. ORCS will provide the annuitant history under that number.

NOTE: If an RRB claim number is entered, ORCS will upload all annuitants associated with that number. If an incorrect annuitant or the wrong RRB claim number was selected, go back to the top of the debtor selection screen and select a new annuitant or claim number.

ORCS alerts the user if an existing case matching the entered SSN or RRB claim number is found. If so, check with the user before continuing so no duplicate case is created.

Click this link to view the DRD Debtor Selection screen.

ORCS will retrieve the mainframe data. Select **“Use PREH”** to continue.

Click this link to view the DRD PREH screen.

The DRD Work Package Confirmation screen will appear. The user will be asked to confirm the annuitant's name and address. This is required because there can be some inconsistencies in the parsing of the name and address when retrieving data from the mainframe. Corrections can be made directly on the confirmation screens. Also, modifications can be made to the name and address on the DRD Work Package Preparation screen, under Employee Information and Annuitant Information.

Click this link to view the Confirm Name screen.

Click this link to view the Confirm Address screen.

The PAR table is uploaded each day with current data. ORCS will show all existing debts, a window will appear asking which debt to be selected. The debt selected will show the previous billing document number.

Click this link to view the DRD Existing PAR Debt screen.

After selecting the appropriate existing debt, press “Submit”. This will bring the user to the DRD Work Package Confirmation screen. If “Cancel” is selected, the user will cancel the entire work package and return to the Main Menu.

Click this link to view the DRD Work Package Confirmation screen.

The DRD Work Package Confirmation screen provides the user with the Employee, Annuitant and Benefit Information that has been retrieved from the mainframe. Each of these items can be opened or closed by pressing the show/ hide buttons on the left side of the screen.

This screen allows the user to confirm that the data entered was correct, if not, the user can go back to the DRD Debtor Selection screen and choose another claim number. Once the Begin Work Package is selected an ORCS record will be established and the DRD Work Package Preparation screen will appear.

Click this link to view the DRD Work Package Preparation screen.

The user has the option to select a different Bill Doc ID. The drop down menu will show all the Bill Doc ID's available for the case.

After reviewing the DRD Work Package Preparation screen select “Process Letter”.

NOTE: DRD only has the option to use the Process Letter feature.

The **DRD Letter Preparation** screen provides the user with Work Package, Employee, Annuitant, and Letter information that has been retrieved from the mainframe. Each of these items can be seen by pressing the show/hide button on the left side of the screen.

Click this link to view the DRD Letter Preparation screen.

The Letter Preparation screen appears only **once**. It primarily provides the user with letter information and the recovery option available. After reviewing the screen, press **Start Letter**. The DRD Letter Edit screen will appear.

The DRD Letter Edit screen provides the DRD user to view all available DRD paragraphs.

Click this link to view the DRD Letter Edit screen.

DRD users can move any available paragraphs to the assigned paragraph column by selecting the paragraph and using the “>” key. Move an assigned paragraph back to the available paragraph column by selecting the paragraph and using the “<” key.

Custom paragraphs are **not** available to the DRD user.

To preview a paragraph, highlight the appropriate available paragraph and select the “Preview” button. Select “Preview” again to close the window.

After selecting the assigned paragraph, click on “Show/Hide Letter”. This will allow the user to view the letter. Click “Show/Hide Letter” again to close window.

When the letter is complete, go to the top right corner and select Status. The **Change Status** screen will appear.

Click this link to view the Change Status screen.

DRD options are close (CL) or delete (DL). Select “Submit Status”. This will activate the Print Download screen. The DRD user will release the letter and attachments.

If a case is incomplete, select “Cancel”. The user will return to the letter edit screen. Select Main Menu and the case will be shown as PE under Work Packages Assigned to You.

DRD Manual Handling of Operations Referrals

DRD receives cases from Operations (RBD and SBD) that need special handling for charges. A G-205 will be completed using a non-entitlement cause code.

Click this link to view the DRD G-205 screen.

The cause code determines which mechanical letter will be produced. The DRD authorizer will upload PAR and ASTRO and send the case to PD (Pending DRD) for completion.

Click this link to view the Non-Entitlement Cause Codes screen.

The cases are sent to an Assign File for release by the DRD manager or leads.

Click this link to view the DRD Assign Work screen.

The DRD manager or lead will select the assignee, check the box(s) and then press "Assign Checked Cases."

Click this link to view the DRD Assignment screen.

The DRD user will find the assigned cases on the Main Menu. Select a case and ORCS will display the DRD Work Package Review screen.

Click this link to view the DRD Work Package Review screen.

The user will review the action taken (PAR, Mechanical Letter and Payment Summary). If acceptable, the user will go to the Change Status screen and change the status to CL (Closed). The letter and attachments will be printed and imaged. DRD will be responsible for releasing the package to the Mailroom. If the user notices an error in the case, return to the change status screen and select PE (pending exam). The case will be returned to Operations. The work package will not be complete until DRD changes the status to CL.

Disability Claims Manual (DCM)

Section DCM 12

12.1 On-Line Disability Decision Sheet (OLDDS)

12.1.1 Introduction to On-Line Disability Decision Sheets

The On-Line Disability Decision Sheets (OLDDS) allow examiners to enter disability data via a desk-top terminal into mainframe systems and also retains information in the database indefinitely for easier access. This system pre-fills information from other database systems and also contains edits for basic content accuracy. These features will cut down on errors and shorten processing times.

12.1.2 Accessing OLDDS

A. General

To create a record on OLDDS, the main menu should be accessed and completed as described in this section. Once the menu is completed and the proper form selected, the appropriate items should be completed on the screen and hit PF2 to create a record. To add or change any entry on an unprotected field, the data can be typed over and then hit PF3 to modify the entry. To delete a record hit PF4. To page forward use PF8 and page back use PF7. To return to the OLDDS main menu hit clear or PA1. To leave OLDDS completely hit ATTN.

To browse a record on OLDDS, the main menu should be accessed and completed as described in the DCM. Once the form is completed and the proper form is selected, the latest record completed will be displayed. To view the next record hit PF12. To view the prior record hit PF11. To page forward use PF 8 and to page back use PF7. To return to the OLDDS main menu hit clear or PA1. To leave OLDDS completely hit ATTN.

Once a disability rating is completed, a print-out of OLDDS screens should be used as folder records of the disability decisions under the RR Act and disability decisions under the SS Act needed for disability freeze, vested dual benefits, PIA computations, O/M inclusion and Medicare purposes.

B. Sign-On to OLDDS

To access OLDDS sign on the Terminal Productivity Executive (TPX) system in the normal manner. From the TPX menu, move the cursor next to the Railroad Automated Processing Integrated Database (RRAPID) and press enter. Once on the RRAPID menu select option '32'. This brings the OLDDS main menu on the screen.

12.1.3 Completing The Main Menu Screen

By entering the employee's prefix and SSA number, the OLDD's user will be able to either create a new record or select a record to browse.

To complete the **Main Menu Screen** make the following entries:

Prefix - Enter the appropriate prefix in the proper space provided.

SSA No. - Next enter the employee's SSA number for the claim. If there is no SSA number for the employee and the claim has a 6 digit RRB number enter zeros in the first three spaces. If the employee has a SSA number and the RRB number is a six digit number, then enter the SSA number in this space and enter the six digit number on the first page of the Disability Decision Sheet.

After completing the above information hit, '**ENTER**'.

The screen will list any record that has been previously entered on OLDDS under the claim number entered (up to a maximum of ten records). The list will display the following data:

- Claimant's name (See Note)
- Birth year
- Twin code
- Type of record (G-325, G-325a or G-831)
- Activity type (pending or released).

Note: The claimant's name will reflect the information that is entered on the Disability Decision sheet. For employees, this will be the first initial and first four characters of the last name. The claimant name for widows and children will reflect the widow or child's name. The claimant name for the G-831 record will appear as "Employee".

All pending cases will be listed first, followed by all released cases from most recent to oldest.

Access a record by placing an 'X' before the claimant's name. If the activity type for the case selected is PENDING the record can be modified. If the activity type for the case selected is RELEASED, you will only be able to browse the record.

The user can browse records by returning to the Main Menu Screen or by accessing a record type and browsing that record type by using the PF-11 and PF-12 keys.

Creating a New Record

To create a new record, move the cursor to the record type fields (G-325, G-325a or G-831) found at the bottom of the screen. Select the type of record to be created by placing an 'X' in front of the record type and hit '**ENTER**'.

Two fields will appear on the screen:

- DOB
- Twin Code

DOB Field - Enter the claimant's date of birth. After the birth year field is completed the cursor will move to another **Twin Code** field.

Twin Code Field - No entry is required for this field unless there are records being created for claimants with the same birth year (i.e., twins, triplets, etc.). If the user is creating a record for people with the same birth year, the twin code field can be properly completed by entering a number from 1 through 9. OLDDS automatically defaults to a twin code of zero.

12.1.4 Screen G-325, Disability Decision Sheet

This screen is completed by disability examiners and hearings officers in the Bureau of Hearings and Appeals. After completing the OLDDS main menu screen and selecting the G-325, the first page of the G-325 will come up on the screen. If the claim is currently on APPLE, available information will be pre-filled on this screen. Be sure to verify that pre-filled information is correct and/or has not changed.

The first page of the G-325 screen can be completed as soon as an examiner receives a claim for a disability decision. Once the first page of the G-325 is completed hit PF2 to create a record on OLDDS. The examiner name and number are protected fields and are automatically assigned to a claim based on the examiner's sign-on. When a claim is reassigned to another examiner, the examiner number will change based on the new examiner's sign-on as long as the case has not been submitted (i.e., a "Y" entered in the SUBMITTED field and PF-3 being hit). Once a claim has been submitted, the examiner name and number cannot be changed.

When any entries are made on page 2 and/or 3, but the claim is not ready for review enter a 'N' next to submitted on that page.

Complete a G-325 screen for a disability rating as follows:

- Employee - When the employee files an application for a disability annuity, a disability freeze or early Medicare coverage or a survivor file for a disability freeze after the employee's death.

- Spouse - Request a disability rating for a child when the spouse files an application based on a disabled child "in care."
- Child - An application is filed to include a disabled child for inclusion under the O/M, for a survivor annuity or early Medicare coverage.
- Widow(er), Remarried Widow(er) or Surviving Divorced Spouse - An application is filed for a disability annuity and/or early Medicare coverage for a widow(er) remarried widow(er) or surviving divorced spouse.

Examiner entries are as follows:

Page 1

<u>ITEM</u>	<u>FIELD NAME</u>	<u>ENTRY</u>
<u>1A</u>	<u>SSA Number</u>	If the SSA number was entered on the main menu, it will be pre-filled and is a protected field. If a correction is necessary it must be made from the main menu. If a record has not been created, hit clear to return to the main menu and enter the corrected SSA number. If a record has been created, delete the record by hitting PF4 and clear then re-enter the correct number on the main menu.
<u>1B</u>	<u>RRB Number</u>	<p>If the RRB number was entered on the main menu, it will be pre-filled and is a protected field. If a six digit claim number is used and the employee has a SSA number, the SSA number should be entered on the main menu and the six digit number entered in this item. If there is no six digit RRB number, leave this item blank.</p> <p>The RRB number is a protected field and, if incorrect, it must be corrected on the main menu. If no record has been created on OLDDS, hit clear and enter the correct RRB number on the main menu. If a record has been created, delete the record using PF4 and correct the RRB number on the main menu.</p>
<u>2</u>	<u>Type Claim</u>	<p>Enter the number in accordance with the type of disability rating required. Choose from the following:</p> <p>0 When an age and service annuitant is filing an application for early Medicare based on a disability.</p>

		<p>1 For a child's disability rating to qualify a spouse for an annuity based on the disabled child in her care.</p> <p>2 Employee disability annuity or disability freeze determination.</p> <p>3 Widow(er), remarried widow(er) or surviving divorced spouse under age 60 or widow(er), remarried widow(er) or surviving divorced spouse between age 60-65 filing for early Medicare.</p> <p>4 Surviving child filing for an annuity based on disability which began before age 22.</p> <p>5 Disability freeze filed after the employee's death.</p> <p>6 Child of a living employee for inclusion under the O/M and for Medicare entitlement.</p>
<u>3A</u>	<u>Name of EE</u>	Enter the employee's first initial and the first four letters of his surname. If the surname is less than four letters, leave the remaining spaces blank. This item may be pre-filled, if so verify the correct name is entered.
<u>3B</u>	<u>Rating For</u>	If a decision is required for a person other than the employee, enter that person's name. This item may be pre-filled, if so verify the correct name is entered.
<u>4</u>	<u>Type Rating</u>	<p>Enter one of the following:</p> <p>1 For a disability decision under the Railroad Retirement Act only (page 2 to be complete).</p> <p>2 For a disability decision under The Social Security Act only (page 3 to be completed).</p> <p>3 For a disability decision under both The Railroad Retirement Act and Social Security Act (pages 2 and 3 are to be completed)</p>
<u>5A</u>	<u>Annuity Filing Date</u>	Complete the official filing date of the application for an annuity in this space. This also applies when an application for a disability annuity is filed after the

		<p>applicant is paid a reduced age and service annuity. Enter the filing date of the application for the reduced age and service annuity in such cases.</p> <p>This item may be pre-filled, verify the correct date is completed.</p> <p>There is a space after the century and year to put an "*". If any unusual situation involving the annuity filing date exists, enter the "*" and explain in the remarks section (e.g. protected filing date.).</p>
<u>5B</u>	<u>DF Filing Date</u>	<p>Enter the date the AA-1d was filed or the date on which the RRB received a letter or other document evidencing the applicant's intention to apply or reapply for a disability freeze. There is a space after the century and year to put an '*'. If any unusual situation involving the DF Filing Date exists, enter the '*' and explain in the remarks section.</p>
<u>6A</u>	<u>Birth Year</u>	<p>This item is completed on the OLDDS main menu, is pre-filled on the screen and is a protected field. If the birth year is incorrect and a record has not been created yet, hit clear and re-enter the correct birth year on the main menu. If a record has been created on OLDDS, delete the record using PF4 and re-enter on the main menu.</p>
<u>6B</u>	<u>Age</u>	<p>Enter the applicant's attained age in years on his birthday just prior to the official filing date of his application.</p> <p>NOTE: There are two exceptions for this entry. If an employee is qualified for an occupational disability, but will be rated as totally and permanently disability prior to being qualified as occupational, enter the employee's age on the total and permanent onset date. For example, if a claimant is age 60 on his filing date, with 120 to 239 service months, and a current connection, but met the listing of impairments when he was age 58, then item 6B should be age 58.</p> <p>The other exception to this entry occurs when an employee is under age 60 at the time of filing, but has since attained age 60 and is being rated for an occupational disability. The examiner should enter age 60 in these cases.</p>

<u>7</u>	<u>OCC</u>	If the disability decision is for the employee this item must be completed, otherwise leave blank. Enter the employee's last regular railroad occupation only. To determine the last regular railroad occupation; refer to DCM 3.2.2(A).
<u>8</u>	<u>Ver S/M</u>	Enter the number of verified service months in this item. Do not enter a lead zero in this item when less than 100 service months are being entered. Leave blank if rating is for anyone other than employee.
<u>9</u>	<u>C/C</u>	Determine the current connection according to FOM1 225 . Then enter a 'Y' if the employee has a current connection or a 'N' if not. If the rating is for anyone other than the employee, leave blank.
<u>10</u>	<u>Family Group</u>	In any RR Act, Section 2a(1)(iv) case, enter the family group number. For claims filed before 1-1-98, refer to the Provisional Occupational Disability Rating Schedule (PODRS) to determine this number. For claims filed 1-1-98 or later, enter the appropriate letter for employee's occupation in the Tables. The appropriate letters are as follows:
		A – Trainman
		F - Trackman
		B - Locomotive Engineer
		G - Machinist
		C - Train Dispatcher
		H - Shop Laborer
		D – Carman
		I - Sales Representative
		E – Signalman
		J - General Office Clerk
		For occupations that are not covered in the Tables, or if the occupation is in the Tables, but is combined with another job, enter the family group number found in the PODRS.
<u>11</u>	<u>Prescribed Period</u>	Enter the ending date of the prescribed period for the widow(er), remarried widow(er), or surviving divorced spouse. For widow(er), remarried widow(er) or surviving divorced spouse between age 50 and 59 to

		determine when the prescribed period ends see DCM 3.7.6 . For those age 60 and above, see DCM 3.7.7 .
<u>12</u>	<u>RR EMP</u>	Enter the date the employee last worked in the RR industry as shown on the application or G-88a. If the EE was carried on the payroll, received pay for time lost, etc., enter the date last in compensated service to the RR. Space is provided after the century and year for an '*' then show the actual date last worked and any other information about the date last worked in the remarks section (i.e. carried on payroll). This item may be pre-filled, verify correct date has been entered.
<u>13</u>	<u>Non RR EMP</u>	Enter the date the claimant last worked for anyone outside the RR industry as shown on the application, vocational report or G-88. There is a space after the century and year to put an '*'. If any explanation for the date last worked non-RR employment, enter the '*' and explain in the remarks section. This item may be pre-filled, verify the correct date has been entered. If the claimant is still in LPE or self-employment, leave this item blank and enter in REMARKS still in LPE or S/E.
<u>14</u>	<u>AOD</u>	Enter the alleged onset date of disability.
<u>15</u>	<u>DIAG CODE</u>	Enter an appropriate diagnostic code as listed in DCM, Ch. 3 Appendix B.
<u>16</u>	<u>Diagnosis In Order of Severity</u>	This entry is self explanatory and must always be completed.
	<u>REMARKS</u>	Any remarks pertaining to a claim should be entered here. If '*' is shown after a date, an explanation must be entered.

Page 2 - RAILROAD RETIREMENT ACT

<u>ITEM</u>	<u>FIELD NAME</u>	<u>ENTRY</u>
<u>17</u>	<u>OCC DIS</u>	Complete when the employee has eligibility based on an occupational disability. Enter '1' if the rating is not disabled or '2' if the rating is an allowance, in the first position.

		If the employee is disabled, enter the actual onset date in month/day/century/year order in the appropriate spaces.
<u>18</u>	<u>T & P DIS</u>	<p>Complete when the employee has eligibility based on total and permanent disability. Enter '3' if the rating is not disabled or '4' if the rating is an allowance, in the first position.</p> <p>If the employee is disabled, enter the actual onset date in month/day/century/year order in the appropriate spaces.</p>
<u>19</u>	<u>Widow</u>	Complete when disability is claimed by widow(er), remarried widow(er), or surviving divorced spouse. If the claimant is not disabled or the onset is not in the prescribed period, enter a '1' in the first position. If the claimant is disabled enter a '2' in the first position and enter the actual onset date in month/day/century/year order in the appropriate space.
<u>20</u>	<u>Child</u>	<p>Complete when disability is claimed by a child. If the child is not disabled or not disabled before age 22, enter '1' in the first position. If the child is disabled before age 22 enter a '2' in the first position and enter the actual beginning date in month/day/century/year order in the appropriate space.</p> <p>NOTE: In cases where a child becomes re-entitled based on the “disincentive to return to work” the examiner should complete OLDDS with the date the child becomes re-entitled as the onset date. In addition, the examiner should make the following entry in the Remarks section on page 1, “Disabled Child Disincentive to RTW Case”.</p>
<u>21</u>	<u>Rep Payee</u>	<p>Leave this item blank, unless the applicant has a representative payee. If the applicant has a rep payee, complete as follows:</p> <p>0 = No rep payee (the system automatically assumes this answer, leaving the field blank is the same as entering a “0”.)</p> <p>1 = Court appointed rep payee</p> <p>2 = Board appointed rep payee</p>

		3 = Parent for child
<u>22a</u>	<u>RRB Status Code</u>	<p>Enter '0' if no rating has previously been made based on this application.</p> <p>Enter '1' if the application was previously denied and, based on new medical evidence or re-evaluation of the old evidence, the application is now being rated disabled.</p> <p>Enter '2' when a rating is being made in any situation not covered above. Explain why the code '2' is entered (e.g. earlier onset date).</p>
<u>22b</u>	<u>Disability Exclusion Code</u>	<p>No examiner entry required on decisions rated on D-brief. All initial cases (including DAC conversion cases) not rated on D-brief and meeting any of the exclusion circumstances requires a numeric code to be entered. See D-brief instructions DCM 12.5.6.7 Examiner Decision, G325B, and Disability Exclusion Code, and OLDDS Button and Self Authorization for the appropriate circumstances and codes.</p>

If only the Railroad Retirement Act screen (page 2) is to be completed, then go to the Disposition section and follow those instructions. If the Social Security Act (page 3) is to be completed, then hit PF8.

Page 3 - SOCIAL SECURITY ACT

<u>ITEM</u>	<u>FIELD NAME</u>	<u>ENTRY</u>
<u>23</u>	<u>Insured Status</u>	<p>Complete only in employee disability ratings. If the employee has a disability insured status on combined earning as of the disability onset date or later, enter a '1'. (See RCM 5.6 for Insured Status Requirements).</p> <p>Also, enter a '1' if the employee qualifies for early Medicare under the 1974 Act deeming provisions or federal employment. (20/40 based on combined earnings met on ABD, but not on disability onset).</p> <p>If the above situation does not apply, enter a '2' for not fully insured.</p>
<u>24</u>	<u>Employee Dis Code</u>	<p>Complete when disability is claimed by an employee. In the first position enter one of the following:</p>

		<p>0 If the employee is not disabled.</p> <p>1 If the employee is allowed a single freeze. This includes if a previous denial of a single freeze is reversed by the Bureau of Hearings and Appeals or the Board.</p> <p>2 If the employee does not meet the earnings requirement for a disability freeze, but is eligible for early Medicare only based on the 74 Act or federal employment and the impairment meets the medical requirements for a period of disability.</p> <p>4 If the employee is granted a unilateral freeze on appeal of a denial on a SSA-831 by the Bureau of Hearings and Appeals or the Board. Note: When the Bureau of Hearings and Appeals or the Board reverses a single freeze, a '1' should be entered.</p> <p>5 When SSA and RRB do not agree on the freeze decision and DPS grants a unilateral decision.</p> <p>6 If the freeze was granted by the court.</p> <p>7 In a joint freeze case where SSA and RRB are in agreement on granting a period of disability, but cannot agree on a disability onset date.</p> <p>If entry in Employee Dis Code equals 1, 2, 4, 5, 6 or 7 make an entry in the Actual Onset Date, and/or the RRB Date and SSA Date.</p>
	<u>Actual Onset Date</u>	If entry in Employee Dis Code is 1, 2, 4, 5, 6 or 7, enter the actual onset date in this field, enter in month/day/century/year order.
	<u>RRB Date</u>	If entry in Employee Dis Code is 1, 2, 4, 5 or 6, enter the first full month/century/year in the spaces after RRB date, or the first month of the quarter and year in which disability insured status requirements are met, if later.
	<u>SSA Date</u>	If a '7' is entered in the first position of this item a SSA

		date conflicts exists. Enter the month and year used by SSA. The RRB date must also be completed.
<u>25</u>	<u>Widow Dis Code</u>	<p>Complete when disability is claimed by a widow(er), remarried widow(er), or surviving spouse. In the first position enter the following:</p> <p>0 When the claimant is not disabled due to medical reasons, or when the claimant is not disabled due to the onset date not being in the prescribed period. When a '0' is entered, indicate the reason for the denial below by entering an 'X' next to either 'not disabled' or 'onset not within prescribed period.'</p> <p>1 Disabled and meets or equals SSA's listing of impairments. Enter the Actual Onset Date month/day/century/year. Also, enter the first full month/century/year after RRB Date.</p> <p>3 Disabled under OBRA using the medical vocational rules. When a '3' is entered the Actual Onset Date, RRB Date and OBRA Date must be completed. For the Actual Onset Date, enter the month/day/century/year. For the RRB Date, enter the first full month/century/year, however, this date must not be earlier than 08-90.</p> <p>Always enter the first full month/century/year in the OBRA Date.</p>
<u>26</u>	<u>Child</u>	<p>Complete when the disability is claimed by a child. If the child is not disabled or not disabled before age 22, enter '0' in the first position. If the child is disabled before age 22, enter '1' in the first position. Enter the actual month/day/century/year in the Actual Onset Date and after <u>Disabled From</u> enter the actual month/century/year of onset.</p> <p>NOTE: In cases where a child becomes re-entitled based on the "disincentive to return to work" the examiner should complete OLDDS with the date the child becomes re-entitled as the onset date. In addition, the examiner should make the following entry in the Remarks section on page 1, "Disabled Child Disincentive to RTW Case".</p>

27	<u>Freeze Letter Code</u>	<p>For employee freeze decisions only, enter as follows:</p> <p>210 If a freeze is allowed, enter in the Remarks section of OLDDS that no letter is released in cases when the freeze is allowed and a survivor filed the application;</p> <p>212 If the freeze is denied for failure to meet the earnings requirement, even if there is Medicare allowance under section 7(d)(3);</p> <p>2131 If the freeze is denied for failure to meet the disability requirement because of lack of severity;</p> <p>2132 If the freeze is denied for failure to meet the disability requirement because the condition will not or has not lasted for 12 consecutive calendar months;</p> <p>2133 If the freeze is denied because the onset of disability is in or after the 5th month before age 65;</p> <p>2135 If the freeze is denied because the onset of disability occurred within 5 months of death.</p> <p>NOTE: If the rating is a simultaneous denial, leave the space blank.</p>
28	<u>Status Code</u>	<ul style="list-style-type: none"> • Enter '1' if a disability decision under the SS Act provisions has not been previously made for applicant. • Enter '2' if the initial SS Act decision is revised upon reconsideration. • Enter '4' if a new freeze application is filed (or deemed filed), and a subsequent DF decision is made after a previous denial or termination of a disability freeze period for single freeze cases. • Enter '7' if DPS has previously granted a disability freeze and is now giving an earlier onset date because of previously unavailable medical evidence, or if SSA grants a freeze after DPS has granted a freeze unilaterally.

DISPOSITION

When an examiner completes the disability rating, a 'Y' should be entered next to submitted, hit PF3 to modify, and a copy of all completed pages need to be printed out. The examiner should file these pages on the left side of the folder and sign the pages next to their examiner number. The file should then be logged to AFCS sublocation TORE and placed in the review tub.

When the reviewer is assigned the case, the review date will pre-fill when the case is accessed. The reviewer should enter a 'y' next to accepted and hit PF3 if they approve of the rating. This action will release the record to the appropriate databases. The reviewer should sign and date the file copy the examiner has in file.

If the reviewer disagrees with any aspect of the claim the case is to be returned to the examiner for correction. When the reviewer is satisfied with the claim, the correct date and 'Y' should be entered and hit PF3. If the reviewer approves the case on a date different from the pre-fill date, the authorizer can change the review date.

When the first position in item 24 contains a 4 or 6 or if the Bureau of Hearings and Appeals or the Board reverses a decision the screens are completed the same. However, since these cases do not require review by another examiner, the person completing the G-325 should enter the 'y' for submitted, the correct date and 'y' for accepted and hit PF3. A signed printout of all rating screens should be filed on the left side of the folder.

12.1.5 Screen G-325A, Determination Of Continuance/Cessation Of Disability Decision

This screen is used to record determinations of continuance or cessation of disability. When termination is being proposed for a claim, due process must be served. Termination cases are entered on OLDDS and the authorizer puts an "N" in the accepted field. After due process is over the authorizer will change the "N" to a "Y".

Entries are as follows:

PAGE 1

<u>ITEM</u>	<u>FIELD NAME</u>	<u>ENTRY</u>
<u>1</u>	<u>Employee SSA</u>	If the SSA number was entered on the main menu, it will be pre-filled and is a protected field. If a correction is necessary, it must be made from the main menu. If a record has not been created, hit clear, then re-enter using the correct SSA number on

		the main menu. If a record has been created, delete the record by hitting PF4 twice and CLEAR, then reenter using the correct SSA number on the main menu.
<u>2</u>	<u>RRB Claim Number</u>	<p>If a six-digit RRB number was entered on the main menu, it will be pre-filled and is a protected field. If a six-digit claim number is used and the employee has a SSA number, the SSA number should be entered on the main menu and the six-digit RRB number entered in this item. If there is no six-digit RRB number, leave this item blank.</p> <p>If the RRB number is incorrect and is a protected field, it must be corrected on the main menu. If no record has been created on OLDDS, hit clear and enter the correct RRB number on the main menu. If a record has been created, delete the record using PF4 and correct the RRB number on the main menu.</p> <p>If the RRB number is incorrect and is not a protected field, enter the correct number and hit PF3.</p>
<u>3</u>	<u>Type Claim</u>	<p>Enter the number in accordance with the continuing disability review determination required. Choose from the following:</p> <p>0 - Age and service annuitant who has a disability for early Medicare.</p> <p>1 - For a spouse annuity based on a disabled child in care.</p> <p>2 - Employee disability annuity or disability freeze determination.</p> <p>3 - Widow(er) annuity.</p> <p>4 - Survivor child annuity.</p> <p>5 - Survivor DF.</p> <p>6 - Ineligible Person Included (IPI) for inclusion under the O/M or for Medicare entitlement.</p>
<u>4</u>	<u>EE Name</u>	Enter the first initial and first four letters of the employee's last name. If the last name has less than four letters leave the unused spaces blank.

<u>5</u>	<u>Determination For</u>	If the determination is for someone other than the employee, enter that person's name here.
<u>6</u>	<u>Year of Birth</u>	This item is completed on the OLDDS main menu, is pre-filled on the screen and is a protected field. If the birth year is incorrect and a record has not been created, hit clear and reenter the correct birth year on the main menu. If a record has been created on OLDDS, delete the record using PF4 and reenter on the main menu.
<u>7</u>	<u>Age</u>	Enter the present age of the person for which the determination is being made.
<u>8</u>	<u>Type Rating</u>	Enter the type rating for the determination being made. Choose from the following: 1 Railroad only 2 Social Security only 3 Railroad and Social Security
<u>9</u>	<u>Railroad Disability Beginning Date</u>	If the type rating is 1 or 3, enter the month, day, century and year of the disability onset under the Railroad Retirement Act.
10	Date DF Began	If the type rating is 2 or 3, enter the month, day, century and year of the disability onset under the Social Security Act (DF).
11	Employed As	If the determination is made based on earnings, enter the title of the current occupation on this line.
12	Employed From	If the determination is based on earnings, enter the month, century and year of the beginning date for the current employment.
13	Employed To	If the determination is based on earnings, enter the month, century and year of the ending date for the current employment. If the person is still currently employed enter CONT in the century and year.
14	Type of Review	Enter the type of review being done. Choose from the following: 1 Medical

		2 Earnings 3 Medical/Earnings
15	Previous Call-up Date	When the determination being made is due to a diary call-up, enter the month, century and year of the diary call-up. No entry is required if the determination is being done due to another reason.
16R	TWP End Date	Enter the month, century and year the trial work period ends under the Railroad Retirement Act. No entry is required if the trial work period does not apply.
16S	TWP End Date	Enter the month, century and year the trial work period ends under the Social Security Act. No entry is required if the trial work period does not apply.
17A	Type of Diary	Enter the type of diary being set for the determination being made. An entry is always required. Choose from the following: 0 No diary is required 1 MIE 2 MIP 3 MINE 4 Earnings 5 H&A call-up 6 SSA trace 7 Return to RR service 8 Other
17B	Date	Enter the month, century and year of the diary call-up date being set. No entry is required when item 17A is 0.

Remarks

Enter any miscellaneous comments that are pertinent to the case.

PAGE 2 - RAILROAD RETIREMENT ACT

<u>ITEM</u>	<u>FIELD NAME</u>	<u>ENTRY</u>
18	Reconciled	Enter a 'Y' (yes) if the employment can be reconciled with the disability. Otherwise enter a 'N' (no). No entry is required if Type of Review (Item 14) is '1'.
19	Medical Reports Thru	Enter the date of the latest medical report the determination is being based on. No entry is required if Type of Review (Item 14) is '2'.
20	Recovery	Enter a 'Y' (yes) if the medical review indicates a recovery. Otherwise enter a 'N' (no). No entry is required if type of review (Item 14) is '2'.
21	Disability Continued/ Ceased	<p>'X' the appropriate selection(s) to the left of the determination shown and enter the month, century and year the decision is effective when appropriate.</p> <p>A - Continues - Check this if the beneficiary is still disabled</p> <p>B - Ceased - Check this if the disability ceased and enter the month, century and year of cessation.</p> <p>C - Disability Annuity Terminated at the Close of the Last Day of - Check this and enter the month, century and year to indicate the month of the annuity termination. The month of termination is the second month after the month in which cessation occurs. (e.g. ceased in 12/94 terminated 02/95).</p> <p>D - Reentitlement Period Applies From - Check this to indicate the beginning of the month of a reentitlement period. The reentitlement period begins with the first of the month immediately following completion of the 9th month of trial work.</p> <p>E - Reinstatement Allowed - Check this and enter the month, century and year a reinstatement is allowed during the reentitlement period. The reinstatement allowed month is the month that SGA ceased during the reentitlement period.</p> <p>F - Suspended After Reinstatement - Check this if the annuity is suspended after reinstatement during the</p>

		<p>reentitlement period. The suspension after reinstatement month is the month a reinstated annuitant returns to SGA during the reentitlement period.</p> <p>G - Reentitlement Period Ends - Check this and enter the month, century and year that the reentitlement period ended</p>
--	--	---

If only the Railroad Retirement Act screen (page 2) is to be completed, then go to the Disposition section and follow those instructions. If the Social Security Act (page 3) is to be completed then hit PF8.

PAGE 3 - SOCIAL SECURITY ACT

<u>ITEM</u>	<u>FIELD NAME</u>	<u>ENTRY</u>
22	Reconciled	Enter a 'Y' (yes) if the employment can be reconciled with the disability. Otherwise enter a 'N' (no). No entry is required if Type of Review (Item 14) is '1'.
23	Medical Reports Thru	Enter the date of the latest medical report the determination is being based on. No entry is required if Type of Review (Item 14) is '2'.
24	Recovery	Enter a 'Y' (yes) if the medical review indicates a recovery. Otherwise enter a 'N' (no). No entry is required if Type of Review (Item 14) is '2'.
25	Disability Continued/ Ceased	<p>'X' the appropriate selection(s) to the left of the determination shown and enter the month, century and year the decision is effective when appropriate.</p> <p>A. Continues - Check this if the beneficiary is still disabled.</p> <p>NOTE: This item is not to be selected in CDR cases where a decision to continue the disability is reached at the reconsideration or H&A level that reverses a previous termination decision. Rather, the Reconsideration specialist or Hearings officer should select Reinstatement allowed (see E below) and enter the appropriate date. This will update the PREH record with the correct information. See DCM 7.4.3.1 for detailed instructions.</p>

		<p>B. Ceased - Check this if the disability ceased and enter the month, century and year of cessation.</p> <p>C. Period of Disability Terminated at the Close of the Last Day of - Check this and enter the month, century and year to indicate the month the period of disability terminated. The month of termination is the second month after the month in which cessation occurs. (e.g. ceased in 12/94 terminated 02/95).</p> <p>D. Reentitlement Period Applies From - Check this to indicate the beginning of the month of a reentitlement period. The reentitlement period begins with the first of the month immediately following completion of the 9th month of trial work.</p> <p>E. Reinstatement Allowed - Check this and enter the month, century and year a reinstatement is allowed during the reentitlement period. The reinstatement allowed month is the month that SGA ceased during the reentitlement period.</p> <p>NOTE: See the Note found in the section "A. Continues".</p> <p>F. Suspended After Reinstatement - Check this if the annuity is suspended after reinstatement during the reentitlement period. The suspension after reinstatement month is the month a reinstated annuitant returns to SGA during the reentitlement period.</p> <p>G. Benefit Termination Month - Check this and enter the month, century and year that the reentitlement period ended.</p>
26A	Extended Medicare	If extended Medicare coverage applies use an 'X' to mark the entry, otherwise leave blank.
26B	Date	Enter the month, century and year through which the extended Medicare coverage applies.

DISPOSITION

When an examiner completes the CDR rating, a 'Y' should be entered next to submitted, hit PF3 to modify, and a copy of all completed pages needs to be printed out. The examiner should file these pages on the left side of the folder

and sign the pages next to their examiner number. The file should then be logged to AFCS sub-location TORE and placed in the review tub.

In cases not involving a proposed termination, the reviewer should enter the date they are reviewing the case, enter a 'Y' next to ACCEPTED and hit PF3 if they approve of the rating. This action will release the record to the appropriate databases. The reviewer should sign and date the file copy the examiner has in file.

If the reviewer disagrees with any aspect of the claim, the case is to be returned to the examiner for correction. When the reviewer is satisfied with the claim, the correct date and 'Y' should be entered before hitting PF3.

In cases involving a proposed termination, the reviewer should sign and date the paper Form G-325a, release the termination letter and place the folder in dormant with a sixty-day call-up. If the annuitant does not request a reconsideration of the proposed termination, the examiner will then complete the OLDDS screens. The file should then be forwarded to the reviewer for approval. The reviewer will enter a 'Y' next to ACCEPTED and hit PF3 to submit the record to the database.

If the annuitant requests reconsideration of the proposed termination, the reconsideration specialist will make the appropriate entries on OLDDS.

12.1.6 Screen SSA-831, Disability Determination And Transmittal

This screen is completed by the disability examiners in DPS post section for joint freeze determination information. This screen is used to enter the freeze determinations that have been certified by GLPSC on form SSA-831.

NOTE: When a claim for widow(er)s or children is part of the financial interchange, the disability determination must be coordinated with GLPSC. The claim is handled as any joint freeze with the disability rating being signed off by GLPSC on a SSA-831. However, this form will not update the widow(er)s or children disability records. Therefore, do not enter widow(er)s or children disability information using the SSA-831 screen on OLDDS. When the completed disability determination comes back from GLPSC on the signed SSA-831, enter the disability decision information by using OLDDS screens for the G-325. This will ensure that the correct records are updated.

Entries are as follows:

ITEM	FIELD NAME	ENTRY
1	Employee SSA	If the SSA number was entered on the main menu, it will be prefilled and is a protected field. If a correction

		is necessary it must be made from the main menu. If a record has not been created, hit clear to return to the main menu and enter the correct SSA number. If a record has been created, delete the record by hitting PF4 and clear, then re-enter using the correct SSA number on the main menu.
2	RRB Number	<p>If a six digit RRB number was entered on the main menu, it will be prefilled and is a protected field. If a six digit claim number is used and the employee has a SSA number, the SSA number should be entered on the main menu and the six digit number in this item. If there is no six digit number, leave this blank.</p> <p>If the RRB number is incorrect and is a protected field, it must be corrected on the main menu. If no record has been created on OLDDS, hit clear and enter the correct RRB number on the main menu. If a record has been created, delete the record using PF4 and correct the RRB number on the main menu.</p> <p>If the RRB number is incorrect and is not a protected field, enter the correct number and hit PF3.</p>
3	Year of Birth	This item is completed on the OLDDS main menu, is pre-filled on the screen and is a protected field. If the birth year is incorrect and a record has not been created, hit clear and reenter the correct birth year on the main menu. If a record has been created on OLDDS, delete the record using PF4 and reenter on the main menu.
4A	Diagnostic Code	Enter an appropriate diagnostic code as listed in DCM Ch. 3, Appendix B .
4B	Diagnosis	Enter the appropriate diagnosis.
5	SSA Dis Code	If the claimant is not disabled enter '0'. If the claimant is a disability allowance enter '1'.
6	Actual Onset Date	If the claimant is rated disabled, complete the actual disability onset date by entering the MM/DD/CCYY.
7	Disability Onset Date	If the claimant is rated disabled, enter the first full month/century/year of the disability onset.
8	Cessation	If the disability ceased, enter a '3' otherwise leave

	Code	blank. NOTE: Do not make an entry in this item, when the information being entered is for a closed period.
9	Cessation Date	If item 8 contains '3' enter the month/century/year the decision is effective.
10	Freeze Letter Code	<p>For freeze decisions enter codes as follows:</p> <p>210 If a freeze is allowed, enter in the Remarks section of OLDDS that no letter is released in cases when the freeze is allowed and a survivor filed the application;</p> <p>212 If the freeze is denied for failure to meet the earnings requirement, even if there is Medicare allowance under section 7(d)(3);</p> <p>2131 If the freeze is denied for failure to meet the disability requirement because of lack of severity;</p> <p>2132 If the freeze is denied for failure to meet the disability requirement because the condition will not or has not lasted for 12 consecutive calendar months;</p> <p>2133 If the freeze is denied because the onset of disability is in or after the 5th month before age 65;</p> <p>2135 If the freeze is denied because the onset of disability occurred within 5 months of death.</p>
11	Examiner	<p>The examiner name and number is automatically assigned to a claim based on the examiner's signon and are protected fields. When the examiner completes the rating a "Y" should be entered next to SUBMITTED and PF2 hit. If the rating is not complete, enter "N" and hit PF2. This will hold the record in OLDDS until it is ready for release.</p> <p>When a signed off joint freeze decision is returned from GLPSC, the examiner enters the information from the form SSA-831, enters a "Y" next to SUBMITTED, and hits PF-2.</p>

12	Reviewer	If the date the case is completed by the reviewer is different from the date on the SSA-831, the reviewer is to enter the date the SSA-831 is being accepted and enter a "Y" next to ACCEPTED and hit PF-2.
----	----------	---

For certain categories of cases an examiner can complete the disability rating and accept the case. The examiner completes the disability rating as detailed above, but does not send the folder to TORE. The examiner will approve the rating by entering a "Y" next to ACCEPTED and hitting PF-3 to modify the record. When the reviewer is the same person as the examiner, an edit will appear after hitting PF-3, showing that the reviewer and examiner are the same. Pressing PF-3 again will allow the case to be reviewed.

When the decision is approved, a copy of this screen should be filed down on the left side of the folder.

EXHIBIT 1

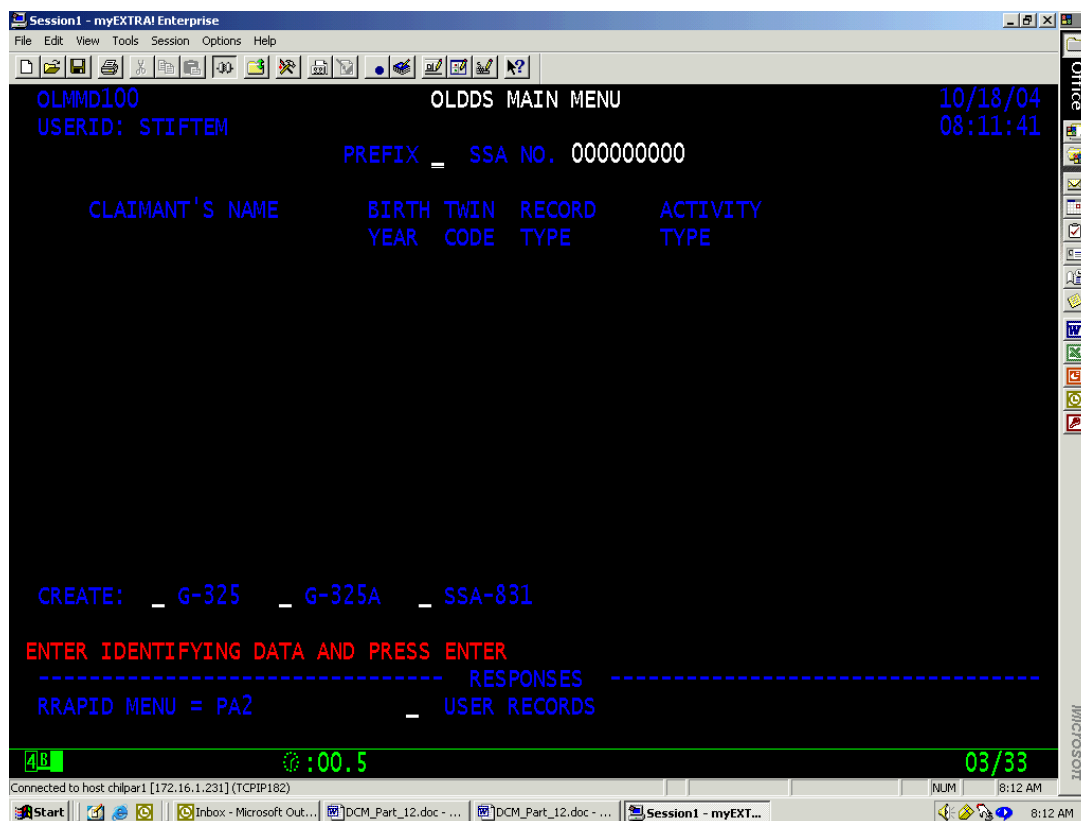


EXHIBIT 2

Session1 - myEXTRA! Enterprise

File Edit View Tools Session Options Help

OLMUD101 DISABILITY DECISION SHEET 10/18/04
 USERID: STIFTEM G-325 08:13:39
 PAGE 1 OF 3

1A SSA NO A 111-11-1112 1B RRB NO 2 TYPE CLAIM

3A NAME OF EE 3B RATING FOR 4 TYPE RATING

5A ANNUITY FILING DATE MM - DD - CCYY 5B DF FILING DATE MM - DD - CCYY

6A BIRTH YEAR 1945 6B AGE 7 OCC 8 VER S/M

9 C/C 10 FAMILY GR 11 PRESCRIBED PERIOD MM - DD - CCYY

12 RR EMP MM - DD - CCYY 13 NON RR EMP MM - DD - CCYY 14 AOD MM - DD - CCYY

15 DIAG. CODE 00000 16 DIAGNOSIS IN ORDER OF SEVERITY:

REMARKS:

THERE IS NO PENDING G325 AVAILABLE

----- RESPONSES -----

ADD = PF2 MODIFY = PF3 DELETE = PF4
 RRAPID MENU = PA2 OLDDS MENU = PA1 OR CLEAR KEY NEXT PAGE = PF8

4B :00.2 04/37

Connected to host chilpar1 [172.16.1.231] (TCP182)

Start Inbox - Microsoft Ou... DCM_Part_12.doc - ... DCM_Part_12.doc - ... Session1 - myEXT... 8:14 AM

EXHIBIT 3

Session1 - myEXTRA! Enterprise

File Edit View Tools Session Options Help

OLMUD102 DISABILITY DECISION SHEET 10/18/04
 USERID: STIFTEM G-325 10:24:01
 A 11111112 1945 (RAILROAD RETIREMENT ACT) PAGE 2 OF 3

17 OCC DIS MM - DD - CCYY
 18 T&P DIS MM - DD - CCYY
 19 WIDOW MM - DD - CCYY
 20 CHILD MM - DD - CCYY
 21 REP PAYEE
 22 RRB STATUS CODE

EXAMINER 791 STIFTEM DATE SUBMITTED
 REVIEWER MM - DD - CCYY ACCEPTED

----- RESPONSES -----
 ADD/MODIFY = PF3 DELETE = PF4 PAGE 1 = PF7
 RRAPID MENU = PA2 OLDDS MENU = PA1 OR CLEAR KEY PAGE 3 = PF8

48 :00.1 05/17

Connected to host chilpar1 [172.16.1.231] (TCP:182)

Start Inbox - Microsoft Outlook DCM_Part_12.doc - Micro... Session1 - myEXTRA! E... 10:24 AM

EXHIBIT 4

DCM Part_12 On-Line Disability Decision Sheet

EXHIBIT 6

Session1 - myEXTRA! Enterprise

File Edit View Tools Session Options Help

OLMUD112 DISABILITY DECISION SHEET 10/18/04
 USERID: STIFTEM G-325A 10:26:14
 A 11111112 1945 (RAILROAD RETIREMENT ACT) PAGE 2 OF 3

18 RECONCILED 19 MEDICAL REPORTS THRU MM - DD - CCYY 20 RECOVERY

21 DISABILITY CONTINUED/CEASED

A _	CONTINUES	
B _	CEASED	MM - CCYY
C _	DISABILITY ANNUITY TERMINATED AT	
	THE CLOSE OF THE LAST DAY OF	MM - CCYY
D _	REENTITLEMENT PERIOD APPLIES FROM	MM - CCYY
E _	REINSTATEMENT ALLOWED	MM - CCYY
F _	SUSP. AFTER REINSTATEMENT	MM - CCYY
G _	REENTITLEMENT PERIOD ENDS	MM - CCYY

EXAMINER 791 STIFTEM | DATE | SUBMITTED
 REVIEWER | MM - DD - CCYY | ACCEPTED

----- RESPONSES -----

ADD/MODIFY = PF3 DELETE = PF4 PAGE 1 = PF7
 RRAPID MENU = PA2 OLDDS MENU = PA1 OR CLEAR KEY PAGE 3 = PF8

4B :00.1 05/16

Connected to host chilpar1 [172.16.1.231] (TCP/IP182)

Start Inbox - Microsoft Outlook DCM_Part_12.doc - Micro... Session1 - myEXTRA! E... NUM 10:26 AM

EXHIBIT 7

Session1 - myEXTRA! Enterprise

File Edit View Tools Session Options Help

OLMUD113 DISABILITY DECISION SHEET 10/18/04
 USERID: STIFTEM G-325A 10:26:46
 A 11111112 1945 (SOCIAL SECURITY ACT) PAGE 3 OF 3

22 RECONCILED 23 MEDICAL REPORTS THRU MM - DD - CCYY 24 RECOVERY

25 DISABILITY CONTINUED/CEASED

A _	CONTINUES	
B _	CEASED	MM - CCYY
C _	PERIOD OF DISABILITY TERMINATED AT	
	THE CLOSE OF THE LAST DAY OF	MM - CCYY
D _	REENTITLEMENT PERIOD APPLIES FROM	MM - CCYY
E _	REINSTATEMENT ALLOWED	MM - CCYY
F _	SUSP. AFTER REINSTATEMENT	MM - CCYY
G _	BENEFIT TERMINATION MONTH	MM - CCYY

26A EXTENDED MEDICARE 26B DATE MM - CCYY

EXAMINER 791 STIFTEM | DATE | SUBMITTED
 REVIEWER | MM - DD - CCYY | ACCEPTED

----- RESPONSES -----

ADD/MODIFY = PF3 DELETE = PF4 PRIOR PAGE = PF7
 RRAPID MENU = PA2 OLDDS MENU = PA1 OR CLEAR KEY

4B :00.1 05/16

Connected to host chilpar1 [172.16.1.231] (TCP/IP182)

Start Inbox - Microsoft Outlook DCM_Part_12.doc - Micro... Session1 - myEXTRA! E... NUM 10:27 AM

EXHIBIT 8

Session1 - myEXTRA! Enterprise

File Edit View Tools Session Options Help

OLMUD105 DISABILITY DECISION SHEET 10/18/04
 USERID: STIFTEM SSA 831-U5 10:27:15

1 EMPLOYEE SSA 111-11-1112 2 RRB NUMBER
 3 YEAR OF BIRTH 1945

4A DIAGNOSTIC CODE 4B DIAGNOSIS:
 5 SSA DIS CODE 6 ACTUAL ONSET DATE MM - DD - CCYY
 7 DISABILITY ONSET DATE MM - CCYY
 8 SS CESSATION CODE 9 CESSATION DATE MM - CCYY
 10 FREEZE LETTER CODE
 REMARKS:

EXAMINER 791 STIFTEM | DATE | SUBMITTED
 REVIEWER | MM - DD - CCYY | ACCEPTED
 THERE IS NO PENDING SSA831 AVAILABLE

----- RESPONSES -----
 ADD = PF2 MODIFY = PF3 DELETE = PF4
 RRAPID MENU = PA2 OLDDS MENU = PA1 OR CLEAR KEY

4B :00.1 04/58

Connected to host: chilpar1 [172.16.1.231] (TCP:182) NUM 10:27 AM

12.2 Federal Financial System (FFS)

12.2.1 Federal Financial System (FFS)

The Railroad Retirement Board (RRB) first used the Federal Financial System (FFS) to secure medical examinations beginning May 2, 1994. FFS is a computer program used by all Federal agencies as a multi-purpose accounting system for the purchase and payment of goods and services. We have made extensive modifications to data input screens and certain FFS processes for convenient on-line entries to secure needed medical examinations.

12.2.2 FFS Access

Only authorized users are able to access FFS and utilize its various functions.

For ordering and paying for medical examinations the authorized users include:

- Disability Benefits Division (DBD) claims examiners (both initial and post),
- DBD Supervisors,
- DBD Senior Claims Examiners,

- DBD Operations and Claims Analyst,
- Reconsideration Examiners,
- Hearing and Appeals Officials, and
- Claims Representatives (ordering examinations only).

For scheduling and paying of consultative opinions made with DBD's outside medical consultant the authorized users include:

- Disability Benefits Division (DBD) claims examiners (both initial and post),
- DBD Supervisors,
- DBD Senior Claims Examiners,
- DBD Operations and Claims Analyst
- Reconsideration Examiners, and
- Hearing and Appeals Officials,
- DBD Lead Clerk or DBD GS-4 Clerk (schedule consultative opinions only)

If you are one of the authorized users you may access the FFS system by:
Accessing the mainframe (screen with train logo),

- Type "TPX" and press ENTER.
- Enter your USERID and password and press ENTER twice
- Select FFS and press ENTER.

On the FFS FRONT END SCREEN enter "1" to select the REFERENCE TABLE START-UP SCREEN and press ENTER.

12.2.3 Reference Table Start-Up Screen

This screen allows you to enter the table to which you wish to access.

Type 'N' in the ACTION field and 'SUSF' in the table ID field and press ENTER.

NOTE: The SUSF screen allows you to create, modify, approve, or schedule a document.

12.2.4 SUSF Screen

After accessing the SUSF screen enter 'new' in the function field. Tab down to the TRAN field and enter the kind of document you wish to create (i.e., to schedule an exam enter ME). In the first column (01), enter your organization number in the organization (ORGN) field and enter the Doc-ID in the number field.

A. Document Number

The Document Number has 11 spaces and all must be filled in. **BE SURE TO CHECK THIS ENTRY FOR ACCURACY BEFORE PROCEEDING TO THE NEXT SCREEN.** Refer to Section [12.2.13](#) if an incorrect DOCUMENT NUMBER is entered.

B. Standard Guide for Document Number

The Document Number is a 9-digit claim number followed by two alpha codes. If the RRB claim number is not 9 digits, pre-fill using zeros. The 9-digit claim number does not include the prefix that distinguishes the type of RRB annuitant. Also, do not include the dash (-) between numbers of a social security number.

C. The First Alpha Code

This alpha code will reflect the month you are placing the order.

A = January	G = July
B = February	H = August
C = March	I = September
D = April	J = October
E = May	K = November
F = June	L = December

D. The Second Alpha Code

This alpha code reflects the beneficiary type of the person being examined.

A = Employee

B = Widow

C = Surviving child

D = Retirement child

NOTE: Whenever medical examinations are ordered after an initial order is processed, it is necessary to create a unique DOCUMENT NUMBER for each subsequent order. An explanation with examples is given in Section 12.2.12 under MULTIPLE DOCUMENT NUMBERS.

Press ENTER.

12.2.5 Medical Exam Order Screen

DO NOT PRESS ENTER UNTIL INSTRUCTED TO DO SO.

DEL DATE: Enter the date (MM DD YY) that the medical report is due in headquarters. Urgent requests are due in 19 workdays and standard requests are due in 25 workdays. Zero-fill when appropriate. For example, 05 09 94.

Press the TAB key.

ACTION: Make no entry. **Press the TAB key** to move the cursor to the next item to be completed. The purpose of the ACTION field and its codes will be explained in Section 12.2.10.

TYPE REQ: Enter 01 if urgent or 02 if standard. A standard request is expected in 25 workdays, and an urgent request is expected in 19 workdays. **Press TAB key.**

EE NAME: Enter employee's FIRST NAME (11 spaces available)/SURNAME (19 spaces available). Use the TAB key to move the cursor to the SURNAME position if the first name is less than 11 spaces. **Press TAB key.**

BENE NAME: Enter the name of the beneficiary if other than the employee. FIRST NAME (11 spaces)/SURNAME (12 spaces). **LEAVE BLANK** if same as employee. **Press TAB key.**

REASON CODE: Enter the appropriate two-digit code identifying the reason for the examination and the type of beneficiary involved. See Section 12.2.14 for a list of these codes. **Press TAB key.**

DESIGN UNIT: Enter the unit that is to receive the medical report(s). Choose from the following: BDMO, BUSI, or BHA. **Press TAB key.**

FO#: Enter the 3-position code identifying the field office that services the area in which the examinee resides. **Press TAB key.**

AUTHORIZED ORDERER: Enter the LAST name of the authorized orderer of medical examinations. This is the name of the claims examiner, contact

representative, or H & A officer placing the order. This line only accommodates 15 spaces. **MAKE NO ENTRY IN TOTAL AMOUNT.** FFS completes this item after all entries are processed.

Move cursor to ACTION field by the pressing TAB key. Type t in ACTION field and **press the TAB key.**

The TEXT SCREEN will display for your use in furnishing required information about the examinee.

12.2.6 Text Screen

The TEXT SCREEN provides ten lines of text-writing for each screen. The first screen displayed is used for identifying information required by the company contracted to secure requested medical examinations. A formatted screen to enter this information is not available, so it is **VERY IMPORTANT** to strictly follow the instructions given for each line entry. Enter only the information specified for each line. If an entry does not apply, leave that line blank and use the TAB key to move the cursor to the next line to be completed.

ACTION: The cursor is positioned here upon access to this screen and the letter 'S' displays.

Press the **TAB** key to move the cursor to Line 01.

LINE 01	Enter the examinee's area code and phone number. Use a dash (-) to separate the area code from the first three digits of the phone number and between the first three and last four digits of the phone number as follows: 123-456-7890. In rep-payee cases, enter the rep-payee's phone number. If no phone number exists, enter 999-999-9999. Press TAB key.
LINE 02	Enter the examinee's <u>street address only</u> . The name of the city is entered on LINE 03. In rep-payee cases, enter the street address of the rep-payee. Press TAB key.
LINE 03	Enter the examinee's <u>city of residence only</u> . In rep-payee cases, enter the rep-payee's city of residence. Press TAB key.
LINE 04	Enter the two-letter abbreviation for the State in which the examinee resides. Leave one space after the State abbreviation, then enter the 5-digit zip code. Do not enter a 9-digit zip code. In rep-payee cases, enter the State and zip code of the rep-payee. Press TAB key.
LINE 05	Enter the names of the examinee's treating physicians. There are

	70 characters available. Leave a space between each name. Press TAB key.
LINES 06 and 07	List the examinee's chief complaints on these two lines only. If only one line is needed, leave line 07 blank. Press TAB key.
LINE 08	Enter the name of the RRB assigned rep-payee, if applicable. LEAVE BLANK IF NO REP-PAYEE. Press TAB key.
LINE 09	<u>FOR RECONSIDERATION OR APPEALS CASES ONLY.</u> Enter the names of the physicians who performed previous consultative examinations. Leave blank if not applicable. Press TAB key.
LINE 10	Enter any miscellaneous information that you believe is important for the company that is arranging for the medical examinations to know. For example, speaks Spanish, uses wheel chair, etc.

NOTE: The information entered on these 10 lines should be all that is needed. Special instructions regarding examinations ordered should no longer be necessary because very detailed instructions were given in the contract signed by the company. However, if additional lines are needed for further communications about this order, refer to Section 12.2.8E.

Move the cursor to the **ACTION** field (#) using the **TAB** key.

Type **A**, then press **ENTER** (the message "ALL LINES ADDED" will display at the bottom of the screen).

Type **E** (cursor still in the **ACTION** field (#)) then press **ENTER** to return to the HEADER SCREEN.

The HEADER SCREEN displays the data just as you left it to enter text.

Press the **ENTER** key to display the next screen.

12.2.7 Exam Data Screen

Upon access to the EXAM DATA SCREEN, the cursor is positioned at the EXAM NUMBER line.

EXAM NUMBER: Enter the 3-digit code that identifies the medical exam you are ordering. For example, exam 12 should be entered 012. A complete list of these codes is in Section [12.2.14](#) and kept in the EXMC table.

EXAM AMOUNT: **MAKE NO ENTRY.** FFS completes this item after all entries are processed.

DELETE EXAM: After entering the EXAM NUMBER, the cursor automatically moves to this item. **MAKE NO ENTRY.** It is only used for canceling an exam. This procedure is given in Section 12.2.13E.

NOTE: To review your entries, move the cursor to the ACTION field at the top of the screen and type "H" to hold the document. FFS returns to the START-UP SCREEN. Now press ENTER to display HEADER entries. Type NS (next screen) in the ACTION field to display the EXAM DATA SCREEN. Repeat this step to display each EXAM DATA SCREEN. To return to the HEADER SCREEN, type NLO (next line zero) in the ACTION field and press ENTER.

Complete an Exam Data Screen for each medical exam to be ordered.

Press the **ENTER** key to display a fresh screen to enter more exams.

Move the cursor to the **ACTION** field once all exams are entered.

Type Q and press **ENTER** (FFS returns to the START-UP SCREEN).

If the exams have been scheduled as indicated, the status at the top of the screen will read "SCHD."

To **EXIT**, press the **CLEAR** key and the FFS FRONT END SCREEN will display. Press the **CLEAR** key again and type 'CESF LOGOFF.'

12.2.8 Use Of Tables On FFS

Processed information on FFS is maintained on tables controlled by the Master Table Inquiry (MTI) facility of FFS. There are three kinds of tables in FFS: inquiry tables, reference tables, and data entry tables. Each table is given an identifying name referred to as a TABLEID code.

A. Suspense File Inquiry Table

Documents can be referenced on the suspense file table until the nightly FFS processing is completed. After the nightly FFS processing is done, data is referenced on a transaction table. Most columns are self-explanatory. The following are highlighted for your attention.

ACTION: FFS pre-fills this code to scan specified transactions.

Press the **TAB** key to move the cursor to the TRAN line.

TRAN: Specify the transaction to be scanned. Type ME for MEDICAL EXAM ORDER scheduled or RM for RECEIVER (payment) scheduled. Press **ENTER**.

STAT: FFS displays the status of your entered data as either ON HOLD, SCHEDULED, REJECTED, OR DELETED.

Variable data entered on a document order can be viewed by typing S (scan) in the ACTION field at the top of the table then pressing the TAB key to move the cursor under the TRAN CODE column at the line of the document to be scanned. Press **ENTER** and the selected transaction can be viewed.

To **EXIT** viewing or changing entries, move the cursor to the ACTION field at the top of the screen by pressing the TAB key. Type Q (quit), then press **ENTER**. FFS returns to the START-UP SCREEN and displays the message that the document has accepted any changes entered. Now press the **CLEAR** key to return to the SUSF TABLE. If no further action is required from this table, move the cursor to the ACTION field at the top of the screen, type 'E' to **EXIT** the table, then press **ENTER**.

NOTE: To view additional documents on the screen, press the ENTER key. The ACTION code 'R' allows you to roll from one screen to the next by simply pressing the ENTER key.

B. Orders Header Inquiry Table (OBLM)

Following the nightly FFS processing, medical exams ordered are maintained on this table. Use the transaction code and document number (order number) to view data from this table.

ACTION: The 'S' (scan) code is displayed by FFS. Press the **TAB** key to move the cursor to the **TRANS CODE** line.

TRANS CODE: Type ME (Medical Exams) and the cursor will automatically move to the ORDER NUMBER LINE.

ORDER NUMBER: Type the document number that you want to view. If the document number is unknown, press the ENTER key with only the TRANS CODE entered and FFS will display the first document maintained under ME. **ROLL** through the table by pressing the ENTER key until your number appears.

To **EXIT** the table enter 'E' in the ACTION field.

C. Commodity Line Inquiry Table (OBLC)

The COMMODITY LINE INQUIRY table allows you to view individual line entries, i.e., exam line entries of a document (order) processed on the nightly FFS run.

- ACTION:** The 'S' (scan) code is displayed by FFS. Press the **TAB** key to move the cursor to the **TRANS CODE** line.
- TRANS CODE:** Type ME and the cursor will automatically move to the ORDER NUMBER line.
- ORDER NUMBER:** Type the document number that you want to view. If the document number is unknown, press the ENTER key with only the TRANS CODE entered and FFS will display the first document maintained under ME. **ROLL** through the table by pressing the ENTER key until your number appears.

To **EXIT** the table enter 'E' in the ACTION field.

D. Medical Exam Cost Reference Table (EXMC)

This is a reference table of all medical exams and their costs. A brief description of each exam is also given. "No-Show" charges determined for each exam are identified beginning with code 500. (See Section 12.2.13F on Handling "No-Shows.")

- ACTION:** The ACTION 'S' (scan) code is displayed by FFS. Press the TAB key to move the cursor to the NUMBER line.
- NUMBER:** Type the number of the exam being referenced. If the number is unknown, press the **ENTER** key and the table will display the first exam number. **ROLL** to successive screens by pressing the ENTER key.

To **EXIT** the table enter 'E' in the ACTION field.

E. Text Table (PTEX)

The TEXT TABLE can be referenced to view typed information that was added during the process of scheduling examinations as described in Section [12.2.6](#). Text information on a medical exam order (ME) previously scheduled can be viewed or changed using appropriate table command codes. It will be necessary to identify the document to be viewed or changed by entering the purchase order identifier (PO ID) and commodity line (COMM LINE) of the ME text. Changes to text should only be made on the day that the ME is placed.

NOTE: It is not expected that additional lines will be needed for scheduling examinations besides the ten lines furnished on the first screen. Specific instructions regarding requested examinations and their

reports should no longer be necessary since such requirements are part of the contract with controls established for quality assurance.

ACTION: Command codes used are as follows:

A-enter text

S-scan text previously entered

C-change text previously entered

N-move to next (fresh) screen

R-roll from screen to screen when multiple pages are involved

E-exit the table

PO ID: The purchase order identifier is the transaction code (ME) and the DOCUMENT NUMBER.

COMM LINE: THIS WILL ALWAYS BE 000 for text associated with scheduled orders (ME).

To **EXIT** the table enter 'E' in the ACTION field.

12.2.9 Data Entry Action Codes

Command codes entered in the ACTION field, i.e., the first line of any given screen, allow for a variety of navigational or scheduling actions. Codes used on data entry screens are unique from those used on table screens.

- H:** This command allows you to put a document on **HOLD** to be completed at a later time or date. This feature is especially useful in situations that may detain you for a period that exceeds 20 minutes. A "time-out" results if no entry is made during a 20-minute period. Any information entered on a TEXT screen is lost and a "locked hold" is placed on other data entered that requires an override action to continue. Time-out can be prevented by simply pressing any key, such as the TAB key, before 20 minutes elapses.
- Q:** This command performs a **QUALITY** check of entries required by FFS. Entries which pass this quality check effectively set the order for processing by FFS done on a nightly basis. Examinations are thereby scheduled.
- P:** This command allows you **PAUSE** during data entry to access reference tables, then return to the data entry screen from which you paused.

- DD:** This command allows you **DELETE** an entire **DOCUMENT** if such determination is made after completing the Q action and before the nightly FFS processing. Enter DD in the ACTION field then move the cursor to the DOCID by pressing the TAB key. Erase the letters ME by pressing the SPACE BAR and press **ENTER**.
- DL:** This command allows you to **DELETE** an exam data **LINE** if such determination is made after completing the Q action and before the nightly FFS processing. Enter DL in the ACTION field of the EXAM DATA SCREEN (LINE SCREEN). Move the cursor to the EXAM NUMBER line using the TAB key. Erase the exam number by pressing the SPACE BAR. Now press ENTER.
- F:** This command will **FINISH** the scanning action used to view previously inputted data. It can only be used when the SCAN mode is selected on the FRONT END SCREEN.
- IL:** This command allows you to **INSERT LINES** to enter additional exams to an order after a Q action is completed and before the nightly FFS processing. Upon re-entering the document, at the HEADER SCREEN'S ACTION line, type IL. Press the ENTER key and a fresh screen will display. Move the cursor to the DEL DATE line before pressing the ENTER key.
- NS:** This command allows you to move to the **NEXT SCREEN** in a forward progression only.
- NL:** This command allows you to display the **NEXT LINE** (EXAM DATA). This feature is mostly used to move back to the HEADER screen. To do this, type NLO in the ACTION field and press ENTER.
- XD:** This command allows you to **cancel all entries made prior to scheduling** the document, i.e., before the Q action. Type XD in the ACTION field and press ENTER.

12.2.10 Table Action Codes

- A:** Written text is **ADDED** to a TEXT table using this code typed in the ACTION field at the top of the TEXT screen.
- C:** Written text can be **CHANGED** by recalling the original text page and entering this code in the ACTION field at the top of the TEXT screen.
- E:** Enter the **EXIT** command when you have completed your activity in any given table function.
- N:** This command allows you to move from one table to the **NEXT**. Type N in the ACTION field at the top of the table that you are currently using. The

cursor automatically moves to the TABLEID allowing you to enter the name of the next table desired. The action command is completed by pressing the ENTER key.

- R:** This action code is automatically displayed by the system allowing you to **ROLL** from one screen to the next on tables with numerous pages (screens) of data to view. The action is completed by pressing the ENTER key.
- S:** Like the R command, **SUCCESSIVE** entries in a table can be viewed using this command code.
- <:** Enter the symbol '<' in the ACTION field to **view previous pages** (screens) in a table. This function is limited to viewing four screens prior to the currently displayed screen.

12.2.11 Edit Referral Messages

A quality check ('Q' in the ACTION field) is the last step in the data entry process of scheduling medical examinations on FFS. It verifies completion of all required items and edits those which have been restricted to accept only certain entries. Edit messages will display on the bottom line of the data entry screen to indicate unacceptable or missing items. Usually, multiple edit messages are displayed even if only one item is unacceptable or missing. When the item is correctly entered and another quality check ('Q' in the ACTION field) is made, the document is accepted by FFS for processing in the nightly run.

Many of the edit messages are self-explanatory, but a list of them, their meaning, and the necessary corrective action follows:

NOTE: Whenever Edit Referral Messages appear after a quality check it is necessary to correct not only the missing or unacceptable item but also to enter the TOTAL AMOUNT on the Medical Exam Order Screen. (Refer to the Edit Referral Message H--Code 900E - DOC TOTAL NOT = DETAIL listed below.) Then do another quality check ('Q' in the ACTION field) and press ENTER.

A--*S302 - ACTION NOT AUTHORIZED: This message appears on the Entry and Correction Screen when an incorrect TRANS CODE was entered.

CORRECTIVE ACTION: Tab the cursor to the TRANS CODE position on the DOCUMENT ID line and type ME (Medical Exams). Press the ENTER key.

A--*CD13 - BATCH AND DOC TYPE INVALID: This message appears on the Entry and Correction Screen if no TRANS CODE was entered.

CORRECTIVE ACTION: Tab the cursor to the TRANS CODE position on the DOCUMENT ID line and type ME (Medical Exams). Press the ENTER key.

A--*CE53 - CURSOR POSITION INVALID: This message appears when the cursor was moved to an invalid position on the screen.

CORRECTIVE ACTION: Tab the cursor to a valid position.

A--*CD2A - DOCUMENT ID IS INCOMPLETE: This message appears on the Entry and Correction Screen if no entry is made under either DIVISION or DOCUMENT NUMBER.

CORRECTIVE ACTION: Tab the cursor to the DIVISION position and/or DOCUMENT NUMBER position on the DOCUMENT ID line. Type 2500 in the DIVISION position and/or the correct DOCUMENT NUMBER. Press the ENTER key.

A--*CD23 - DOCUMENT SEC 1 INVALID: This message appears on the Entry and Correction Screen if the entry for DIVISION on the DOCUMENT ID line is not a valid DIVISION code.

CORRECTIVE ACTION: Tab the cursor to the DIVISION position on the DOCUMENT ID line and type 2500. Press the ENTER key.

A--*CD31 - DUPLICATE DOCUMENT ID: This message appears on the Entry and Correction Screen if the DOCUMENT NUMBER entered on the DOCUMENT ID line was previously used.

CORRECTIVE ACTION: Tab the cursor to the DOCUMENT NUMBER position on the DOCUMENT ID line and type the correct DOCUMENT NUMBER. Press the ENTER key.

NOTE: The exact same DOCUMENT NUMBER is **used only** when correcting an order that has been "held," canceling an order, or handling "No-Shows."

A--*CQ8H - DOCUMENT HELD: This message displays on the bottom line of the Entry and Correction Screen indicating that the entries made are being held for completion at a later time or date.

CORRECTIVE ACTION: None.

A--*CU13 - CONTINUING SAME DOCUMENT: This message appears on the bottom line of the Exam Data Screen to indicate that continuous screens are available to enter individual exam data.

CORRECTIVE ACTION: None.

A--CE11 - DOC ID CHANGE INVALID: Once a DOCUMENT NUMBER is entered on the Entry and Correction Screen it cannot be changed on subsequent screens. FFS displays the number on the top line of each data entry screen. This message appears if the number is changed in any way.

CORRECTIVE ACTION: Tab the cursor to the DOC ID position at the top of the screen and type the DOCUMENT NUMBER exactly as it was originally entered on the Entry and Correction Screen.

A--*CX2J - NO DETAILS PRESENT ON SCREEN: This message appears when attempting to view a data entry screen to determine if entries have been made when they were not.

CORRECTIVE ACTION: None.

A--*27 - 2ND ACTION INCONSISTENT W/1ST: This message indicates that an invalid action code was entered.

CORRECTIVE ACTION: Tab the cursor to the ACTION field at the top of the screen and type the correct code.

H--900 E - DOC TOTAL NOT = DETAIL: This message will appear whenever missing or incorrect entries prevent FFS from computing the TOTAL AMOUNT on the Medical Exam Order Screen. FFS has been programmed to calculate and enter the total cost of all exams ordered. FFS will only do this calculation once. Therefore, any system edits which detect missing or incorrect entries prevent that automatic one-time-calculation from taking place and result in no TOTAL AMOUNT being entered on the Medical Exam Order Screen.

CORRECTIVE ACTION: Tab the cursor to the TOTAL AMOUNT position and type in the correct total cost of all exams ordered. Press ENTER and FFS will display the first exam ordered with the cost shown in the EXAM AMOUNT position. Repeat this step to view the EXAM AMOUNT of any other exams ordered. After viewing all the exams ordered, and determining the sum total of their costs, return to the Medical Exam Order Screen. Do this by moving the cursor to the ACTION field, typing NLO (next line zero), and pressing ENTER. Tab the cursor to the TOTAL AMOUNT position on the Medical Exam Order Screen and enter the sum of all the exam costs. For example, if the sum total is \$268 then type 268.00. Press the space bar to delete the zeros displayed to the right of this position.

H--S188EE - DELIVERY DATE INVALID: This message appears when an invalid DELIVERY DATE was entered on the Medical Exam Order Screen. FFS does not accept impossible dates, such as the number 45 entered as a month, or dates in the far future.

CORRECTIVE ACTION: Tab the cursor to the DEL DATE position and type the correct DELIVERY DATE.

H--S215E - DELIVERY DATE < TRANS DATE: This message appears if the DELIVERY DATE was prior to the date on which it was entered.

CORRECTIVE ACTION: Tab the cursor to the DEL DATE position and type the correct DELIVERY DATE.

H--S153E - DELIVERY DATE BLANK: This message appears if no DELIVERY DATE was entered on the Medical Exam Order Screen.

CORRECTIVE ACTION: Tab the cursor to the DEL DATE position and type the DELIVERY DATE.

H--ME09E - BENEFICIARY NAME REQUIRED: This message indicates that the BENEFICIARY NAME to be entered on the Medical Exam Order Screen was omitted.

CORRECTIVE ACTION: Tab the cursor to the BENE NAME position and type the BENEFICIARY'S NAME (FIRST NAME/SURNAME).

NOTE: A BENEFICIARY'S NAME must be entered if the second digit of the REASON CODE entered on the Medical Exam Order Screen is any number other than 1 or 2.

H--ME10E - DESIG UNIT = BDMO BHA, BUSI: This message appears if the DESIGN UNIT entered on the Medical Exam Order Screen is other than BDMO, BHA, or BUSI.

CORRECTIVE ACTION: Tab the cursor to the DESIG UNIT position and type BDMO, BHA, or BUSI depending on which unit is to receive the final exam report.

H--ME11E - AUTH ORDERER NAME REQUIRED: The name of the person ordering the examinations must be entered on the Medical Exam Order Screen.

CORRECTIVE ACTION: Tab the cursor to the AUTHORIZED ORDERER position and type the LAST name of the AUTHORIZED ORDERER.

H--ME13E - INVALID FIELD OFFICE (SHIP): This message appears if the field office number entered on the Medical Exam Order Screen is invalid.

p> **CORRECTIVE ACTION:** Tab the cursor to the FO # position and type the correct field office number.

H--ME07E - EMPLOYEE NAME REQUIRED: The railroad employee's name was not entered on the Medical Exam Order Screen.

CORRECTIVE ACTION: Tab the key to move the cursor to the EE NAME position and type the railroad employee's name (FIRST NAME/SURNAME).

H--S807E - NEW ORDER EXISTS: This message displays if the scheduling was attempted using a DOCUMENT NUMBER on which medical examinations have already been ordered.

CORRECTIVE ACTION: Tab the cursor to the DOCUMENT NUMBER and type the correct DOCUMENT NUMBER.

H--S216E - NO ACCOUNT LINE ENTERED: This message appears if no EXAM NUMBERS were entered on the Exam Data Screen.

CORRECTIVE ACTION: Press ENTER to access the Exam Data Screen. Tab the cursor to the DEL DATE line, complete, and then press ENTER.

H--ME08E - REASON CODE MUST BE NUMERIC: This message indicates that the REASON CODE entered on the Medical Exam Order Screen was not a valid code.

CORRECTIVE ACTION: Tab the cursor to the REASON CD position and type the correct REASON CODE.

H--S183E - TOT ACCT LINE NOT = COMM LINE: This message appears if a number of exams were entered on the Exam Data Screen and one or more was "erased" or changed without properly deleting the line.

CORRECTIVE ACTION: Refer to Section 12.2.13 for instructions.

H--ME06E - TYPE REQ MUST = 01, 02, 03: This message appears if the TYPE REQUEST entered on the Medical Exam Order Screen was not a valid code.

CORRECTIVE ACTION: Tab the cursor to the TYPE REQ position and type the correct code.

01--S474E - DECR ON ORIG ENTRY ILLEGAL

01--EP46E - CANNOT DECR COMM LINE ON NEW ENTRY

01--A031E - MISSING ACCOUNT LINE: These messages appear if the DELETE EXAM INDICATOR is entered on a new entry.

CORRECTIVE ACTION: Tab the cursor to the DELETE EXAM IND position and remove the entry by using the space bar.

01--ME05E - INVALID EXAM NUMBER: This message indicates that an invalid exam number was entered on the Exam Data Screen.

CORRECTIVE ACTION: Tab the cursor to the EXAM NUMBER position and type the correct EXAM NUMBER.

01--S164E - MISSING COMMODITY CODE

01--A031E - MISSING LINE AMOUNT

01--S162E - MISSING UNIT OF MEASURE

01--EP48E - MISSING COMM LINE NUMBER

01--S196W - UNIT COST = ZERO ON ENTRY

01--S105E - QUANTITY = ZERO ON ENTRY: These messages appear when an invalid EXAM NUMBER was entered on the Exam Data Screen.

CORRECTIVE ACTION: Tab the cursor to the EXAM NUMBER position and type the correct EXAM NUMBER.

***CA93 - DOCUMENT REJECTED:** This message appears if a required entry was omitted or a restricted entry was incorrectly completed.

CORRECTIVE ACTION: Refer to the other Edit Referral Messages to determine which items were omitted or incorrectly completed. This message will disappear when the other items are corrected, the TOTAL AMOUNT is entered on the Medical Exam Order Screen, and a new quality check ('Q' in ACTION field) is done.

01--A032E - INVALID INC/DEC IND

01--S057E - INVALID UNIT/INC/DEC WD

01--S05E - INVALID QUANT INC/DEC IND: These messages will appear if attempting to delete an exam(s) using a code other than D in the DELETE EXAM INDICATOR on the Exam Data Screen.

CORRECTIVE ACTION: Refer to Section 12.2.13C, DELETING A LINE, for complete instructions.

01--*L006 - ADD KEY FOUND: This message appears on the TEXT Screen when adding or changing information which was previously entered while scheduling an exam. The message appears once for each line of TEXT up through the last TEXT line with typed information.

CORRECTIVE ACTION: None.

NOTE: Information can only be added ('A' in ACTION field) prior to the nightly FFS run.

06--*L030 - ALL LINES ADDED

06--*L030 - ALL LINES CHANGED

06--*L030 - ALL LINES DELETED: These messages appear to indicate that the desired action (add, change, or delete) on the TEXT SCREEN was accepted by FFS.

CORRECTIVE ACTION: None.

01--*L008 - END OF FILE: This message indicates that no subsequent screens follow the one being viewed.

CORRECTIVE ACTION: None.

05--*L033 - NO LINES ADDED: This message appears when entering additional information on a TEXT SCREEN.

CORRECTIVE ACTION: None.

NOTE: This Edit Referral message does not mean that the information added was not accepted. In order to confirm that the additional line of information was added to the system record, check the TEXT LINE column on the right side of the screen. If numbers appear in this column after adding the information, the information was accepted.

A--*L003 - REQUESTED TABLE NOT FOUND: The table code entered was invalid.

CORRECTIVE ACTION: Refer to Section [12.2.8](#), USE OF TABLES ON FFS, for the proper codes.

12.2.12 Multiple Document Numbers

The document number is an 11-position identifier that consists of the 9-digit RRB claim number followed by two alpha codes. The claim number prefix is not used in the DOCUMENT NUMBER entry. If the RRB claim number is not 9 digits, pre-fill using zeros. For example, claim number A 892431 should be shown as 000892431 plus the two alpha codes.

FFS allows only one order to be placed per document ID number. Since multiple orders are often required for one particular disability application, it may be necessary to use different alpha codes at the end of the document number to accommodate these requests.

A. The First Alpha Code

The alpha code will reflect the month you are placing the order. To keep this as simple as possible, we have designated the codes as follows:

A = January

G = July

B = February	H = August
C = March	I = September
D = April	J = October
E = May	K = November
F = June	L = December

EXAMPLE: If you are ordering exams 18, 45, and 55 for the Employee Jones, claim number 600-10-1111, in June 1994, the first 10 positions of the document ID number would be 600101111F.

There are times when additional examinations will need to be ordered in the same month, regardless of the year, as the initial order (reconsideration, appeals, etc.). These can be easily handled using alpha codes as follows:

M = January	S = July
N = February	T = August
O = March	U = September
P = April	V = October
Q = May	W = November
R = June	X = December

EXAMPLE: Using the above situation, if you need to place another order for Mr. Jones in June 1995, the first 10 characters of the document ID number will look like this: 600101111R. FFS will not accept 600101111F because that was used when the June 1994 order was placed.

If you need to order a third or fourth time for Mr. Jones and you need to place the order in June of any year, you should first use "Y" and, if necessary, then "Z" in the tenth position. These two codes are "wild cards" and can be used for any month in which multiple orders are placed.

B. The Second Alpha Code

The last position will be used to designate the type of beneficiary for whom medical examinations are being ordered. The codes are:

A = Employee

B = Widow

C = Surviving child

D = Retirement child

EXAMPLE: Using the same situation as before, four orders have been placed in the month of June, regardless of the year. These document ID codes would look like this:

First order: 600101111 FA

Second order: 600101111 RA

Third order: 600101111 YA

Fourth order: 600101111 ZA

As you can see, the above method allows up to four orders to be placed for any particular case in the same month, regardless of the year. But there is even greater flexibility using the second alpha code to accommodate more orders for the same month.

To place a fifth order in the month of June, regardless of the year, the last alpha code needs to be different from that of any of the four previous orders. You should, therefore, use the following codes:

E = Employee

F = Widow

G = Surviving child

H = Retirement child

EXAMPLE: In Mr. Jones' case, the fifth order placed in June, regardless of the year, would use this document ID number:

600101111FE

The rule of thumb is to exhaust all options in the first alpha code before changing the second alpha code. Subsequent document ID numbers for orders placed in June of any year will look like this:

Sixth order: 600101111RE

Seventh order: 600101111YE

Third order: 600101111ZE

It will be rare, indeed, for so many multiple orders to be placed in a particular month, regardless of the year. But if it does happen, FFS can accommodate it.

12.2.13 Special Situations

Even after carefully reviewing your entries before approving an order, changes may be required to correct errors or to react to new developments in a case. The following situations are possible and can be handled using appropriate action commands.

A. Correcting a Wrong Claim Number

The claim number entered on the START-UP SCREEN under DOCUMENT NUMBER is later found to be incorrect because of a transposed number. If this mistake is determined on the same day that it is entered, it will be necessary to delete the order. However, if the order was already processed with the nightly FFS run, it will be necessary to communicate this mistake to the vendor using electronic mail through Hybrid Systems Limited (HSL).

B. Deleting an Order

An order can be deleted if it has not been processed on the nightly FFS run. Each night FFS processes data which was entered during the day to actually complete the transaction of scheduling medical examinations. Prior to this nightly processing, entries can be changed including deletion of the entire order that was entered.

From the Suspense File, find the Document Number you wish to delete. Press the ENTER key to display the HEADER screen with previously entered data shown. Move the cursor to the ACTION field at the very top of the screen by pressing the TAB key and type DD (delete document). TAB to the DOCID and remove the transaction code, ME, by pressing the SPACE BAR and then press ENTER. The order will be deleted.

C. Deleting a Line

Erroneous or incorrect entries on an EXAM DATA SCREEN (LINE SCREEN) can be deleted using the delete line (DL) action command code if the order has not been processed on the nightly FFS run. The DL command allows deletion of one or more lines when it is not necessary to delete the entire order.

From the Suspense File, find the Document Number you intend to work on. Press the ENTER key to display the HEADER screen with previously entered data shown. Move the cursor to the ACTION field at the very top of the screen by pressing the TAB key and type NS (next screen) to

display the EXAM DATA SCREEN. Repeat the NS action until the desired screen to be deleted is shown.

Enter DL in the ACTION field at the top of the EXAM DATA SCREEN to be deleted. Move the cursor to the EXAM NUMBER line and erase the entry by pressing the SPACE BAR and then press ENTER.

It will be necessary to enter the TOTAL on the HEADER SCREEN before entering 'Q' (quality check) in the ACTION field successfully completes the transaction for processing on the nightly FFS run.

D. Canceling an Order

Once entries for an order are processed on the nightly FFS run, changes cannot be made to the previously entered data. If it is necessary to cancel an order, the vendor must be informed using electronic mail via Hybrid Systems Limited (HSL). For example, medical exams are scheduled on May 2, 1994, and a notice of death is received May 4, 1994. An HSL message is needed to inform the vendor about the death and to cancel the exams ordered on May 2, 1994. Also, corrective action is needed to remove the entries maintained on FFS to place the order.

From the Suspense File, find the Document Number you intend to work on. Press the ENTER key to display the HEADER screen; it will not display previously entered data. Move the cursor to the ACTION field directly across from the DEL DATE entry by pressing the TAB key and type an 'X.' Move the cursor to the ACTION field at the top of the screen by pressing the TAB key and enter a 'Q' (quality check). Press the ENTER key to complete the action.

This action will appear on the suspense table (SUSF) as a SCHED (scheduled) action. That means FFS is ready to process your request to cancel on the nightly run.

E. Canceling an Exam

It may be necessary to cancel only one or more exams from a previous order involving multiple exams. As previously explained under CANCELING AN ORDER, changes cannot be made once entries for an order are processed on the nightly FFS run. The vendor must be informed using HSL. For example, medical exams 018 and 013 are scheduled on May 2, 1994, and on May 4, 1994, a report is received from the applicant's treating physician that provides information which would be obtained from exam 018. An HSL message to cancel that exam should be sent to the vendor.

Corrective action to remove the ME obligation on the exam being canceled requires entries on FFS. From the Suspense File, find the Document Number you intend to work on. Press the ENTER key to display the HEADER screen; it will not display previously entered data. Move the cursor to the ACTION field directly across from the DEL DATE entry by pressing the TAB key, type an 'M' (modify), and then press ENTER. The EXAM DATA screen displays. Now type the exam number to be canceled; the cursor automatically advances to the DELETE EXAM IND. Type 'D' on this line. If additional exams are to be canceled, press the ENTER key and repeat the above steps for completing the EXAM DATA screen. Once all exams to be canceled have been entered, move the cursor to the ACTION field at the top of the screen and type 'Q' (quality check). Press ENTER to complete the action.

F. Handling "No-Shows"

Once notification is received that the person scheduled for an examination cannot, or did not, show up for an appointment, and it is appropriate to pay a no-show fee, a modified ME transaction is necessary to set up payment of the no-show fee. The examinee is required to notify the company contracted by the RRB to secure requested examinations if an appointment must be canceled. If the cancellation notice is received less than 24 hours before the appointment, a no-show fee must be paid. The no-show amounts have been determined and identified by separate codes explained below.

From the Suspense File, find the Document Number you intend to work on. At the HEADER SCREEN, simply enter an 'M' (modify) in the ACTION field across from the DEL DATE line. No other entries are required. Now press the ENTER key. When the EXAM DATA SCREEN displays, enter the exam number that you wish to cancel and type 'D' in the DELETE EXAM IND field. Press the ENTER key to move to the next screen. Enter the appropriate no-show code on the EXAM CODE line. The no-show codes are determined by adding "5" to the first digit of the three-digit exam code. For example, the "no-show" number for exam 018 is 518 or exam 153 is 653. A complete list is available in the MEXC table. Now move the cursor to the ACTION field at the top of the screen to complete the entries by typing 'Q' (quality check) in the ACTION field.

12.2.14 Reason Code

The reason code entered on the MEDICAL EXAM ORDER SCREEN (HEADER) is a two-digit code that identifies the reason for the examination and the type of beneficiary. Enter the appropriate two-digit code from the following list:

A. First Digit (Reason for Examination)

- 1 Initial development by the district office
- 2 Initial annuity determination, BDMO request
- 3 Annuity continuance, BDMO request
- 4 Initial freeze or early Medicare determination, BDMO request
- 5 Freeze or early Medicare continuance, BDMO request
- 6 Reconsideration, BDMO request
- 7 Appeal, BDMO request
- 8 Appeal, H & A request
- 9 RUIA eligibility, BUSI request
- 0 Reserved for future use

B. Second Digit (Type of Beneficiary)

- 1 Employee, A & S
- 2 Employee, D/A
- 3 Retirement child (IPI or Non-IPI)
- 4 Survivor child (DCIA)
- 5 Widow(er), remarried widow(er) or surviving divorced spouse (WIA)
- 6 Young mother, father or surviving divorced spouse (WICIA)
- 7 Disabled widow(er) or surviving divorced spouse (DWIA)
- 8-0 Reserved for future use

12.3 Continuing Disability Review Call-up Program

Use the Continuing Disability Review (CDR) call-up program to set call-ups for annuitants after a freeze determination has been made. Also, use it to close out the call-up when the CDR is completed. Click on a topic to for instructions that illustrate how to use the program for setting and closing call-ups.

12.3.1 Main Menu

This screen appears when you start the program.

<div data-bbox="277 226 1175 1035"> <div>CDR Call-ups</div> <div>Continuing Disability Review</div> <div>Call-ups</div> <div>Main Menu</div> <div>Select Multiple Call-ups</div> <div>Find Individual Call-up</div> <div>Add New Call-up</div> <div>Print Expiring Call-ups Count</div> <div>Completed Call-ups</div> <div>Exit</div> </div>	
Part	Function
Select Multiple Call-ups	<p>Click on this item to select call-ups for a specific period and/or other selection criteria.</p> <p>From there go to the:</p> <p>Open Call-ups screen to view the call-ups you selected. Then to the</p> <p>Edit Call-ups screen to</p> <p>Close a Call-up or</p> <p>Add a New Call-up</p>

Find Individual Call-up	Click on this item to go to the Edit Call-ups screen for a specific claim.
Add a New Call-up	Click on this item to add a new call-up for a specific claim.
Print Expiring Call-ups Count	This item is only for those with supervisory access. Click on this item to produce a count of call-ups by type of call-up for a specified period.
Completed Call-ups	Click on this item to see the information about all completed call-ups or a specific completed call-up.
Compact Database	This button will not appear unless you are authorized to use it.
Exit	To exit the call-up program, click this item.

12.3.2 Selection Screen

This screen appears after clicking on Select Multiple Call-ups on the Main Menu screen

CDR Call-ups

Selection Screen

Beginning Date: _____

Ending Date: _____

Digits: 00 -- 99

Call-up Reason: All ▼

Beneficiary Code: All ▼

View Selected Records
Return

Step	Action
1	Type the beginning date for call-ups you wish to work with; i.e. 01012000.
2	Type the ending date for call-ups you wish to work with.
3	The digits will default to all (00-99). Change this as necessary.
4	Call-up Reason is an optional item. All reasons will appear if you do not specify. To select a reason, click on the arrow to give you the pull down menu of call-up reasons and then click on the one you wish to specify.
5	Beneficiary Code is an optional item. All codes will appear if you do not specify. To select a code, click on the arrow to give you the pull down menu of codes and then click on the one you wish to specify.

6	Next, click on the View Selected Records and the Open Call-ups screen will appear. If you do not wish to continue, click on the Return button and you will go back to the Main Menu.
---	--

12.3.3 Open Call-ups Screen

Access this screen by selecting the type of records you need and click the View Selected Records on the Selection Screen.

All call-ups meeting the criteria specified on the Selection screen will appear.

CDR Call-ups

Open Call-ups

Claim	Beneficiary	Call-up Reason	Call-up Date
306-38- 1	T&P	MINE	1/1/1999
430-78- 1	Occ.	MINE	1/1/1999
467-84- 1	Occ.	MIP	1/1/1999
420-62- 1	Occ.	MINE	1/1/1999
420-62- 1	Occ.	MIP	1/1/1999
218-44- 1	T&P	MIP	1/1/1999
420-66- 1	T&P	MIP	1/1/1999
421-70- 1	T&P	MIP	1/1/1999
466-72- 1	T&P	MIP	1/1/1999
223-70- 1	Occ.	MINE	1/1/1999

1/1/1999 Thru 1/2/2001 Beneficiary: All
 Digits: 00 - 99 Reason: All

Click the claim number to display all call-ups for that number.

[Print Preview](#)
[Return](#)

Record: 1 of 4902

Click on the claim number you want to edit.

Step	Action
------	--------

1	Click on a claim number to display the Edit call-ups screen showing all call-ups for the specified claim number.
2	Click the Print Preview button if you wish to view the list. To print, click File/Print, otherwise click File/Exit.
3	If you do not wish to work with any call-ups in the list, click the Return button to go back to the Selection screen.

12.3.4 Edit Call-Ups

While on the Open Call-ups screen, click the specific claim number you wish to edit.

With this screen you can perform several actions for an individual claim number.

CDR Call-ups

Edit call-ups for 600-00-0006

Prefix	Claim Code	Payee Code	Initial and Name	Beneficiary Code
	600000006	1	D CASTAWAY	Occ. <input type="button" value="v"/>
Call-up Reason	<input type="button" value="v"/> MIF	Call-up Date	1/1/95	Examiner: JME
Completed Reason:	<input type="button" value="v"/>	Date Complete:		Closed By:
Comments:				

The only fields you will be able to complete are the:

- Completed Reason
- Date Completed (This will pre-fill when the reason is selected.)
- Closed By
- Comments

Undo Print Preview Completed Call-ups Add a New Call-up Return

Record: 1 of 1 (Filtered)

Supervisors will have access to a delete key for erroneous entries.

CDR Call-ups

Edit call-ups for 600-00-0006

Prefix: 6000000006 Claim Code: 1 Payee Code: D Castaway Beneficiary Code: Occ. [v]

Call-up Reason: MIF Call-up Date: 1/1/95 Examiner: JME

Completed Reason: [v] Date Complete: Closed By:

Comments:

Delete

Supervisors will be able to edit any field and delete erroneous entries.

Undo Print Preview Completed Call-ups Add a New Call-up Return

Record: 1 1 of 1 (Filtered)

Part	Function
Return	This will take you back to the Open Call-ups screen. Click here for instructions about closing out a call-up.
Add a New Call-up	If you wish to add a new call-up for the claim number on your Edit Call-up screen, click on the Add a New Call-up button and that screen will appear with pre-filled prefix, payee code, beneficiary code and name.
Undo Button	You may use this button on the Edit call-ups screen

	at any time to erase your entries and start over for the current record.
Print Button	Use this button to preview a print of all call-ups for the claim you are editing. To print, click on File in the upper left hand corner of your screen and then click print.
Completed Call-ups	Click on this button for a historical view of all call-ups closed under this claim number.

12.3.5 Closing out a Call-up

Close out a call-up after you complete a CDR

CDR Call-ups

Edit call-ups for 500-00-0005

Prefix Claim Payee Code Initial and Name Beneficiary Code
 500-00-0005 1 W Mountaine Occ.

Call-up Reason: MIP Call-up Date: 1/1/1999 Examiner: MAT
 Completed Reason: Death Date Complete: 8/17/2000 Closed By: L Stiles

Comments:

Undo Print Preview Completed Call-ups Add a New Call-up Return

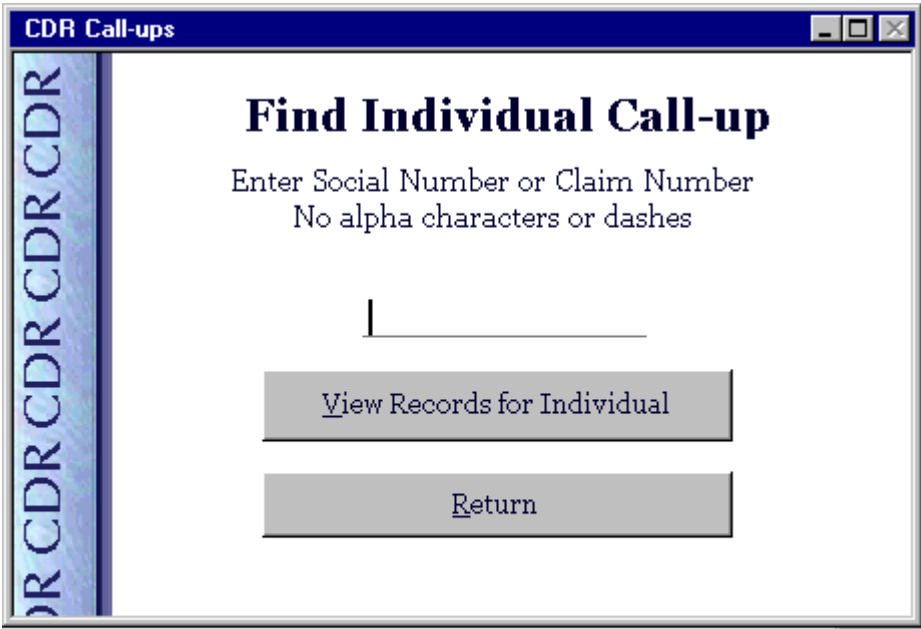
Record: 1 of 1 (Filtered)

Step	Action
1	Click on the arrow for the pull down menu to select a completed reason and select one by clicking on it. The program will pre-fill the Date Completed with today's date. Change this as necessary.

2	Enter your first initial and last name in the "Closed By" space.
3	Type in any remarks about this case under Comments.
4	Click on the Print button and place the print in the file.
5	Click on the Return button. This will complete your action by printing a copy of the completed call-up and moving it from the active area to the completed area. Place the print in the file. The Return button will then take you back to the Open Call-ups screen where you can choose another claim to work.

12.3.6 Find Individual Call-up

This screen appears after clicking on the button by the same name on the Main Menu screen.



CDR Call-ups

Find Individual Call-up

Enter Social Number or Claim Number
No alpha characters or dashes

|

View Records for Individual

Return

After you type in the claim just hit enter, you don't have to tab or click the View button.

Step	Action
1	Enter the social security number or claim number for the call-up you wish to work.
2	Hit Enter or click on the View Record for Individual button which will bring up the Edit call-ups screen for that claim.
4	Use the Return button at any time to cancel your action and return to the Main Menu.

12.3.7 Adding New Call-ups

Access this screen using the Add New Call-up button on either the Edit Call-ups screen or the Main Menu

If you clicked the Add New Call-up button on the Edit Call-up screen, this will appear with pre-filled prefix, payee code, beneficiary code and name. If you used the button on the Main Menu it will be blank. You will then need to complete the claim number, payee code, beneficiary code and name.

CDR Call-ups

Add New Call-up

Prefix Claim Payee Code Beneficiary Code Initial and Name

Call-up Reason: Call-up Date:

Examiner: Setup Date: 8/29/00

Comments:

Accept New Record, Print and Return Cancel New Record and Return

Step	Action
1	Select a call-up reason by clicking on the arrow for the pull down menu and then clicking on the reason you want.
2	Enter a call-up date for the first of the month.
3	Enter you first Initial and Last Name in the Examiner field.
4	The setup date will default to today, change this as necessary.
5	Enter any comments you wish to make about the case.
6	Click on the Accept New Record, Print and Return button. Place the print in the file. You return to the Open Call-ups screen.
7	Click on the Cancel New Record and Return button at any time if you decide not to proceed with adding the call-up. This will take you back to the Open Call-ups screen.

12.3.8 Expiring Call-ups

This screen appears after clicking on the Print Expiring Call-ups Count button on the Main Menu screen.

This screen is a management tool for determining expired or expiring call-ups for a given time period.

CDR Call-ups

Expiring Call-up Count

Beginning Date: _____

Ending Date: _____

If you complete only the beginning date, you will get all records on or after that date.

If you complete only the ending date, you will get all the records on or before that date.

If you leave both blank you will get all records.

[Print Preview](#) [Return](#)

Step	Action
1	Read the screen for you time period options.
2	Click the Print button. This will give you a preview of the call-up counts by reason code for the time period requested. To print a copy of the report, click on file in the upper left corner of the PC screen and then click Print.
3	Click the Return button to return to the Main Menu screen.

12.3.9 Completed Call-ups

This screen appears after clicking on the Completed Call-ups button on the Main Menu or the Edit Call-ups screens.

This screen shows all completed Call-ups. You can view them all by scrolling.

The screenshot shows a window titled "CDR Call-ups". Inside, there is a red header line: "*****All Completed Call-ups*****". Below this, three call-up records are displayed, each with a vertical label "CDR" on the left. The records are as follows:

Claim Number	Payee Name	Beneficiary Code	Call-up Reason	Call-up Date	Examiner	Completed	Date Completed	Closed by
300-00-0003 1	Willie Coke	T&P	H&A	1/1/00	CJB	Age 54 1/2	8/21/00	diintzenich
300-00-0003 1	Willie Coke	T&P	MIP	2/1/03	dli	Age 54 1/2	8/17/00	dli
400-00-0004 1	Lester Alex	T&P	MIP	1/1/00	CHP	Death	8/16/00	dli

At the bottom of the window, there are two buttons: "Find Call-up" and "Return". A note states: "When using the Find Claim button, enter only the claim number, no dashes, prefix or payee code." The status bar at the bottom shows "Record: 1 of 50".

Step	Action
1	To find a specific completed call-up, click on the Find Call-up button.
2	Enter the claim number in the "Find What" box of the screen that appears and click on the Find First button.

CDR Call-ups

*****All Completed Call-ups*****

300-00-0003 1 Willie Coke Beneficiary Code: T&P

Call-up Reason: H&A Call-up Date: 1/1/00 Examiner: CJB

Completed: Age 54 1/2 Date Completed: 8/21/00 Closed by: dlintzenich

Comments:

300-00-0003 1 Willie Coke Beneficiary Code: T&P

Call-up Reason: MIP Call-up Date: 2/1/03 Examiner: dli

Completed: Age 54 1/2 Date Completed: 8/17/00 Closed by: dli

Comments:

Find in field: 'txtSSA'

Find What:

Search: All ☐ Match Case ☐ Search Fields As Formatted ☒ Search Only Current Field

Buttons: Find First, Find Next, Close

Buttons: Find Call-up, Return

When using the Find Claim button, enter only the claim number, no dashes, prefix or payee code.

Record: 1 of 50

3

Click the Return button to return to the Main Menu screen.

12.3.10 Compacting the Database

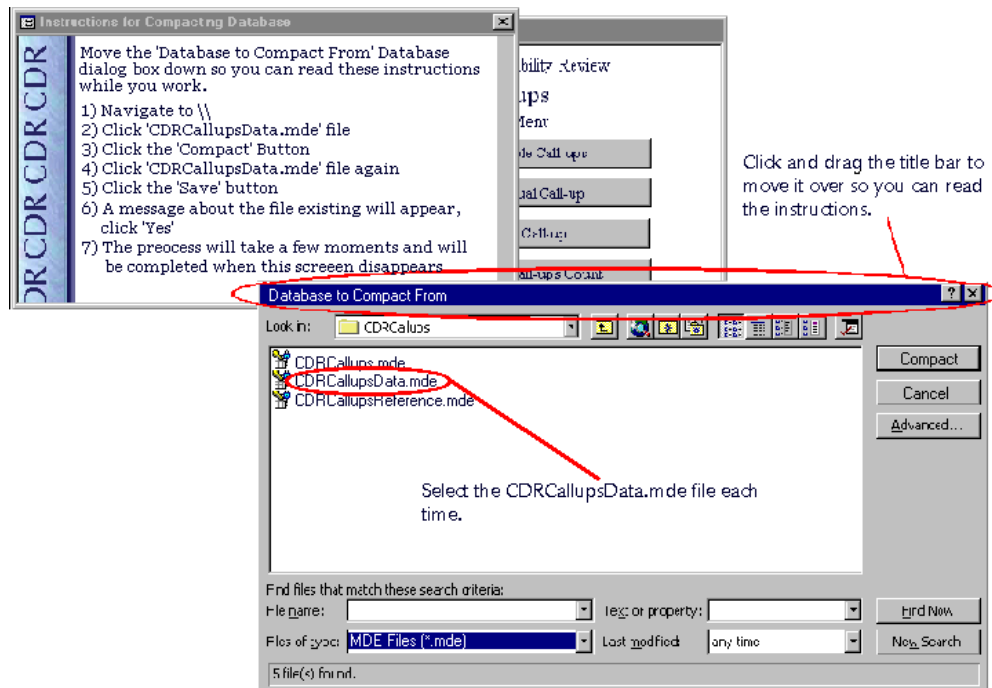
This button is on the Main Menu of the Supervisor's version.

Be very careful when you complete these steps.

Complete these steps when the program is NOT in use.

Make sure you are clicking on the files specified in the instructions.

DATA CAN BE LOST IF YOU ARE NOT CAREFUL!!



Step	Action
1	Click the Compact Database Button
2	Two screens will appear, move the top dialog box to the lower right part of your screen to view the instructions.
3	Complete the instructions. You will have to move the dialog box two times.

12.4 RL-121f Letters on RRAILS

12.4.1 Navigation of RL-121f Letters on RRAILS

12.4.1.1 Overview


An RL-121f letter is sent as a notification of disability rating in all cases in which an initial disability decision is an allowance. It is also sent in cases in which an initial disability allowance is re-evaluated to determine whether an earlier onset date can be set. More information about the purpose and content of the letter is contained in [DCM 11.3.3](#).

Since the information given in an RL-121f letter differs according to the type of annuitant, letters containing different combinations of standard and variable paragraphs have been designed for each type of annuitant. These include

- employees,
- widows,
- survivor children,
- spouses with disabled children in care (IC Spouse), and
- disabled children (IPI Child) to be included in the Overall Minimum Computation (O/M).

An RL-121f letter has also been designed for use in cases in which the annuitant has previously been rated disabled and was subsequently asked for additional information to determine whether or not an earlier onset could be established. This letter is referred to as “previous” as opposed to “initial.”

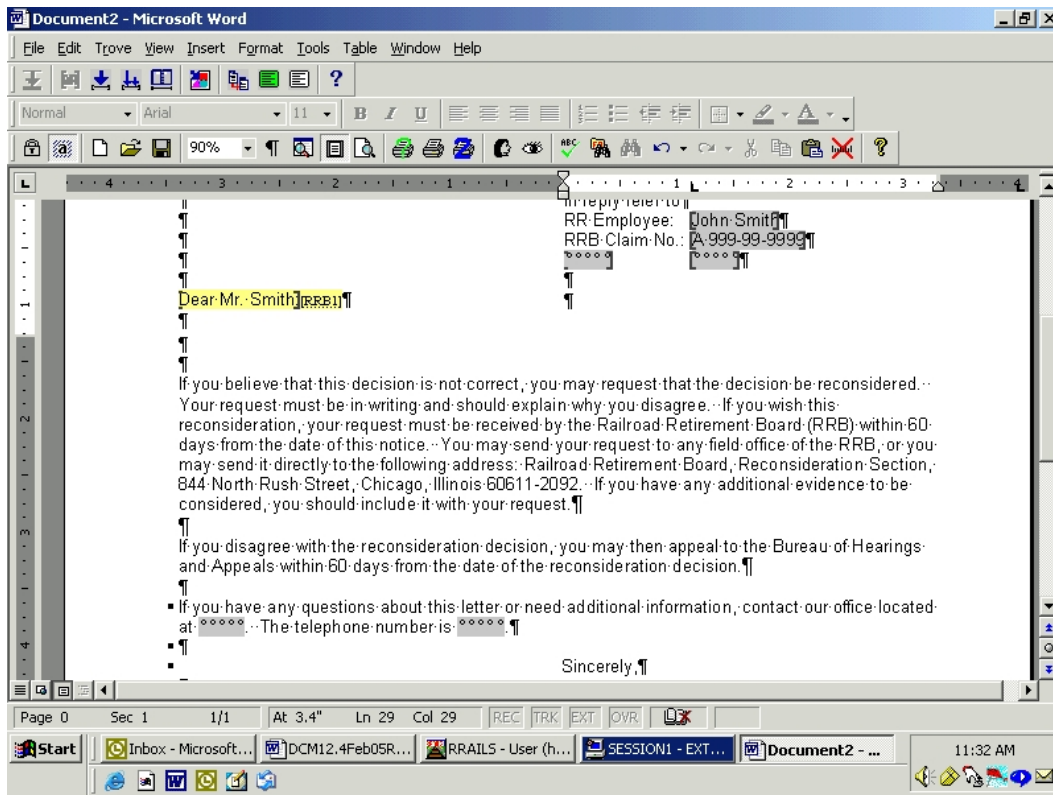
12.4.1.2 Access of the Letter

The letter can be accessed through the RRAILS PC program. On the initial RRAILS screen, download name, claim number, address, etc. per instructions in  [FOM1 1596.20](#). If the case involves multiple beneficiaries or multiple applications, multiple tabs will be displayed. Click on the appropriate tab.

Note: If the rating is for an IPI child to be included in the O/M, click on the tab associated with the employee.

Select RL-121f from the menu on the right side of the RRAILS screen.

The RL-121f template will appear, with the beneficiary address and other identifying information pre-filled from the system you selected for the download.



A reconsideration paragraph and a standard closing paragraph with spaces for the name, address, and phone number of the appropriate field office will be automatically included on all letters.

12.4.1.3 Access Of The Dialogue Box

Once you have accessed the letter, press control/shift/F2 and a dialogue box will appear.

The answers to the questions initially shown on the dialogue boxes are system defaults. You will need to change the answers when appropriate.

Depending upon the selections made in questions 1-3, different questions will appear after question 3, which the examiner must answer.

- select yes or no for other questions that appear and,
- fill in date boxes and, if applicable, box for child's name.

Depending upon the question and upon the answer, RRAILS will

- print an appropriate paragraph in the letter, or
- ask for paragraph inserts, such as the onset date, or

- prompt the examiner to compose a paragraph by printing ***** in the letter, or
- some combination of the preceding, or
- skip ahead to the next item.

For more detailed instructions on dialogue box completion for the various types of letters see:

[12.4.2](#) for Initial employee

[12.4.4](#) for Initial IPI disabled child for employee O/M

[12.4.6](#) for initial widow

[12.4.8](#) for Initial spouse with disabled child in care

[12.4.10](#) for Initial survivor disabled child

[12.4.12](#) for previous rating, possible earlier onset date (any type annuitant)

When you have completed the dialogue box, click on the OK box at the bottom left and the letter will re-appear.

12.4.1.4 Code Paragraphs and Finishing Touches

Code paragraphs can be used to substitute for examiner-composed paragraphs. To access code paragraphs, press Ctrl/Shift/F4. A window, labeled "Make Selection", containing the paragraph numbers will appear.

Note: This is different from other RRAILS letters. In other RRAILS letters, code paragraphs are accessed by pressing Ctrl/Shift/F2. In all other respects, the instructions for inserting code paragraphs for the RL-121f is the same as for other RRAILS letters. See [FOM1 1596.50](#).

If you are using a code paragraph in place of an examiner composed explanation of a difference between claimed and determined onset dates, you must delete the sentence that begins "The disability onset differs from that claimed because *****". If you are not using a code paragraph, delete the asterisks and complete the sentence by typing a free form explanation.

Instructions for using the Field Office Lookup Feature and for sending RRAILS letters to authorization folders or imaging are contained in [FOM1 1596.50](#).

For the exact text for the various types of letters see:

12.4.3 for Initial employee

[12.4.5](#) for Initial IPI disabled child for employee O/M

[12.4.7](#) for Initial widow

[12.4.9](#) for Initial spouse with disabled child in care

[12.4.11](#) for Initial survivor disabled child

[12.4.13](#) for previous rating, earlier onset date (any type annuitant)

12.4.2 Initial Employee Dialogue Box

If the employee tab (rather than a beneficiary tab) is selected on the initial RRAILS screen, the following dialogue box will appear:

UserForm1

1. Is this letter addressed to the beneficiary directly? ☒ Yes ☐ No

2. Choose whether this letter refers to the Employee or to a disabled IPI child of Gerald R. Gemmer. ☒ Employee ☐ IPI Child

3. Is this an initial letter? or Was disability previously awarded? ☒ Initial ☐ Previous

4. Has Medical Evidence or other information been requested for possible establishment of an earlier onset date? ☐ Yes ☒ No

Established onset date. (MM/DD/YYYY)

Claimed onset date. (MM/DD/YYYY)

Annuity beginning date. (MM/DD/YYYY)

Letter Date. (MM/DD/YYYY)

OK Cancel

The answers to questions 1-4 shown above are system defaults. You may need to change those answers depending on the situation. The following instructions describe situations for a letter to an employee in an initial (as opposed to “previous”) decision.

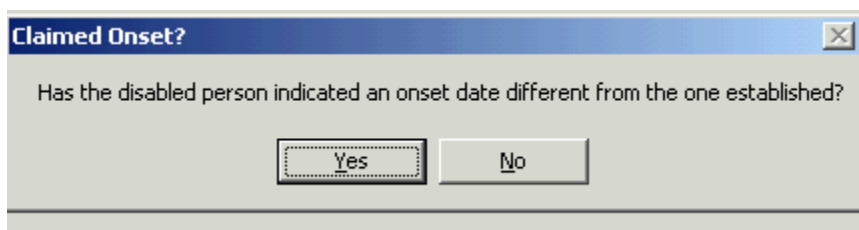
Question 1: Is this letter addressed to the beneficiary directly? Select whether the letter will go directly to the annuitant. The only situation in which it will not go directly to the annuitant is when there is a rep payee. Your answer to this question will not affect the appearance of the dialogue box. However, if you select “no”, the text of the letter itself will be changed to replace pronouns such as “you” or “your” with the annuitant’s name or the annuitant’s name with an apostrophe “s” (’s) and to correct verb forms accordingly. If you have pre-filled from a system such as APPLE, which knows the sex of the applicant, the first “you” will be replaced by the annuitant’s name and all subsequent pronouns will be replaced by he/she/his/her as appropriate.

Question 2: Choose whether this letter refers to the Employee or to a disabled IPI child of (employee’s name). If employee is selected, continue to Question 3. (If IPI child is selected, go to [DCM 12.4.4.](#))

Question 3: Is this an initial letter? Or was disability previously awarded? If initial is selected, continue to Question 4. (If previous is selected, go to [DCM 12.4.12.](#))

Question 4: Has medical evidence or other information been requested for possible establishment of an earlier onset? This question is answered “no” as a system default; you may need to change this answer. If “yes” is selected, a paragraph will be inserted in the letter to that effect. (Click here to see text of that paragraph.)

Date Boxes: Enter established onset date in the date box provided. A box will appear regarding claimed onset.



Has the disabled person indicated an onset different from the one established?

If “yes” is selected, the examiner must fill in the box for the claimed onset date. A sentence with asterisks will appear in the letter to prompt the examiner to give a free form explanation. (Click here to see that the text of that sentence.)

If “no” has been selected, RRAILS will fill the claimed onset box with the same date that was entered in the established onset box. The box for annuity beginning date will show an ABD based on the onset date, however, this date will not appear in the letter.

RRAILS will use this date to determine whether or not the claimant is in the waiting period and select the appropriate estimated payment date paragraph for the letter.

NOTE: If the waiting period is expired, but the employee's ABD is in the future because he has filed in advance of the last day of compensated service, manually change the date in the Annuity Beginning Date box to the day after the last day of compensated service. The appropriate estimated payment date paragraph will appear in the letter.

To see the paragraph used when the employee is still in the waiting period, or in the future because of advance filing, click [here](#). To see the paragraph used when the employee is not in the waiting period or does not have a future ABD, click [here](#).

Established onset date. (MM/DD/YYYY)	Claimed onset date. (MM/DD/YYYY)	Annuity beginning date. (MM/DD/YYYY)	Letter Date. (MM/DD/YYYY)
01/05/2005	03/01/2004	07/01/2005	02/03/2005

Applicant is still in waiting period

The Established Onset Date Waiting Period ABD of 7/1/2005 is later than the Claimed Onset Date Waiting Period ABD of 9/1/2004.

Does the difference in onset date have an adverse effect on the ABD? ☒ Yes ☐ No

OK Cancel

Does the difference in onset date have an adverse effect on ABD? This question only appears if the established onset date is different from the claimed onset date. If "no" is selected, RRAILS will print an appropriate sentence in the letter. (Click [here](#) to see the text of that sentence.)

When all entries have been made in the dialogue box, select OK. The dialogue box will close and the letter will re-appear.

12.4.3 Initial Employee Letter Text

Some paragraphs (standard) are always contained in an employee initial letter. Other paragraphs (variable) will be included depending upon entries in the dialogue box.

Standard Paragraphs

Exact text and order of the standard paragraphs are shown below:

Dear:

We have determined that you meet the requirements for a disability annuity. We have established a railroad retirement disability onset date of **[RRAILS inserts date from dialogue box]** in your case. Under the law, a disability annuity cannot begin earlier than the first day of the sixth month following the month in which the onset of disability occurs or earlier than the day after your last day of railroad compensation. Other factors also can affect your annuity beginning date or the amount of monthly benefits to which you are entitled.

[Variable paragraphs which depend on the way in which you answer the dialogue box questions are inserted here.]

If you have selected direct deposit, we will send your payment to the financial institution shown on your application. If you have changed financial institutions since you filed your application, please notify your field office right away.

Railroad Retirement disability annuities are subject to United States Federal income tax. If you did not file a form RRB W-4P, we must withhold taxes from your annuity as if you were married with three withholding allowances. If you wish to change the amount of your tax withholding, your field office can assist you.

You may have received benefits under the Railroad Unemployment Insurance Act after your annuity beginning date. If so, we will deduct the amount of those benefits from your first annuity payment.

If you believe that this decision is not correct, you may request that the decision be reconsidered. Your request must be in writing and should explain why you disagree. If you wish this reconsideration, your request must be received by the Railroad Retirement Board (RRB) within 60 days from the date of this notice. You may send your request to any field office of the RRB, or you may send it directly to the following address: Railroad Retirement Board, Reconsideration Section, 844 North Rush Street, Chicago, Illinois 60611-2092. If you have any additional evidence to be considered, you should include it with your request.

If you disagree with the reconsideration decision, you may then appeal to the Bureau of Hearings and Appeals within 60 days of the reconsideration decision.

If you have any questions about this letter or need additional information, contact our office located at **[Field office look up will insert district office address]**. The telephone number is **[Field office look up will enter phone number]**.

Sincerely,

Variable Paragraphs

Exact text and order of the variable paragraphs is shown below:

Estimated payment date paragraph used when ABD is in the future: Therefore, your annuity cannot begin before **[RRAILS inserts a date that is 6 months after the disability onset date or the day after the last day of compensated service]**. Within 45 days of that date, you should receive your first payment and a letter explaining more about your monthly benefits.

Estimated payment date paragraph used when ABD is not in the future: We are in the process of calculating your annuity. Your first payment should be issued within the next 20 days. A letter explaining the payment will also be sent when the payment is issued.

Explanatory paragraph used when the established onset date is different from that claimed: The disability onset date differs from that claimed because *****
[The examiner must replace the asterisks with an explanation or delete the entire sentence and replace it with a code paragraph or custom explanation.]

Paragraph used when additional medical evidence requested: If they have not done so already, your field office will be contacting you in regards to providing additional information to determine whether or not an earlier onset date can be established. When this information is received, your case will be reviewed again and we will determine if your onset date should be changed.

Paragraph used when an onset different than claimed is used but has no effect on ABD: Although your established onset date is different than what was alleged, this has no adverse effect on your annuity beginning date.

12.4.4 Initial O/M IPI Child Dialogue Box

If the employee tab is selected, and the answer to question 2 is IPI, the dialogue box will look like this:

UserForm1

1. Is this letter addressed to the beneficiary directly? ☒ Yes ☐ No

2. Choose whether this letter refers to the Employee or to a disabled IPI child of Gerald R. Gemmer. ☐ Employee ☒ IPI Child

Established onset date.
(MM/DD/YYYY)

Letter Date.
(MM/DD/YYYY)

02/03/2005

What is the child's name?

OK Cancel

The following instructions apply to situations for a letter to an employee whose child has been rated disabled for inclusion in the O/M in an initial (as opposed to “previous”) decision.

Question 1: Is this letter addressed to the beneficiary directly? Select whether the letter will go directly to the annuitant. The only situation in which it will not go directly to the annuitant is when there is a rep payee. Your answer to this question will not affect the appearance of the dialogue box. However, if you select “no”, the text of the letter itself will be changed to replace pronouns such as “you” or “your” with the annuitant’s name or the annuitant’s name with an apostrophe “s” (’s) and to correct verb forms accordingly. If you have pre-filled from a system such as APPLE, which knows the sex of the applicant, the first “you” will be replaced by the annuitant’s name and all subsequent pronouns will be replaced by he/she/his/her as appropriate.

Note that although the person being rated is the IPI child, the letter is addressed to the employee. If the employee does not have a rep payee, select “yes”.

Question 2: Choose whether this letter refers to the Employee or to a disabled IPI child of (employee's name). If IPI child is selected, continue to boxes. (If employee is selected, go to [12.4.2.](#))

Boxes: Enter the disability onset date and child's name in the boxes provided. RRAILS inserts the date and the child's name in the appropriate places in the letter.

When all entries have been made in the dialogue box, select OK. The dialogue box will close and the letter will re-appear.

12.4.5 Initial O/M IPI Child Letter Text

A child who is not eligible for an annuity may be rated disabled in order to increase an employee annuity under the O/M provision. The text for the letters sent in these cases is shown below.

Dear:

We have determined that **[RRAILS inserts child's name from dialogue box]** is disabled. A railroad retirement disability onset date of **[RRAILS inserts date from dialogue box]** has been established for **[RRAILS inserts child's name from dialogue box]**. We will send you a letter to explain if this affects your monthly annuity payments. You will also receive a letter concerning **[RRAILS inserts child's name from dialogue box]**'s possible eligibility for Medicare.

If you believe that this decision is not correct, you may request that the decision be reconsidered. Your request must be in writing and should explain why you disagree. If you wish this reconsideration, your request must be received by the Railroad Retirement Board (RRB) within 60 days from the date of this notice. You may send your request to any field office of the RRB, or you may send it directly to the following address: Railroad Retirement Board, Reconsideration Section, 844 North Rush Street, Chicago, Illinois 60611-2092. If you have any additional evidence to be considered, you should include it with your request.

If you disagree with the reconsideration decision, you may then appeal to the Bureau of Hearings and Appeals within 60 days of the reconsideration decision.

If you have any questions about this letter or need additional information, contact our office at **[Field office look up will insert district office address]**. The telephone number is **[Field office look up will enter phone number]**.

Sincerely,

12.4.6 Initial Widow Dialogue Box

If a beneficiary tab (rather than employee tab) is selected on the initial RRAILS screen, the dialogue box will look like this:

UserForm1

1. Is this letter addressed to the beneficiary directly? ☒ Yes ☐ No

2. Is Ma Isabel Sandoval a Widow, Child, or Spouse with disabled child in care. (W, C, S, or I) ☒ Widow ☐ IC Spouse
☐ Child

3. Is this an initial letter? or Was disability previously awarded? ☒ Initial ☐ Previous

4. Has Medical Evidence or other information been requested for possible establishment of an earlier onset date? ☐ Yes ☒ No

7. What is the Widow's DOB?

Employee's Date of Death? Date of Filing?

Established onset date. (MM/DD/YYYY) Claimed onset date. (MM/DD/YYYY) Annuity beginning date. (MM/DD/YYYY) Letter Date. (MM/DD/YYYY)

The answers shown on questions 1-4 above are system defaults. The examiner must change the answers when appropriate. The following instructions describe situations for a letter to a widow in an initial (as opposed to “previous”) decision.

NOTE: Choose the widow radio button for widowers, remarried widows and widowers, and surviving divorced spouses, as well as for widows.

Question 1: Is this letter addressed to the beneficiary directly? Select whether the letter will go directly to the annuitant. The only situation in which it will not go directly to the annuitant is when there is a rep payee. Your answer to this question will not affect the appearance of the dialogue box. However, if you select “no”, the text of the letter itself will be changed to replace pronouns such as “you” or “your” with the annuitant’s name or the annuitant’s name with an apostrophe “s” (’s) and to correct verb forms accordingly. If you have pre-filled from a system such as APPLE, which knows the sex of the applicant, the first “you” will be replaced by the annuitant’s name and all subsequent pronouns will be replaced by he/she/his/her as appropriate.

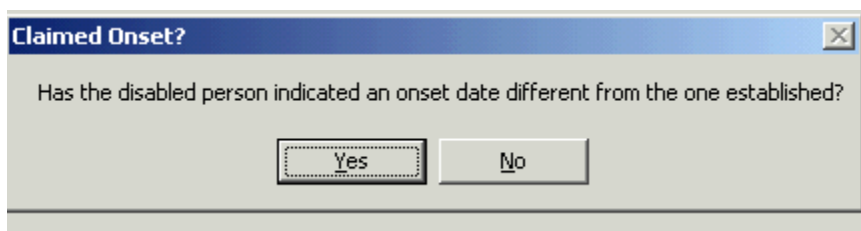
Question 2: Is (claimant's name) a Widow, Child, or Spouse with disabled child in her care? If widow is selected, continue to Question 3. (If child is selected, go to DCM [12.4.10](#). If IC Spouse is selected, go to DCM [12.4.8](#).)

Question 3: Is this an initial letter? Or was disability previously awarded? If initial is selected, continue to Question 4. (If previous is selected, go to [DCM 12.4.12](#).)

Question 4: Has medical evidence or other information been requested for possible establishment of an earlier onset? This question is answered “no” as a system default; you may need to change this answer. If “yes” is selected an appropriate paragraph will be inserted in the letter. Click here to see the text of that paragraph.

Date Boxes: Enter widow's DOB, employee's DOD, and widow's date of filing in the boxes provided.

Enter established onset date in the date box provided. A box will appear regarding claimed onset.



Has the disabled person indicated an onset different from the one established?

If “yes” is selected, the examiner must fill in the box for the claimed onset date. A sentence with asterisks will appear in the letter to prompt the examiner to give a free form explanation. Click here to see the text of that sentence.

If “no” has been selected, RRAILS will fill the claimed onset box with the same date that was entered in the established onset box.

The box for annuity beginning date will show an ABD based on the onset date, however, this date will not appear in the letter. RRAILS will use this date to determine whether or not the claimant is in the waiting period and select the appropriate estimated payment date paragraph for the letter. To see text of the paragraph used when the widow is still in the waiting period, click here. To see text of the paragraph used when the widow is not still in the waiting period, click here.

Established onset date. (MM/DD/YYYY)	Claimed onset date. (MM/DD/YYYY)	Annuity beginning date. (MM/DD/YYYY)	Letter Date. (MM/DD/YYYY)
01/05/2005	03/01/2004	07/01/2005	02/03/2005

Applicant is still in waiting period

Does the difference in onset date have an adverse effect on the ABD? ☒ Yes ☐ No

OK Cancel

Does the difference in onset date have an adverse effect on ABD? This question only appears if the established onset date is different from the claimed onset date. If “no” is selected, RRAILS will print an appropriate sentence in the letter. To see the text of that sentence, [click here](#).

When all entries have been made in the dialogue box, select OK. The dialogue box will close and the letter will re-appear. The following window will appear on the letter:

Survivor Type

Please the type of of survivor disability application:

- 1 = Widow
- 2 = Widower
- 3 = Remarried Widow
- 4 = Remarried Widower
- 5 = Surviving Divorced Spouse

OK Cancel

Type the appropriate number in the white box and click OK. The appropriate annuity type name will appear in the first and fourth sentences of the letter.

12.4.7 Initial Widow Letter Text

Some paragraphs (standard) are always contained in a widow initial letter. Other paragraphs (variable) will be included depending upon entries in the dialogue box.

Standard Paragraphs

Exact text and order of the standard paragraphs is shown below:

Dear:

We have determined that you meet the requirements for a disabled [widow's/widower's/remarried widow's/remarried widower's/surviving divorced

spouse's] annuity. A railroad retirement disability onset date of **[RRAILS will enter date from dialogue box]** has been established in your case. Under the law, a disability annuity cannot begin earlier than the first day of the sixth month following the month in which the onset of disability occurs. In addition, a disabled [widow's/widower's/remarried widow's/remarried widower's/surviving divorced spouse's] annuity cannot begin earlier than the month in which the railroad worker died or earlier than the month in which the [widow/widower/remarried widow/remarried widower/surviving divorced spouse] attained age 50. Other factors may also affect the beginning date of the annuity.

[Variable paragraphs which depend on the way in which you answer the dialogue box questions are inserted here.]

If you have selected direct deposit, we will send your payment to the financial institution shown on your application. If you have changed financial institutions since you filed your application, please notify your field office right away.

Railroad Retirement Board disability annuities are subject to United States Federal income tax. If you wish to elect tax withholding or change the amount of your tax withholding, your field office can assist you.

If you believe that this decision is not correct, you may request that the decision be reconsidered. If you wish this reconsideration, you must request it in writing, and your request must be received by the Railroad Retirement Board (RRB) within 60 days from the date of this notice. You may send your request to any field office of the RRB or you may send it directly to the following address: Railroad Retirement Board, Reconsideration Section, 844 North Rush Street, Chicago, Illinois 60611-2092. If you have any additional evidence to be considered, please include it with your request.

If you disagree with the reconsideration decision, you may then appeal to the Bureau of Hearings and Appeals within 60 days of the date of the reconsideration decision.

If you have any questions about this letter or need additional information, contact our office at **[Field office look up will insert district office address]**. The phone number is **[Field office look up will enter phone number]**.

Sincerely,

Variable Paragraphs

Exact text and order of the variable paragraphs is shown below:

Estimated payment date paragraph used when still in the waiting period:

Therefore, your annuity cannot begin before **[RRAILS will enter a date that is 6 months after the onset date]**. Within 45 days of that date, you should receive your first payment and a letter explaining more about your monthly benefits.

Estimated payment date paragraph used when not still in the waiting period: We are in the process of calculating the monthly annuity. Your first payment should be issued in the next 20 days. A letter explaining the payment will also be sent when the payment is issued.

Explanatory paragraph used when the established onset date is different from that claimed: The disability onset date differs from that claimed because *****
[The examiner must replace the asterisks with an explanation or delete the entire sentence and replace it with a code paragraph or custom explanation.]

Paragraph used when additional medical evidence requested: If they have not done so already, your field office will be contacting you in regards to providing additional information to determine whether or not an earlier onset date can be established. When this information is received, your case will be reviewed again and we will determine if your onset date should be changed.

Paragraph used when an onset different than claimed is used but has no effect on ABD: Although your established onset date is different than what was alleged, this has no adverse effect on your annuity beginning date.

12.4.8 Initial Spouse with Disabled Child Dialogue Box

If the beneficiary tab (rather than employee tab) is selected on the initial RRAILS screen, the answer to question 2 is IC Spouse, and the answer to question 3 is initial, the dialogue box will look like this:

UserForm1

1. Is this letter addressed to the beneficiary directly? ☒ Yes ☐ No

2. Is Ma Isabel Sandoval a Widow, Child, or Spouse with disabled child in care. (W, C, S, or I) ☐ Widow ☒ IC Spouse ☐ Child

3. Is this an initial letter? or Was disability previously awarded? ☒ Initial ☐ Previous

4. Has Medical Evidence or other information been requested for possible establishment of an earlier onset date? ☐ Yes ☒ No

Established onset date. (MM/DD/YYYY)

Letter Date. (MM/DD/YYYY)

02/03/2005

What is the child's name?

OK Cancel

The following instructions apply to situations for a letter to a spouse with a disabled child in his/her care in an initial (as opposed to “previous”) decision.

Question 1: Is this letter addressed to the beneficiary directly? Select whether the letter will go directly to the annuitant. The only situation in which it will not go directly to the annuitant is when there is a rep payee. Your answer to this question will not affect the appearance of the dialogue box. However, if you select “no”, the text of the letter itself will be changed to replace pronouns such as “you” or “your” with the annuitant’s name or the annuitant’s name with an apostrophe “s” (’s) and to correct verb forms accordingly. If you have pre-filled from a system such as APPLE, which knows the sex of the applicant, the first “you” will be replaced by the annuitant’s name and all subsequent pronouns will be replaced by he/she/his/her as appropriate.

Note that while the child is being rated, the letter is addressed to the spouse. If the spouse does not have a rep payee, select “yes”.

Question 2: Is (claimant's name) a Widow, Child, or Spouse with disabled child in her care? If IC Spouse is selected, continue to question 3. (If widow is selected, go to [DCM 12.4.6](#). If child is selected, to [DCM 12.4.10](#).)

Question 3: Is this an initial letter? Or was disability previously awarded? If initial is selected, continue to Question 4. (If previous is selected, go to [DCM 12.4.12](#).)

Question 4: Has medical evidence or other information been requested for possible establishment of an earlier onset? This question is answered “no” as a system default; you may need to change this answer. If “yes” is selected an appropriate paragraph will be inserted in the letter. To see the text of that paragraph, click here.

Enter the disability onset date and the child's name in the boxes provided. RRAILS inserts the date and the child's name in the appropriate places in the letter.

When all entries have been made in the dialogue box, select OK. The dialogue box will close and the letter will re-appear.

12.4.9 Initial Spouse with Disabled Child Letter Text

A child who is not eligible for an annuity may be rated disabled in order to qualify a spouse for an annuity. The text for the letters sent in these cases is shown below.

Dear:

We have determined that **[RRAILS enters child's name from dialogue box]** is disabled. A railroad retirement disability onset date of **[RRAILS will enter date from dialogue box]** has been established in **[RRAILS enters child's name from dialogue box]**'s case. This determination will qualify you for a spouse annuity. **[RRAILS enters child's name from dialogue box]**'s disability onset date and other factors may have an effect on your annuity beginning date.

We are in the process of calculating your annuity. Your first payment should be issued in the next 20 days. A letter explaining the payment will also be sent when the payment is issued.

If you have selected direct deposit, we will send your payment to the financial institution shown on your application. If you have changed financial institutions since you filed your application, please notify your field office right away.

Railroad Retirement Board disability annuities are subject to United States Federal income tax. If you did not file a form RRB W-4P, we must withhold taxes from your annuity as if you were married with three withholding allowances. If

you wish to change the amount of your tax withholding, your field office can assist you.

If you believe that this decision is not correct, you may request that the decision be reconsidered. Your request must be in writing and should explain why you disagree. If you wish this reconsideration, your request must be received by the Railroad Retirement Board (RRB) within 60 days from the date of this notice. You may send your request to any field office of the RRB, or you may send it directly to the following address: Railroad Retirement Board, Reconsideration Section, 844 North Rush Street, Chicago, Illinois 60611-2092. If you have any additional evidence to be considered, you should include it with your request.

If you disagree with the reconsideration decision, you may then appeal to the Bureau of Hearings and Appeals within 60 days of the reconsideration decision.

If you have any questions about this letter or need additional information, our office at **[Field office look up will insert district office address]**. The telephone number is **[Field office look up will enter phone number]**.

Sincerely,

12.4.10 Initial Survivor Disabled Child Dialogue Box

If a beneficiary tab (as opposed to an employee tab) is selected on the initial RRAILS screen, the answer to question 2 is child, and the answer to question 3 is initial, the dialogue box will look like this:

UserForm1

1. Is this letter addressed to the beneficiary directly? ☒ Yes ☐ No

2. Is Ma Isabel Sandoval a Widow, Child, or Spouse with disabled child in care. (W, C, S, or I) ☐ Widow ☐ IC Spouse ☒ Child

3. Is this an initial letter? or Was disability previously awarded? ☒ Initial ☐ Previous

4. Has Medical Evidence or other information been requested for possible establishment of an earlier onset date? ☐ Yes ☒ No

Established onset date. (MM/DD/YYYY)

Claimed onset date. (MM/DD/YYYY)

Letter Date. (MM/DD/YYYY)

The following instructions describe situations for a letter to a survivor child in an initial (as opposed to “previous”) decision.

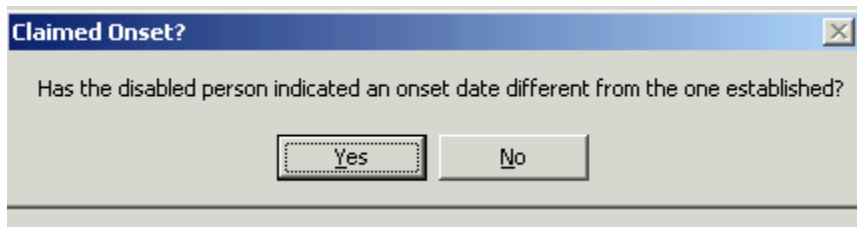
Question 1: Is this letter addressed to the beneficiary directly? Select whether the letter will go directly to the annuitant. The only situation in which it will not go directly to the annuitant is when there is a rep payee. Your answer to this question will not affect the appearance of the dialogue box. However, if you select “no”, the text of the letter itself will be changed to replace pronouns such as “you” or “your” with the annuitant’s name or the annuitant’s name with an apostrophe “s” (’s) and to correct verb forms accordingly. If you have pre-filled from a system such as APPLE, which knows the sex of the applicant, the first “you” will be replaced by the annuitant’s name and all subsequent pronouns will be replaced by he/she/his/her as appropriate.

Question 2: Is (claimant’s name) a Widow, Child, or Spouse with disabled child in her care? If child is selected, continue to Question 3. (If widow is selected, go to DCM [12.4.6](#). If IC Spouse is selected, go to DCM [12.4.8](#).)

Question 3: Is this an initial letter? Or was disability previously awarded? If initial is selected continue to Question 4. (If previous is selected, go to DCM [12.4.12](#))

Question 4: Has medical evidence or other information been requested for possible establishment of an earlier onset? This question is answered “no” as a system default; you may need to change this answer. If “yes” is selected an appropriate paragraph will be inserted in the letter. To see the text of this paragraph, [click here](#).

Date Boxes: Enter established onset date in the date box provided. A box will appear regarding claimed onset.



Has the disabled person indicated an onset different from the one established? If “yes” is selected, the examiner must fill in the box for the claimed onset date. A sentence with asterisks will appear in the letter to prompt the examiner to give a free form explanation. To see the text of this sentence, [click here](#).

If “no” has been selected, RRAILS will fill the claimed onset box with the same date that was entered in the established onset box.

Does the difference in onset date have an adverse effect on ABD? This question only appears if the established onset date is different from the claimed onset date. If “no” is selected, RRAILS will print an appropriate sentence in the letter. To see the text of this sentence, [click here](#).

When all entries have been made in the dialogue box, select OK. The dialogue box will close and the letter will re-appear.

12.4.11 Initial Survivor Child Letter Text

Some paragraphs are always contained in a survivor child’s initial letter. Other paragraphs will be included depending upon entries in the dialogue box.

Standard Paragraphs

Exact text and order of standard paragraphs is shown below:

Dear:

We have determined that you meet the requirements for a disabled child's annuity. A railroad retirement disability onset date of **[RRAILS enter the date from the dialogue box]** has been established in your case.

A survivor annuity cannot begin earlier than the month in which the railroad worker died. Other factors may also affect the beginning date of the annuity. We are in the process of calculating your annuity. Your first payment should be issued in the next 20 days. A letter explaining the payment will also be sent when the payment is issued. After you receive that notice, if you have any questions, contact your nearest field office.

[Variable paragraphs which depend on the way in which you answer the dialogue box questions are inserted here.]

If you have selected direct deposit, we will send your payment to the financial institution shown on your application. If you have changed financial institutions since you filed your application, please notify your field office right away.

Railroad Retirement Board disability annuities are subject to United States Federal income tax. If you wish to elect tax withholding or change the amount of your tax withholding, your field office can assist you.

If you believe that this decision is not correct, you may request that the decision be reconsidered. Your request must be in writing and should explain why you disagree. If you wish this reconsideration, your request must be received by the Railroad Retirement Board (RRB) within 60 days from the date of this notice. You may send your request to any field office of the RRB, or you may send it directly to the following address: Railroad Retirement Board, Reconsideration Section, 844 North Rush Street, Chicago, Illinois 60611-2092. If you have any additional evidence to be considered, you should include it with your request.

If you disagree with the reconsideration decision, you may then appeal to the Bureau of Hearings and Appeals within 60 days of the reconsideration decision.

If you have any questions about this letter or need additional information, contact our office at **[Field office look up will insert district office address.]** The telephone number is **[Field office look up will enter phone number].**

Sincerely,

Variable Paragraphs

Exact text and order of the variable paragraphs is shown below:

Explanatory paragraph used when the established onset date is different from that claimed: The disability onset date differs from that claimed because *****
[The examiner must replace the asterisks with an explanation or delete the

entire sentence and replace it with a code paragraph or custom explanation.]

Paragraph used when additional medical evidence requested: If they have not done so already, your field office will be contacting you in regards to providing additional information to determine whether or not an earlier onset date can be established. When this information is received, your case will be reviewed again and we will determine if your onset date should be changed.

Paragraph used when an onset different than claimed is used but has no effect on ABD: Although your established onset date is different than what was alleged, this has no adverse effect on your annuity beginning date.

12.4.12 Previous for Employee and Beneficiary Dialogue Box

When a case has previously been rated disabled, and the case is now being reviewed to determine whether an earlier onset can be set, answer question 3 “previous.” If the answer to question 3 is previous, then question 4 and all that would follow it in the initial letter will disappear. This is true regardless of which tab is selected (employee or beneficiary) on the initial RRAILS screen and regardless of how question 2 is answered. The dialogue box will contain questions 1, 2, 3, and 5.

UserForm1

1. Is this letter addressed to the beneficiary directly? ☒ Yes ☐ No

2. Choose whether this letter refers to the Employee or to a disabled IPI child of Gerald R. Gemmer. ☒ Employee ☐ IPI Child

3. Is this an initial letter? or Was disability previously awarded? ☐ Initial ☒ Previous

5. Has the claimant submitted additional medical evidence or information? ☐ Yes ☒ No

Previously established onset (MM/DD/YYYY)

Letter Date. (MM/DD/YYYY)

02/03/2005

OK Cancel

Note: The “previous” letters to beneficiaries will contain the same sequence of questions and results as the “previous” letter to employees. The only difference is the choices for question 2.

Question 1: Is this letter addressed to the beneficiary directly? Select whether the letter will go directly to the annuitant. The only situation in which it will not go directly to the annuitant is when there is a rep payee. Your answer to this question will not affect the appearance of the dialogue box. However, if you select “no”, the text of the letter itself will be changed to replace pronouns such as “you” or “your” with the annuitant’s name or the annuitant’s name with an apostrophe “s” (’s) and to correct verb forms accordingly. If you have pre-filled from a system such as APPLE, which knows the sex of the applicant, the first “you” will be replaced by the annuitant’s name and all subsequent pronouns will be replaced by he/she/his/her as appropriate.

Question 2: Choose whether this letter refers to the Employee or to a disabled IPI child of (employee’s name).or

Is (claimant's name) a Widow, Child, or Spouse with disabled child in care?

Select the annuity type, such as employee, IPI child, widow, etc.

Question 3: Is this an initial letter? Or was disability previously awarded? If "previous" is selected, Question 4 will disappear; continue to Question 5. (If initial is selected, go DCM [12.4.2](#) if the letter is for an employee, [12.4.4](#) for an IPI child, [12.4.6](#) for a widow, [12.4.8](#) or IC Spouse, or [12.4.10](#) for survivor child.)

Question 5: Has the claimant submitted additional medical information? ("No" will be shown as a system default. You may need to change this answer.)

If "no" is selected, no further questions will appear. Enter the previously established onset date in the box provided. Click OK and the letter will appear.

If "yes" is selected, questions 6 will appear, with "no" as the default answer. The dialogue box will look like this:

JserForm1

1. Is this letter addressed to the beneficiary directly? ☒ Yes ☐ No

2. Choose whether this letter refers to the Employee or to a disabled IPI child of Gerald R Gemmer. ☒ Employee ☐ IPI Child

3. Is this an initial letter? or Was disability previously awarded? ☐ Initial ☒ Previous

5. Has the claimant submitted additional medical evidence or information? ☒ Yes ☐ No

6. Has an earlier onset date been set based on the additional medical evidence or information? ☐ Yes ☒ No

Letter Date.
(MM/DD/YYYY)

02/03/2005

Does the difference in onset date have an adverse effect on the ABD? ☒ Yes ☐ No

OK Cancel

Question 6: Has an earlier onset date been set based on the additional medical evidence or information? If question 6 is answered yes, boxes will appear for the

previously established and newly established onset dates. The dialogue box will look like this:

UserForm1

1. Is this letter addressed to the beneficiary directly? ☒ Yes ☐ No

2. Choose whether this letter refers to the Employee or to a disabled IPI child of Gerald R Gemmer. ☒ Employee ☐ IPI Child

3. Is this an initial letter? or Was disability previously awarded? ☐ Initial ☒ Previous

4. ☐ Yes ☐ No

5. Has the claimant submitted additional medical evidence or information? ☒ Yes ☐ No

6. Has an earlier onset date been set based on the additional medical evidence or information? ☒ Yes ☐ No

Previously established onset (MM/DD/YYYY)

Newly Established onset (MM/DD/YYYY)

Letter Date. (MM/DD/YYYY)

Enter the appropriate dates in the boxes provided.

If question 6 is answered “no”, the boxes for previously established and newly established onset dates will not appear.

When all entries have been made in the dialogue box, select OK. The dialogue box will close and the letter will re-appear.

12.4.13 Previous Employee or Beneficiary Letter Text

This letter is sent when a disability annuity is already being paid, but additional medical evidence or information has been requested to determine whether an earlier onset date can be established. Some paragraphs are always contained in a “previous” letter. Other paragraphs will be included depending upon entries in

the dialogue box. The text is the same for employees and all types of beneficiaries.

Variable Paragraphs

Exact text and order of variable paragraphs is shown below:

Paragraph used when additional medical evidence was requested for a possible earlier onset date, but it was not submitted. (Question 5 in the dialogue box was answered “no”). A disability onset date of **[RRAILS will enter date from dialogue box]** was established for you. You were requested to provide additional information in order to determine whether or not an earlier onset date could be established. Since you have not provided the requested information, an earlier onset date cannot be established. This decision has no effect on your current annuity payments.

Paragraph used when an earlier onset date was established based on the additional medical evidence that was submitted. (Question 6 in the dialogue box was answered “yes”). You have submitted additional information in connection with your disability annuity. After careful review of this information, it has been determined that your disability onset will be changed from **[RRAILS will enter date from dialogue box]** to **[RRAILS will enter date from dialogue box]**. Your annuity beginning date will be adjusted accordingly. In the near future, you will receive a payment letter explaining the payment amount.

Paragraph used when additional medical evidence was submitted but did not warrant a change in the onset date. (Question 6 in the dialogue box was answered “no”). You have submitted additional information in connection with your disability annuity. After a careful review, it has been determined that an earlier disability onset date cannot be established based on this information. This decision has no effect on your current annuity payments.

Standard Paragraphs

All “previous” letters will end with the following standard paragraphs:

Dear:

[Variable paragraphs, which depend on the way in which you answer the dialogue box questions, are inserted here.]

If you believe that this decision is not correct, you may request that the decision be reconsidered. Your request must be in writing and should explain why you disagree. If you wish this reconsideration, your request must be received by the Railroad Retirement Board (RRB) within 60 days from the date of this notice. You may send your request to any field office of the RRB or you may send it directly to the following address: Railroad Retirement Board, Reconsideration

Section, 844 North Rush Street, Chicago, Illinois 60611-2092. If you have any additional evidence to be considered, please include it with your request.

If you disagree with the reconsideration decision, you may then appeal to the Bureau of Hearings and Appeals within 60 days from the date of the reconsideration decision.

If you have any questions about this letter or need additional information, contact our office located at **[Field office look up will insert district office address]**. The telephone number is **[Field office look up will enter phone number]**

Sincerely,

12.5 D-BRIEF Program

12.5.1 Introduction

The Disability Briefing Document Program (D-BRIEF) is an interactive PC program that is accessed through RRAILS. This program is used by disability examiners for the completion of initial disability rationales. The D-BRIEF program asks the examiner all of the sequential evaluation questions involved in an initial disability annuity decision. It provides space for free form discussion of the medical evidence. It also asks questions needed for a simultaneous single disability freeze decision and those questions needed for the occupational disability Quality Assurance report (formerly taken from the Form G-253). Most questions that are answered by choosing a radio button will include a radio button for “*unanswered*”. This button is the default. Every question that contains this option will show as “*unanswered*” until the examiner changes it. The examiner can access D-BRIEF at any point in the decision process. The examiner can also exit the program at any point and all the entries made will be saved. This means that a decision can be begun on one day and finished on another. An uncompleted decision can also be re-assigned to another examiner.

The D-BRIEF program produces a document called a G-325B. This form replaces the G-325.1 in initial disability annuity decisions and the G-253 in occupational disability annuity decisions. A blank G-325B must be accessed from the RRAILS menu for those initial cases that are not done on D-BRIEF. Only post cases will be done on the G-325.1.

The D-BRIEF program must be used for all initial disability decisions, except for the following types of cases:

- Disability decisions being re-done to grant an earlier onset date
- Completed disability decisions that must be re-opened due to the death of the claimant during the waiting period.

- A child being rated for the employee O/M.
- A child being rated to qualify a spouse for an annuity.
- A disabled survivor child who was previously rated disabled for O/M or Medicare purposes. (These are considered to be post rather than initial cases and should be done on a G-325.1.)
- A child who had been previously entitled to a disabled survivor child's annuity, been terminated, and now files a new application. (See DCM [3.10.10](#) for re-entitlement requirements.)
- A widow or survivor child whose annuity grant is based solely on alcohol or drug addiction.
- A widow or survivor child allowance where the case is included in the financial interchange. (See [DCM 6.7.3D](#))

The D-BRIEF program must not be used for disability decisions other than initial disability decisions.

12.5.2 Access And Pre-fills

Access D-BRIEF from the **Main Screen** for RRAILS. Ensure that the **RRAILS SHELF** and **Cases** sections are open, as shown in the picture in Method 1, Step 1 below. See [FOM 1596.10](#) for details about the **Main Screen** for RRAILS.

Information about the claimant must be either downloaded or manually typed into each field in the **Disabled Applicant Information** and **Employee Information** sections of D-BRIEF by the rating examiner. There are three primary methods of entering information into D-BRIEF, two of which are automated. The rating and reviewing examiners are each responsible for ensuring that accurate information is entered into each field regardless of whether the information is automatically transferred or manually typed into D-BRIEF.

METHOD 1 (Automated Entry Of Claimant Information From RRAILS)

Step	Action
1	Click on the New Case button on the Control Bar or in the Cases section.

2 The RRAILS **New Contact** client window will appear. See [FOM 1596.20](#) for general information how to download information from the mainframe at this screen.

After typing in the employee's SSA number (hyphens are not needed) in the **Number** box, click anywhere in the **Lookup No:** box.

3

Click on either the **APPLE** button or **REQUEST** button in the **Lookup Information** dialogue box.

When deciding whether to click on the **APPLE** or **REQUEST**

buttons, consider the following:

- **APPLE** will have protected filing date information; **REQUEST** converts a protected filing date to a regular filing date. Protected filing date information may affect the annuity beginning date (ABD) and time-lapse exclusion. For information on time lapse exclusion, see [DCM 4.3.9](#).
- **APPLE** must be selected if the individual is already receiving an annuity but is now filing a claim for potential dual entitlement. The claim would be filed as a disabled widow(er), surviving disabled divorced spouse, or remarried disabled widow(er). Do not select the **FSIS** or **PREH** buttons.
- **REQUEST** will have the most updated information on employee's service months, C/C determination, and address. Service month information comes into play when lag or settlement months are needed for eligibility. You will need the most current address if you use the Decision Letters feature in D-BRIEF for RL-121f (annuity grant) and RL-210 or RL-210d (DF allowance), RL-260, RL-260a, or RL-260b (DF denial), or for RL-216 (annuity technical denial) letters.

4

If the case only has one application or beneficiary, only one tab will be shown.

If multiple tabs are displayed, search each tab for a prefix such as “EMP” (designating information about a railroad employee) or “DIS” (designating information about a disabled widow or child) and then

search the first few letters of the first name of the person who filed the application. Multiple tabs showing the same information most likely mean that there have been multiple applications by that person. Ensure that the correct tab is selected by clicking on it. The information for that applicant or beneficiary will be displayed. (In the example image below, there are two applications for disabled widow annuity when information is loaded using the **APPLE** button. Ensure that the correct application is chosen by selecting the correct tab.)

The screenshot shows the RRAILS application interface. The main window displays case information for Robert E. Lee, 000-01-0001. The 'Disability' tab is selected in the 'RRAILS SHELF' on the right. The 'DBrief' option is highlighted in the list. A red arrow points to the 'DBrief' option. Another red arrow points to the 'Open' button. A third red arrow points to the 'Get from RRAILS' button in the top left corner of the screen.

After ensuring that the correct tab is selected:

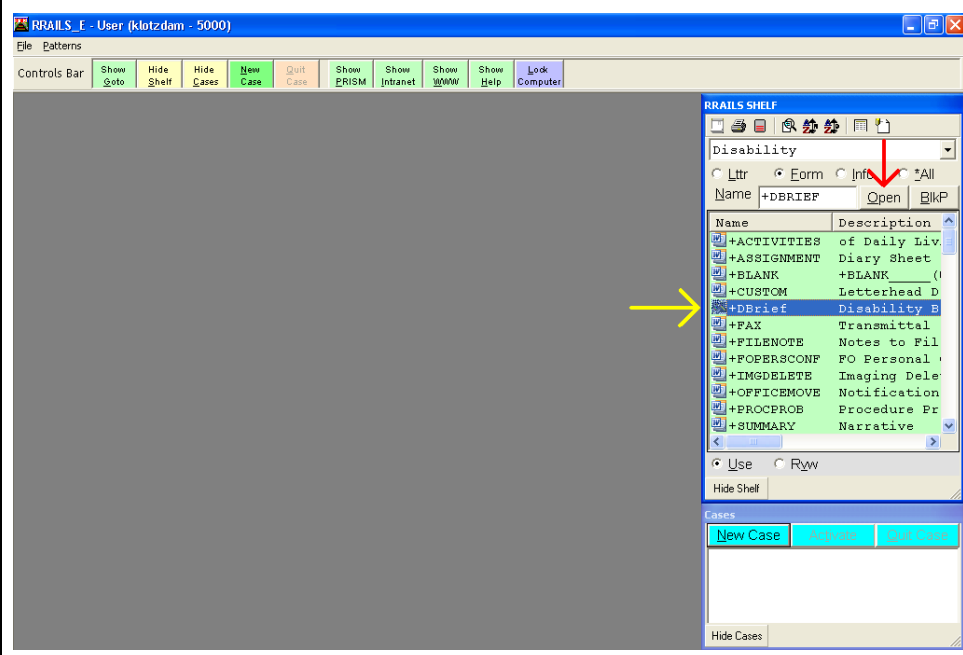
- highlight **+DBrief** and then click on **Open**, or
- double click on **+DBrief**.

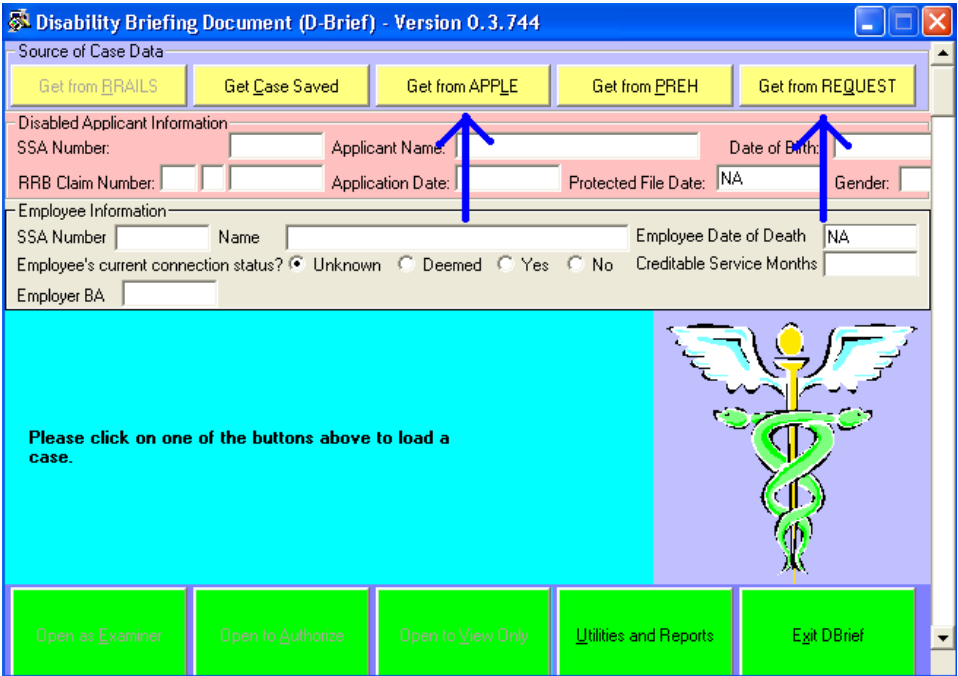
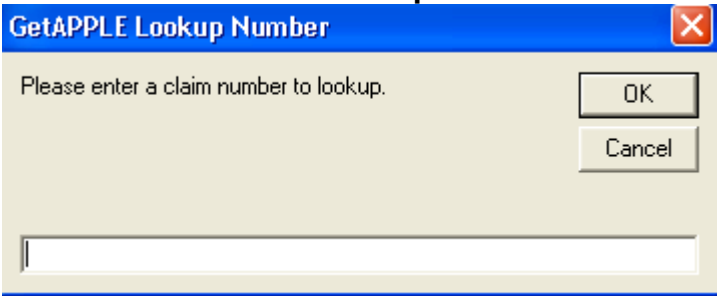
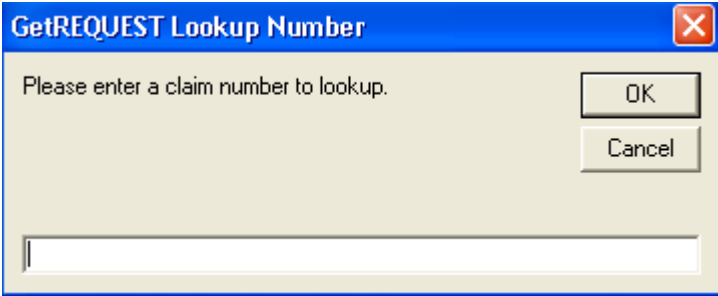
5

Click on **Get from RRAILS** (yellow button at the top left corner of screen).

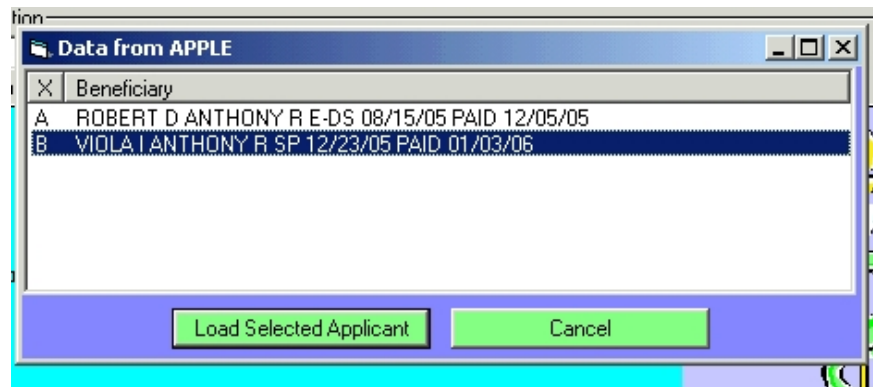
METHOD 2 (Automated Entry of Claimant Information Directly From APPLE Or REQUEST)

Step	Action
1	On the Main Screen for RRAILS screen, either a) highlight +DBrief and then click on Open , or b) double click on +DBrief .

	 <p>A blank D-BRIEF Main screen will appear.</p>
2	<p>On the D-BRIEF Main screen, click on either Get from APPLE or Get from REQUEST. (Yellow buttons at top of screen).</p> <p>NOTE: The Get from APPLE button <u>must</u> be selected if the individual is already receiving an annuity but is now filing a claim for potential dual entitlement. The claim would be filed as a disabled widow(er), surviving disabled divorced spouse, or remarried disabled widow(er).</p>

	
3	<p>Either the GetAPPLE Lookup Number</p>  <p>or GetREQUEST Lookup Number</p>  <p>window will appear. Enter a claim number (hyphens are not needed) in the box provided and then click OK.</p>
4	<p>If there is only one application on the number you have entered, the prefills will appear on the Main Screen.</p>

If there is more than one application on the claim number you have entered, the **Data from** window will appear (sample image shown below). Select the applicant whose case you are rating. Click the **Load Selected Applicant** button. The window will close and the prefills will appear on the **Main Screen**.



Method 3 (Manual Entry Of Claimant Information By Examiner)

Step	Action
1	<p>On the Main Screen for RRAILS, either</p> <ul style="list-style-type: none"> a) highlight +DBrief and then click on Open, or b) double click on +DBrief.

2	All fields must be entered by typing the correct information.

Disability Briefing Document (D-Brief) - Test Version 0.3.748

Source of Case Data

Get from PRAILS Get Case Saved Get from APPLE Get from PREH Get from REQUEST

Disabled Applicant Information

SSA Number: Applicant Name: Date of Birth: RRB Claim Number: Application Date: Protected File Date: NA Gender:

Employee Information

SSA Number Name Employee Date of Death: NA Employee's current connection status? ☒ Unknown ☐ Deemed ☐ Yes ☐ No Creditable Service Months Employer BA

Please click on one of the buttons above to load a case.

Open as Examiner Open to Authorize Open to View Only Utilities and Reports Exit DBrief

For two additional methods of accessing cases that have already been entered on D-BRIEF, see [DCM 12.5.9](#).

12.5.3 Main Screen

Disabled Applicant Information and Employee Information Sections

When using APPLE, all of the **Disabled Applicant Information** in the pink section and all of the **Employee Information** in the gray section is pre-filled from APPLE. When using REQUEST, all of the Applicant Information and all of the Employee Information are pre-filled from REQUEST except for the **Protected Filing Date** field. In employee-only cases in which the employee has died since the filing date, enter the employee's date of death in MM/DD/CCYY format in the box provided. All of your corrections will be saved when you exit the program.

The rating examiner and reviewer must each ensure that the fields identified in the above image contain accurate information before completing any other D-BRIEF field or screen. If inaccurate information is found in any of the fields identified in either the **Disabled Applicant Information** or **Employee Information** sections, the rating examiner is required to manually type the correct information before submitting the case for authorization. If a change is made in the **Date of Birth** field, D-BRIEF will re-calculate the age at filing and the age today.

Dual-entitlement claims must be closely reviewed since the identifying information in the **Disabled Applicant Information** section is different from the identifying information in the **Employee Information** section.

When completing D-BRIEF in cases involving potential dual-eligibility, information in the **Employee Information** section always refers to the deceased railroad

employee, not the applicant. In addition, special attention to accuracy must be afforded to the following fields when completing D-BRIEF in potential dual-eligibility claims:

- **Bene Sym** field (to the left of the Prefix) in the **Disabled Applicant Information** (pink) section must contain a “W”,
- the correct **RRB claim number** is shown in the **Disabled Applicant Information** section,
- the correct social security numbers are entered in the **SSA Number** field in the **Disabled Applicant Information** and **Employee Information** sections, and
- the deceased railroad employee’s name is correctly entered into the **Name** field in the **Employee Information** section.

Item 1 Type of Disability Claim? Based on applicant information pre-fills, choose the radio button for Employee, Widow, or Child.

Item 2 Type of Claim The radio button for *None* will be the system default. When *None* is selected, changes can be made to the pre-filled information above it. Once any necessary changes are made, select the radio button for *Initial Disability Decision*.

Item 3 Application Type? The default radio button for this question is *Unknown*. The other choices will depend upon how item 1 is answered. Based on the age, creditable service months, and C/C information in the Employee Information section, employees will show either a radio button for *Occupational* or a radio button for *Total and Permanent*. For a widow (including claims involving potential dual-entitlement), your only choice will be the radio button for *widow*. For a child, choose from among the following radio buttons: *Survivor, IPI Child, Child (Qualifies Spouse)*

Click on the **Open as Examiner** button.

12.5.4 Control Center Screen

After clicking on the **Open as Examiner** button from the **Main** screen, the D-BRIEF **Control Center** screen will appear. In widow and child cases in which the applicant has died since the filing date, enter the date of death in MM/DD/CCYY format in the box labeled Applicant DOD on the right. In employee cases, this will be pre-filled from the employee DOD entry on the **Main** screen.

Employee DBrief Control Center

Name:

Line 1:

Line 2:

Line 3:

Line 4:

Salutation:

Phone No:

Fax No:

E-Mail:

Rate as Occupational Disability.

A E McManus Female Employee
 SSA Number: 000-02-0002
 Claim Number: A000-02-0002
 Date of Birth: 11/01/1955
 Application File Date: 08/22/2005
 Protected File Date:
 Age at Filing: 49 Years, 10 Months
 Age Today: 50 Years, 1 Months
 Applicant DOD:
 RR Employee
 A E McManus CSM: 325
 SSA #: 000-02-0002 CC: Yes
 Last Worked RR:
 Last Worked Non RR:
 Employee Date of Death:

1. Is there a Representative Payee? ☐ Unanswered ☐ No ☒ Court Appointed ☐ Board Appointed ☐ Parent for Child
 Payee Name:

2. Is the employee in compensated railroad service? ☐ Unanswered ☐ Yes ☒ No

3. Alleged Disability Onset Date?

Done - Employee Qualifications **Go to Decision Summary** **Go to Letters** **Return to Main**

Item 1 Is there a Representative Payee? Click on the appropriate radio button. If there is a rep payee, type the payee's name in the box provided.

Item 2 Is the employee/widow/child in compensated railroad service? Select the appropriate radio button. In all cases in which yes is selected, item 3 will not appear.

For occupational employees, if you select yes, only those questions needed for QA report (formerly taken from Form G-253) will appear on the Employee Occupational Qualifications Screen. For total and permanent employees, widows, and survivor children, if you select yes, the **Qualifications** button will not appear.

Item 3 Alleged Disability Onset Date Enter the alleged onset date. Click anywhere inside the box and then type in the date in a MM/DD/CCYY format.

Click on the **Qualifications** button. After the **Qualifications** screen is completed and you have returned to the **Control** screen, the **Qualifications** button will display the word "done." Click on the **Decision Summary** button.

For Instructions on completion of the **Employee Occupational Qualifications** screen, see [DCM 12.5.5.1](#).

For instructions on completion of the **Employee Total and Permanent Qualifications** screen, see [DCM 12.5.5.3](#).

For instructions on completion of the **Widow Qualification** screen, see DCM [12.5.5.4](#).

For instructions on completion of the **Child Qualification** screen, see DCM [12.5.5.5](#).

For instructions on completion of the **Decision Summary** screen, see DCM [12.5.6](#).

12.5.5 Qualifications Screens

The type of questions and order of questions on the **Qualifications** screens will depend on the annuity type. In addition, extra buttons that open windows will appear on some of the screens. For employee occupational cases, the **Qualifications** screen will have a button that opens an additional **Qualifications** window that contains the questions that used to be asked on the G-253. Employee and widow cases may contain an **RFC Documentation** button. Occupational cases with a simultaneous DF, total and permanent employee cases, and widow cases may contain a **Vocational Rule Documentation** button.

For instructions on **Employee Occupational Qualifications** screen, see DCM [12.5.5.1](#).

For instructions on **Employee Total and Permanent Qualifications** screen, see [DCM 12.5.5.3](#).

For instructions on **Widow Qualifications** screen, see [DCM 12.5.5.4](#).

For instructions on **Child Qualifications** screen, see [DCM 12.5.5.5](#).

12.5.5.1 Occupational Employee Qualifications Screen (General)

Item 1. Click the Employee Occupational Qualifications Button to the right to view or edit Employee Occupational Qualification Information. For instructions on filling out the entries shown after clicking this button, go to [DCM 12.5.5.2](#).

Item 2. Is the employee still working in non-railroad service in Substantial Gainful Activity (SGA)? For information on SGA, see [DCM 10.4](#).

Item 2a. Is the employee still working in non-railroad service and earning more than \$850 per month? If yes, a reminder regarding work deductions will appear on the **Decision Summary Screen**. For information on disability work deductions, see [DCM 3.5.1](#).

Item 3. Enter Disability 5-digit Diagnostic Code. Using the drop down, select the appropriate diagnostic code; or type the diagnostic code in the box provided. If you type in the code, you must tab out of the box to get to the next question.

Item 4. List medical diagnoses in order of severity. (OLDDS limit 100 characters) Click inside the box. Type the names of the impairment(s) in order of severity. Check for correct spelling in the medical dictionary. If you need more than 100 characters for the diagnosis, type the remaining text in the box labeled **Diagnosis continued in Remarks.**

Item 5. Is the impairment expected to last at least 12 months or result in death? If this question is answered *No*, no further questions will appear on this screen.

Item 6. Does the employee have a Disability Freeze insured status? Select the *Yes*, *No* or *Deferred* radio button. The *Deferred* button should be selected if all Disability Freeze (DF) determinations are being handled by the Disability Post Section.

If this question is answered *No*, item 7 will prefill with *Yes-Other* and the following statement will appear: *“This is a Simultaneous Freeze Denial because employee is not insured for a Disability Freeze.”*

(Note: If you click on the words “insured status” in this question, an EDMA screen with the employee’s earnings will pop up for use in determining the insured status. See [DCM 6.3.2](#).)

Item 7. Is this a simultaneous Single Freeze decision? If the *Deferred* radio button was clicked in **Item 6**, the *No-Other* radio button will be prefilled and the sentence *“The disability freeze determination is being deferred because it was referred to the post section.”* will appear.

If the (DF) is a Joint Freeze, select the *No-Joint SSA* radio button, and the following statement will appear in the box provided: *“The disability freeze determination is not being made because it is a joint decision with the Social Security Administration.”*

If the (DF) is a Single Freeze but is being deferred, select the *No-Other* radio button. The following sentence fragment will appear in the box provided: *“The disability freeze determination is being deferred because”*. Click in the box and complete the sentence.

(All sentences will appear under the **General Case Information** heading on the **Data Collection** screen and under the **Disability Freeze Conclusion** heading on the **Disability Conclusion** screen.)

Item 8. Is there a physical or mental RFC in file from the treating physician, the medical exam contractor, from SSA, or from the medical consultant?

This question will appear in ICE cases, cases that meet or equal the listings, and in cases in which a simultaneous DF decision is being made and the employee has a DF insured status and is not working in SGA. If the impairment meets or equals the listings and using an RFC will not provide an earlier onset date than the date that the listings are met or equaled, answer *No*.

Otherwise, answer this question “yes” if you have any

- physical RFCs from the treating physician, the medical exam contractor, SSA, and/or
- any mental RFCs from RRB's medical consultant or from SSA.

For purposes of this question, do not consider **mental** restrictions provided on a G-250a or a consultative examination to be an RFC. For purposes of this question, a G-250 with the revision date of 09-05 or later is not considered to be an RFC.

If you selected *Yes*, click on the **RFC Documentation** button. For instructions on filling out the entries shown after clicking this button, go to [DCM 12.5.5.6](#).

After you have completed the **RFC Documentation** screen, return to the **Employee Qualifications** screen and go to **Item 8a**.

Item 8a Is there conflicting medical evidence in file that is relevant to the decision? This question only appears in initial occupational ICE cases.

This question refers only to objective medical findings. It does not refer to opinions or to RFCs. A piece of medical evidence is relevant to the decision if it concerns the medical impairment on which the decision is based. For example, a piece of medical evidence describing an evaluation for carpal tunnel syndrome that was done 5 years ago is not relevant to the decision if the decision is based on a recent knee injury. A piece of medical evidence is conflicting if its overall contents substantially contradict the findings of another piece of medical evidence. For example, a flow volume loop that shows severe restrictions is conflicting if there is a pulmonary function test (PFT) in file that shows only mild restrictions. Of course, both the flow volume loop and the PFT are relevant only if the decision is based on a respiratory impairment.

Item 9 Is the claimant able to do Past Relevant Work? For occupational cases, this question only appears if you are making a simultaneous DF decision and the claimant has a DF insured status and the claimant is not in SGA. If *Yes*, as the claimant described or *Yes, as normally done in the national economy* is selected, no further questions will appear on this screen. Otherwise, **Item 10** will appear.

Item 10 Is a medical vocational rule to be applied This item will appear if:

- This is a simultaneous DF decision, and
- The employee has a DF insured status, and
- The employee is not working in SGA, and
- A physical RFC for which the lifting and carrying restrictions meet the criteria for sedentary, light, or medium work has been entered, and
- The employee is not able to do past relevant work

If this question is answered Yes, click on the **Vocational Rule Documentation** button and answer the questions on that screen. For instructions on filling out the entries shown after clicking this button, go to [DCM 12.5.5.7](#). After you have completed the **Medical Vocational Rule Documentation** screen, return to the **Employee Qualifications** screen.

When all questions on the **Employee Qualification** screen are completed, click on the red button labeled **Close Qualifications Window**. The **Control** screen will re-appear.

To return to instructions for the **Control** screen, click here: [DCM 12.5.4](#).

To go to instructions for the **Decision Summary** screen, click here: [DCM 12.5.6](#).

12.5.5.2 Employee Occupational Qualifications Button (G253 Information)

Employee Occupational

1. Does the Employee have a covered RR job title? ☐ Unanswered ☒ Yes ☐ No

a. What was the employee's railroad job title? Locomotive Engineer

2. Enter 3-digit body system code corresponding to the basis for your decision. 004 Cardiovascular disorder

3. Was a G-251a or G251b Job Information Form received from the RR employer? ☒ No ☐ G-251a ☐ G251b

a. Has it been at least 30 days since the G-251a/G-251b form was released to the employer? ☐ Unanswered ☒ Yes ☐ No

4. Was the medical evidence of record sufficient to make a determination? ☐ Unanswered ☒ Yes ☐ No

List Medical Exams Ordered The number of medical exams ordered is 0

b. Was a consultative medical opinion ordered? ☐ Unanswered ☐ Yes ☒ No

5. Does the impairment meet or equal the Listing of Impairments? ☐ Unanswered ☒ No ☐ Meets ☐ Equals

6. Has the employee been carrier disqualified? ☐ Unanswered ☐ Yes ☒ No

7. Were the Tables or ICE used to make occupational disability decision? ☐ Unanswered ☒ Tables ☐ ICE

a. The following tables were used to make the decision:

multiple infarctions meets table 'D' rating - page 18

Return to Employee Screen

Item 1. Does the employee have a covered railroad job title? Select the appropriate radio button to respond *yes* or *no*. The covered job titles are: Trainman, Locomotive Engineer, Train Dispatcher, Carman, Signalman, Trackman, Machinist, Shop Laborer, Sales Representative, and General Office Clerk.

Item 1a. What was the employee's railroad job title? If **item 1** was answered *yes*, use the drop down menu and select the appropriate job title. If **item 1** was answered *no*, type the job title in the box provided.

Item 2. Enter the 3-digit body system code corresponding to the basis for your decision. Use the drop down menu. After you have answered this question, a bold sentence will appear as to whether this body system is covered by the tables. Another bold sentence will appear as to whether the job title is covered by the tables.

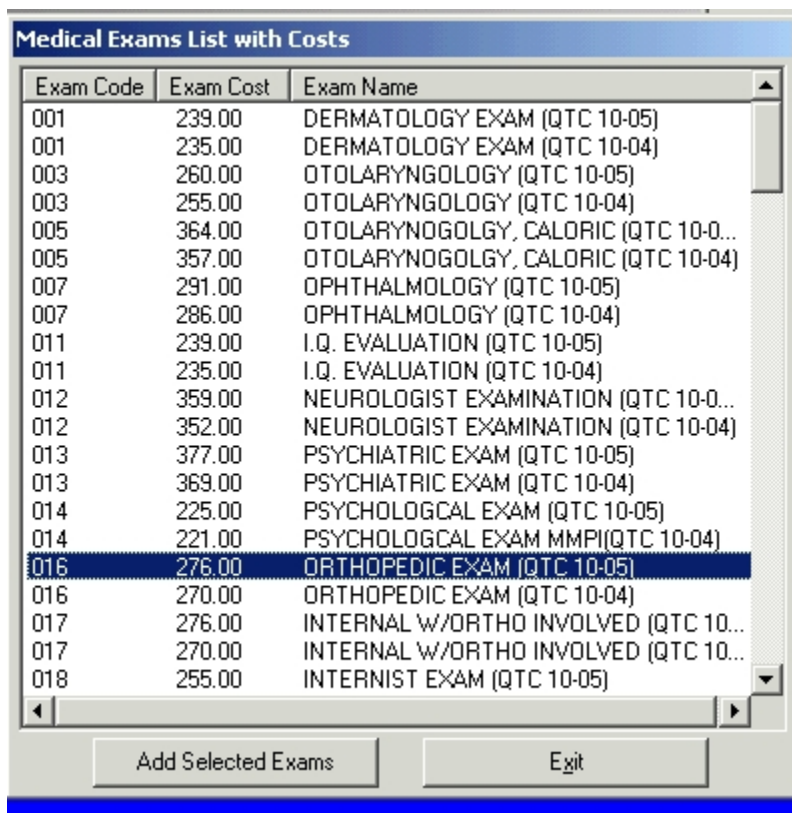
Item 3. Was a G-251a or G-251b Job Information Form received from the RR employer? If you select the *No* radio button, you must answer **Item 3a**. If you select the *Yes* radio button, **Item 3a** will not appear; however, another question will appear: **Are there material differences between the G-251a/b and the vocational report?** If the listings are met or equaled, the tables are met, or there is a carrier disqualification, answer this question *No*. Otherwise, self explanatory.

Item 3a. Has it been at least 30 days since the G-251a/G-251b was released to the employer? Self Explanatory.

Item 4. Was the medical evidence of record sufficient to make a determination? If any exams have been ordered, select *No*. If you have selected *No*, the **Exams Ordered** window will appear.

Exam Code	Exam Cost	Exam Name
-----------	-----------	-----------

Click on **Select Exams** button. The **Medical Exams List with Costs** window will appear.



Exam Code	Exam Cost	Exam Name
001	239.00	DERMATOLOGY EXAM (QTC 10-05)
001	235.00	DERMATOLOGY EXAM (QTC 10-04)
003	260.00	OTOLARYNGOLOGY (QTC 10-05)
003	255.00	OTOLARYNGOLOGY (QTC 10-04)
005	364.00	OTOLARYNOGOLGY, CALORIC (QTC 10-0...
005	357.00	OTOLARYNOGOLGY, CALORIC (QTC 10-04)
007	291.00	OPHTHALMOLOGY (QTC 10-05)
007	286.00	OPHTHALMOLOGY (QTC 10-04)
011	239.00	I.Q. EVALUATION (QTC 10-05)
011	235.00	I.Q. EVALUATION (QTC 10-04)
012	359.00	NEUROLOGIST EXAMINATION (QTC 10-0...
012	352.00	NEUROLOGIST EXAMINATION (QTC 10-04)
013	377.00	PSYCHIATRIC EXAM (QTC 10-05)
013	369.00	PSYCHIATRIC EXAM (QTC 10-04)
014	225.00	PSYCHOLOGICAL EXAM (QTC 10-05)
014	221.00	PSYCHOLOGICAL EXAM MMPI(QTC 10-04)
016	276.00	ORTHOPEDIC EXAM (QTC 10-05)
016	270.00	ORTHOPEDIC EXAM (QTC 10-04)
017	276.00	INTERNAL W/ORTHO INVOLVED (QTC 10...
017	270.00	INTERNAL W/ORTHO INVOLVED (QTC 10...
018	255.00	INTERNIST EXAM (QTC 10-05)

To select an exam, move the cursor to the exam and click on it. The exam will be highlighted. Note: there are two entries for each type of exam; one has a designation of the month and year that begins the current fiscal year and the other has a designation for the month and year that began the previous fiscal year. Choose the designation for the fiscal year in which the exam was ordered. For example, if the exam was ordered before 10/1/2005, select the exam designated (QTC 10-04). If the exam was ordered after 9/30/2005, select the exam designated (QTC 10-05). Multiple exams can be selected by holding down the **control key** and selecting the exams.

After all exams are selected, click on **Add Selected Exams** button at the bottom left of the **Medical Exams List with Costs** window. The **Exams Ordered** window will re-appear. The exam code, exam cost, and exam name for all of the exams you have selected will appear in the window.

Exam Code	Exam Cost	Exam Name
016	276.00	ORTHOPEDIC EXAM (QTC 10-05)

Review the list of exams. If an exam on the list is not correct, select that exam and click on the **Remove Exam** button. If all is correct, click on **Keep Exam List** button. The **General Medical Documentation** screen will re-appear showing the number of exams ordered.

Item 4b. Was a consultative medical opinion ordered? Self Explanatory.

Item 5. Does the impairment meet or equal the Listing of impairments? If you select the *No* radio button, **Item 6** will appear. If you select the *Meets* radio button or the *Equals* radio button, **Item 5a** will appear.

Item 5a The Impairment Listing considered is Enter the appropriate listing number in the box provided. If a listing number is not provided for a case in which *Equals* is selected, enter the words “per medical opinion.” No further questions will appear on this screen.

Item 6. Has the employee been carrier disqualified? If you select the *No* radio button, **Item 7** will appear. If you select the *Yes* radio button, no further questions will appear on this screen.

Item 7. Were the Tables or ICE used to make occupational disability decision? If either the job title or the 3 digit body code is not covered, the system will pre-fill this answer as *ICE* and will pre-fill **Item 7a** as *D*. Otherwise, you must choose the radio button for *Tables* or *ICE*.

Item 7a. (ICE selected in Item 7) Tables were not used because (Choose one: A,B,C,D.)

A. there is no matching disability test

B. there is no D rating,

C. the information is not consistent or can not be simply clarified,

D. the job title and/or medical condition is not covered by the tables.

7. Were the Tables or ICE used to make occupational disability decision? ☐ Unanswered ☐ Tables ☒ ICE

a. Tables were not used because (Choose one A, B, C, or D) ☐ Unanswered

☐ A. there is no matching disability test.

☐ B. there is no "D" rating.

☐ C. the information is not consistent or simply clarified.

☒ D. the job title and/or medical condition is not covered by tables.

Item 7a. (Tables selected in Item 7) The following tables were used to make this decision. A box will appear. Enter the Table information inside the box provided. This should include the body system, the job title, and the page number on which the specific table criteria appears in the Disability Manual for Assessment of Occupational Disability Claims.

Click on the **Return to Qualifications Screen** button at the bottom of the screen.

To return to instructions for the general occupational **Employee Qualifications** screen, go to [DCM 12.5.5.1](#).

12.5.5.3 General Employee Qualifications Screen for Total and Permanent Annuity

NOTE: In Railroad Retirement and Survivors Improvement Act of 2001 (RRSIA) cases in which the employee is under age 62, the order of **items 1** and **2** is reversed. This is necessary because an employee filing for a disability annuity under the RRSIA provisions must have an insured status under the Social Security Act. See [DCM 3.2.1](#).

Item 1. What was the employee's railroad job title? Self-explanatory.

Item 2. Does the employee have a Disability Freeze insured status? Select the Yes, No, or *Deferred* radio button. The *Deferred* button should be selected if all DF determinations are being handled by the Disability Post Section **EXCEPT in RRSIA cases**.

If the employee is filing for an annuity under the RRSIA provisions, determine if the EE has a DF insured status and select Yes or No. (Note: If you click on the words "insured status" in this question, an EDMA screen with the employee's earnings will pop up for use in determining the insured status. See [DCM 6.3.2](#))

In RRSIA cases in which the employee is under age 62, if this question is answered no, **Item 3** will not appear, **Item 4** will pre-fill with code 80010, **item 5** will pre-fill with a denial reason, and no further questions will appear on this screen after **Item 5**. If this question is answered No, **item 7** will prefill with Yes-

Other and the following statement will appear: *This is a Simultaneous Freeze Denial because employee is not insured for a Disability Freeze.*

Item 3. Is the employee still working in non-railroad service in Substantial Gainful Activity (SGA)? If you answer yes, **Item 4** will pre-fill with code 80010 and **item 5** will pre-fill with a denial reason. No further questions will appear on this screen after **Item 5**. For information on SGA, see [DCM 10.4](#).

Item 3a. Is the employee still working in non-railroad service and earning more than \$850 per month? If yes, a reminder regarding work deductions will appear on the **Decision Summary** screen. For information on disability work deductions, see [DCM 3.5.1](#).

Item 4. Enter Disability 5-digit Diagnostic Code. Using the drop down, select the appropriate diagnostic code; or type the diagnostic code in the box provided. If you type in the code, you must tab out of the box to get to the next question. In technical denial cases described under **Item 2** and **Item 3**, this will be pre-filled with code 80010.

Item 5. List medical diagnoses in order of severity. (OLDDS limit 100 characters). Click inside the box. Type the names of the impairment(s) in order of severity. Check for correct spelling in the medical dictionary. If you need more than 100 characters for the diagnosis, type the remaining text in the box labeled **Diagnosis continued in Remarks**. In technical denial cases described under **Item 2** and **Item 3**, this will be pre-filled with a denial reason and no further questions will appear on this screen.

Item 6. Is the impairment expected to last at least 12 months or result in death? If *No* is selected, no further questions will appear on this screen.

Item 7. Is this a simultaneous Single Freeze decision?

If **item 6** was answered Yes, then:

- If the (DF) is a Joint Freeze, select the *No-Joint* SSA radio button, and the following statement will appear in the box provided: *"The disability freeze determination is not being made because it is a joint decision with the Social Security Administration."*
- If the (DF) is a Single Freeze but is being deferred, select the *No-Other* radio button, and the following sentence fragment will appear in the box provided: *"The disability freeze determination is being deferred because"*. Click in the box and complete the sentence.

NOTE: If the *Deferred* radio button was clicked in item 6, the *No-Other* radio button will be prefilled and the sentence *"The disability freeze determination is being deferred because it was referred to the post section."* will appear.

(All sentences will appear under the **General Case Information** heading on the **Data Collection** screen and under the **Disability Freeze Conclusion** heading on the **Disability Conclusion** screen.)

Item 8. Does the impairment meet or equal the listing of impairments?

No/Meets/Equals If you select the *Meets* radio button or the *Equals* radio button, Item 8a will appear.

Item 8a The Impairment Listing considered is Enter the appropriate listing number in the box provided. If a listing number is not provided for a case in which *Equals* is selected, enter the words “per medical opinion”.

Item 9. Is there a physical or mental RFC in file from the treating physician, the medical exam contractor, from SSA, or from the medical consultant?..

NOTE: This question will appear even if the impairment meets or equals the listing. If an RFC will provide an onset date that is earlier than the date the listings are met or equaled, answer “yes”. If the impairment meets or equal the listings and using an RFC will not provide an earlier onset date, answer *No*.

If you selected *Yes*, click on the RFC Documentation button. For instructions on filling out the entries shown after clicking this button, go to [DCM 12.5.5.6](#). After you have completed the RFC Documentation screen, return to the *Employee Qualifications* screen and go to **Item 10**. If you selected *No*, no further question will appear on this screen. Otherwise, **Item 10** will appear.

Item 10. Is the claimant able to do Past Relevant Work? If *Yes, as the claimant described* or *Yes, as normally done in the national economy* is selected, no further questions will appear on this screen.

Item 11. Is a medical vocational rule to be applied? This item will appear if:

- The employee is not working in SGA, and
- A physical RFC that meets the lifting and carrying criteria for sedentary, light, or medium work has been entered, and
- The employee is not able to do past relevant work

If this question is answered *Yes*, click on the Vocational Rule Documentation button and answer the questions on that screen. For instructions on filling out the entries shown after clicking this button, go to [DCM 12.5.5.7](#). After you have completed the **Medical Vocational Rule Documentation** screen, return to the **Employee Qualifications** screen.

When all questions on the **Employee Qualifications** screen are completed, click on the red button labeled *Close Qualifications Window*. The **Control** screen will re-appear.

To return to instructions for the **Control** screen, click here: [DCM 12.5.4](#).

To go to instructions for the **Decision Summary** screen, click here: [DCM 12.5.6](#).

12.5.5.4 Widow Qualifications Screen

This screen is used for widows, widowers, remarried widows and widowers, and surviving divorced spouses.

Item 1. Was the claimant previously entitled to an annuity on this claim number (disability or young parent)? If you answer *yes*, Item 1a will appear. If you answer *no*, the prescribed period ending date will appear in the box provided. (Note: If you click on the words “previously entitled” in this question, PREH will open for you to check annuities on this claim number. If the employee died prior to 1995, however, you will have to check the file for previous entitlement information.)

Item 1a. Date of Last Previous Entitlement Enter the last date to which the widow was entitled to the previous annuity in the box provided. For example, if the annuity terminated effective June 1, 2002, enter May 31, 2002 and tab out of the box. The prescribed period ending date will appear in the appropriate box.

If the alleged onset date is after the prescribed period ending date, **Items 2 and 3** will not appear; **Item 4** will pre-fill with code 80010; and **item 5** will pre-fill with a denial reason. No further questions will appear on this screen after **Item 5**.

Item 2. Has the widow(er) remarried since marriage to the employee ended? If you answer yes, Items 2a and 2b will appear.

2. Has the widow(er) remarried since marriage to the employee ended?.....	<input type="radio"/> Unanswered	<input checked="" type="radio"/> Yes	<input type="radio"/> No
a. Enter the date of re-marriage.	<input type="text" value="06/02/2005"/>		
b. Is the widow(er) married now?.....	<input type="radio"/> Unanswered	<input type="radio"/> Yes	<input checked="" type="radio"/> No

Item 2a. Enter the date of remarriage Self-explanatory

Item 2b. Is the widow remarried now? Self-explanatory. If the AOD is after the date of re-marriage and the widow is still married, Item 3 will not appear; Item 4 will pre-fill with code 80010; and item 5 will pre-fill with a denial reason. No further questions will appear on this screen after Item 5. If the date of remarriage is prior to attainment of age 50 and the widow is still married, Item 3 will not appear; Item 4 will pre-fill with code 80010; and item 5 will pre-fill with a denial reason; no further questions will appear on this screen after **Item 5**.

Item 3. Is the widow still working in non-railroad service in Substantial Gainful Activity (SGA)? If you answer yes, Item 4 will pre-fill with code 80010 and item 5 will pre-fill with a denial reason. No further questions will appear on this screen after Item 5. For information on SGA, see [DCM 10.4](#).

Item 4. Enter Disability 5-digit Diagnostic Code. (Select from list above). Using the drop down, select the appropriate diagnostic code; or type the diagnostic code in the box provided. If you type in the code, you must tab out of the box to get to the next question. For various technical denial situations described under Item 1a and Item 2b, code 80010 will be pre-filled.

Item 5. List the medical diagnoses in order of severity. (OLDDS limit 100 characters) Click inside the box. Type the names of the impairment(s) in order of severity. Check for correct spelling in the medical dictionary. If you need more than 100 characters for the diagnosis, type the remaining text in the box labeled **Diagnosis continued in Remarks**. For various technical denial situations described under **Item 1a** and **Item 2b**, a denial reason will be pre-filled.

Item 6. Is the impairment expected to last at least 12 months or result in death? If you answer *No*, no further questions will appear on this screen. If you answer *Yes*, **item 7** will appear.

Item 7. Does the impairment meet or equal the listing of impairments?
No/Meets/Equals If you select the *Meets* radio button or the *Equals* radio button, Item 7a will appear.

Item 7a The Impairment Listing considered is Enter the appropriate listing number in the box provided. If a listing number is not provided for a case in which *Equals* is selected, enter the words “per medical opinion”.

Item 8. Is there a physical or mental RFC in file from the treating physician, the medical exam contractor, from SSA, or from the medical consultant? If you selected *Yes*, click on the **RFC Documentation** button. For instructions on filling out the entries shown after clicking this button, go to [DCM 12.5.5.6](#). After you have completed the **RFC Documentation** screen, return to the **Widow Qualifications** screen and go to **Item 9**. If you selected *No*, no further question will appear on this screen. Otherwise, **Item 9** will appear.

NOTE: This question will appear even if the impairment meets or equals the listing. If an RFC will provide an onset date that is earlier than the date the listings are met or equaled, answer “yes”. If the impairment meets or equal the listings and using an RFC will not provide an earlier onset date, answer *No*.

Item 9. Is the claimant able to do Past Relevant Work? If *Yes, as the claimant described* or *Yes, as normally done in the national economy* is selected, no further questions will appear on this screen. Otherwise, **Item 10** will appear.

Item 10. Is a medical vocational rule to be applied? This item will appear if:

- A physical RFC that meets the criteria for sedentary, light, or medium work has been entered, and
- The widow is not able to do past relevant work

If this question is answered *Yes*, click on the **Vocational Rule Documentation** button and answer the questions on that screen. For instructions on filling out the entries shown after clicking this button, go to [DCM 12.5.5.7](#). After you have completed the **Vocational Rule Documentation** screen, return to the **Widow Qualifications** screen.

When all questions on the **Widow Qualification** screen are completed, click on the red button labeled **Close Qualifications Window**. The **Control** screen will re-appear.

To return to instructions for the **Control** screen, click here: [DCM 12.5.4](#).

To go to instructions for the **Decision Summary** screen, click here: [DCM 12.5.6.](#)

12.5.5.5 Child Qualifications Screen

Item 1. Is the child still working or does he/she have a history of working in non-railroad service in Substantial Gainful Activity (SGA) that would direct a denial? If you answer yes, Item 2 will pre-fill with code 80010 and item 3 will pre-fill with a denial reason. No further questions will appear on this screen after Item 3. For information on SGA, see [DCM 10.4.](#)

Item 2. Enter Disability 5-digit Diagnostic Code. (Select from list above). Using the drop down, select the appropriate diagnostic code; or type the diagnostic code in the box provided. If you type in the code, you must tab out of the box to get to the next question. If the AOD is after the child attains age 22 or if the child is working in SGA, code 80010 will be pre-filled.

Item 3. List the medical diagnoses in order of severity. (OLDDS limit 100 characters) Click inside the box. Type the names of the impairment(s) in order of severity. Check for correct spelling in the medical dictionary. If you need more than 100 characters for the diagnosis, type the remaining text in the box labeled **Diagnosis continued in Remarks**. If the AOD is after the child attains age 22 or if the child is working in SGA, a denial reason will be pre-filled and no further questions will appear on this screen.

Item 4. Is the impairment expected to last at least 12 months or result in death? If you answer Yes, no further questions will appear on this screen. If you answer No, **item 5** will appear.

Item 5. Does the impairment meet or equal the listing of impairments? **No/Meets/Equals** If you select the *Meets* radio button or the *Equals* radio button, **Item 5a** will appear. If you select *No*, item **5a** will not appear, but **Item 6** and **Item 7** will appear.

Item 5a The Impairment Listing considered is Enter the appropriate listing number in the box provided. If a listing number is not provided for a case in which *Equals* is selected, enter the words “per medical opinion”. No further questions will appear on this screen.

Item 6. Is there an assessment of physical impairments that is non-severe? Self-explanatory.

Item 7. Is there an assessment of mental impairments that is non-severe? Self-explanatory.

When all questions on the **Child Qualification** screen are completed, click on the red button labeled **Close Qualifications Window**. The **Control** screen will re-appear.

To return to instructions for the **Control** screen, click here: [DCM 12.5.4.](#)

To go to instructions for the **Decision Summary** screen, click here: DCM [12.5.6.](#)

12.5.5.6 RFC Documentation Button (Used for Employee Occupational, Employee Total and Permanent, and Disabled Widow's Annuities)

On the **Qualifications** screens for employees and widows, click on the red button labeled **RFC Documentation**. A window will open for the entry of RFCs.

In employee total and permanent and employee occupational and widow disability annuity cases, you must **completely** describe **every physical RFC** in the file from the following sources, including RFCs that are partially acceptable, completely acceptable, or completely unacceptable:

- The treating physician (a G-250 with the revision date of 09-05 or later is not considered to be an RFC for purposes of filling out this item. If there is a G-250a in file, enter the restrictions on that form as an RFC.)
- The medical exam contractor
- SSA
- RRB's medical consultant.

In employee total and permanent, employee occupational and widow disability annuity cases, you must **completely** describe **every mental RFC** in the file, including RFCs that are partially acceptable, completely acceptable, or completely unacceptable, from the following sources.

- RRB's medical consultant
- SSA

NOTE: Whenever you must enter more than one RFC, enter the RFC that you are actually using in the decision first.

A view list box will appear with the following column headings:

- *Physician's Name,*
- *Type,*
- *Acceptability,*

- *Date*,
- *Source*, and
- *Severity*.

To enter an RFC, click the **Add RFC** button.

Both the acceptable and the unacceptable portions of a partially acceptable RFC must be described.

Physician and date fields are free form text boxes. The *Type* field contains a drop down with the following choices:

- physical
- mental

The *Acceptability* field contains a drop down with the following choices:

- not supported by the medical evidence,
- entirely supported by the medical evidence,
- partially supported by the medical evidence.

If you have selected “*not supported*” from the drop-down under the *Acceptability* column, the following sentence fragment will appear:

The RFC is not acceptable because.

The sentence fragment will be followed by a box with a drop-down which contains the following choices:

- The claimant’s condition has changed since the RFC was given;
- the claimant has had surgery since the RFC was given;
- the physical findings do not support the severity of restrictions,
- the RFC is based on medical evidence that is more than one year old;
- the RFC is for an impairment unrelated to job duties;
- the RFC is within 3 months after surgery,
- OTHER.

If you select “OTHER”, type free form text in the box provided.

The *Source* field contains a drop down with these choices:

- treating physician,
- medical exam contractor,
- SSA,
- medical consultant.

The *Severity* field contains a drop down with these choices:

- less than 10 lbs. occasionally,
- up to 10 lbs occasionally and up to 10 lbs. frequently
- up to 20 lbs. occasionally and up to 10 lbs. frequently,
- up to 50 lbs. occasionally and up to 25 lbs. frequently,
- up to 100 lbs occasionally and up to 50 lbs. frequently,
- more than 100 lbs. occasionally and more than 50 lbs. frequently
- non-severe
- non-exertional

Do not leave the *Severity* column blank for a physical RFC unless the physician has not given any lifting restrictions. For a mental RFC, select either non-exertional or non-severe for the *Severity* column.

For physical RFCs, another box appears under the view list box with a button that is labeled **Physical Restrictions**. (If you do not have physical restrictions other than lifting and carrying, ignore the button.) Click the button to enter restrictions not covered by lifting and carrying requirements such as climbing, walking, fingering, stooping, sitting, crouching, kneeling, crawling, exposure to temperature extremes. A window will appear with a list of restrictions:

Physical Restrictions reported by Dr. Smith

- unable to walk on uneven terrain
- must periodically alternate sitting and standing to relieve pain or discomfort
- speaking
- color vision
- far visual acuity
- near visual acuity
- accommodation
- field of vision
- hearing
- pulling limited in lower extremities
- pushing limited in lower extremities
- pulling limited in upper extremities
- pushing limited in upper extremities
- sitting
- standing
- walking
- balancing
- bending
- climbing ladders
- climbing stairs
- climbing scaffolds
- climbing ropes
- climbing ramps
- crawling
- crouching
- squatting
- feeling (skin receptors) left hand
- feeling (skin receptors) right hand
- feeling (skin receptors) both hands
- fingering (fine manipulation) left hand
- fingering (fine manipulation) right hand
- fingering (fine manipulation) both hands
- handling (gross manipulation) left hand

Physical Restrictions reported by Dr. Smith are as follows:

Erase Save Cancel


Step 1: Highlight a restriction from the list on the left side. You may need to use the scroll bar.

Step 2: Click on the appropriate green button in the upper right corner. Different buttons appear for different types of restrictions.

- If you have highlighted any of the following restrictions from the list on the left side:

unable to walk on uneven terrain
must periodically alternate sitting and standing to relieve pain or discomfort
speaking
color vision

you will see the following button in the upper right corner:

-  Click the "Select" button. If you have highlighted any of the following restrictions from the list on the left side:

far visual acuity
 near visual acuity
 accomodation
 field of vision
 hearing
 pulling limited in lower extremities
 pushing limited in lower extremities
 pulling limited in upper extremities
 pushing limited in upper extremities

, you will see the following buttons in the upper right corner:

Right
Left
Both

. Click the appropriate button.

- If you have highlighted any of the following restrictions from the list on the left side:

sitting
 standing
 walking

you will see the following buttons in the upper right corner:

Less than 2 hours in an 8 hour workday
At least 2 hours in an 8 hour workday
At least 6 hours in an 8 hour workday
Less than 6 hours in an 8 hour workday

. Click the appropriate button.

- If you have highlighted any of the following restrictions from the list on the left side:

balancing
 bending
 climbing ladders
 climbing stairs
 climbing scaffolds
 climbing ropes
 climbing ramps
 crawling
 crouching
 squatting
 feeling (skin receptors) left hand
 feeling (skin receptors) right hand
 feeling (skin receptors) both hands
 fingering (fine manipulation) left hand
 fingering (fine manipulation) right hand
 fingering (fine manipulation) both hands
 handling (gross manipulation) left hand
 handling (gross manipulation) right hand
 handling (gross manipulation) both hands
 kneeling
 reaching in all directions including overhead left hand
 reaching in all directions including overhead right hand
 reaching in all directions including overhead both hands
 stooping

you will see the following buttons in the upper right corner:

Never
Occasionally
Frequently
Constantly

. Click on the appropriate button.

- If you have highlighted any of the following restrictions from the list on the left side:

must avoid extreme cold
 must avoid extreme heat
 must avoid fumes, odors, dust, gases, poor ventilation, etc.
 must avoid hazards such as machinery and heights
 must avoid humidity
 must avoid noise
 must avoid vibration
 must avoid wetness

you will see the following buttons in the upper right corner:

Avoid all exposure
Avoid concentrated exposure
Avoid moderate exposure
Unlimited

. Click on the appropriate button.

Step 3: Repeat steps one and two until all of the restrictions are entered. The text associated with the restriction will appear in the white box on the lower right side of the Restrictions window. If there are physical restrictions not covered the choices in the list, type them in the white box.

Step 4: Click on the gray **Save** button; and the RFC window will re-appear. The restrictions will be contained in the white RFC narrative section of the RFC window.

NOTE: If you click on the **Cancel** button or the **Erase** button, all of your entries in the physical restrictions window will be deleted and the window will close.

For mental RFCs, another box appears under the view list box with a button that is labeled **Mental Restrictions**. If you have entered “*non-severe*” from the drop-down under severity, ignore the button. Otherwise, click on the button to open the **Mental Restrictions** window, and make entries as follows:

Mental Restrictions reported by Dr. Smith	
The ability to remember locations and work-like procedures	Not significantly limited
The ability to understand and remember very short and simple instructions	Moderately limited
The ability to understand and remember detailed instructions	Markedly limited
The ability to carry out very short and simple instructions	No evidence of limitation in this category
The ability to carry out detailed instructions	Not ratable on available evidence
The ability to maintain attention and concentration for extended periods	Mental Restrictions reported by Dr. Smith are as follows: <div style="border: 1px solid black; height: 150px; width: 100%;"></div>
The ability to perform activities within a schedule, maintain regular attendance,	
The ability to sustain an ordinary routine without special supervision	
The ability to work in coordination or in proximity to others without being distract	
The ability to make simple work-related decisions	
The ability to complete a normal workday and workweek without interruptions fr	
The ability to interact appropriately with the general public	
The ability to ask simple questions or request assistance	
The ability to accept instructions and respond appropriately to criticism from sup	
The ability to get along with coworkers or peers without distracting them or exhi	
The ability to maintain socially appropriate behavior and to adhere to basic stan	
The ability to respond appropriately to changes in the work setting	
The ability to be aware of normal hazards and take appropriate precautions	
The ability to travel in unfamiliar places or use public transportation	
The ability to set realistic goals or make plans independently of others	
<div style="display: flex; justify-content: flex-end; gap: 10px;"> Erase Save Cancel </div>	

Step 1: Highlight a restriction from the list on the left side.

Step 2: Click on the appropriate green button on the upper right corner:

Not significantly limited, Moderately limited, Markedly limited, No evidence of limitation in this category, or Not ratable on available evidence.

Step 3: Repeat steps one and two until all mental restrictions that you are using in your decision are entered. The text associated with the restrictions will appear in the white box on the lower right of the **Mental Restrictions** window. If there are mental restrictions not covered by the list on the left, type them in the white box.

Step 4: Click on the gray **Save** button; and the **RFC** window will re-appear. Note: If you click on the **Cancel** button or the **Erase** button, all of your entries in the mental restrictions window will be deleted and the window will close.

After you have completed the **Mental** or **Physical Restriction** window, or if you do not have any mental or physical restrictions to add to the RFC, click on the **RFC Narrative** button. All of the text for your RFC will appear in the white box below it. The text in this box is completely editable. Remove any "xxxxxxx" that appear. Complete any incomplete sentences (such as when describing unacceptable RFCs.) When you are satisfied with the text, click on the **Update** button.

Repeat the above procedure for each RFC that you wish to add.

If you wish to delete an RFC

- Use your cursor to select the RFC information from the gray box at the top of the window.
- Click on the **Delete** button.

If you wish to edit an RFC

- Use your cursor to select the RFC information from the gray box at the top of the window.
- Click on the **Edit** button.
- Make the changes you wish to make, click on the **RFC Narrative** button to check text. When you are satisfied with the text, click on the update button.

When you are finished adding/deleting/editing RFCs, click on the red button labeled **Return to Disability Qualifications Window**.

To return to instructions for **Employee Occupational Qualifications** screen, click here: [DCM 12.5.5.1.](#)

To return to instructions for **Employee Total and Permanent Qualifications** screen, click here: [DCM 12.5.5.3.](#)

To return to instructions for **Widow Qualifications** screen, click here:
[DCM 12.5.5.4.](#)

12.5.5.7 Vocational Rules Button (Used for Employee Occupational with Simultaneous Disability Freeze, Employee Total and Permanent, and Disabled Widow's Annuities)

On the **Employee or Widow Qualifications** screen, click on the button labeled **Vocational Rule Documentation**. The **Vocational Rules** window will open.

Item 1 Is the rule to be applied strictly or as a framework? Self-explanatory.

A sentence will be displayed that gives the claimant's age on the alleged onset date and age now. A date box will follow the phrase "Apply vocational rule using". By default, the alleged onset will be entered in the box. However, the examiner can change that date to whatever date the vocational rule will be applied. For example, the claimant was age 53 and 1 month on the alleged onset date, but is age 55 years and 8 months now. The examiner may wish to change the date to the date on which the claimant attained age 55. All vocational rules that apply to the age on the date shown and the RFC will be displayed in the box below. For example, if the claimant is age 54 on the date shown and has lifting and carrying requirements of 50 lbs. occasionally and 25 lbs frequently, and the rule is to be applied strictly, all vocational rules that pertain to a medium RFC for a person age 50-54 will be displayed. With the same facts, except that the RFC is to be applied as a framework, all vocational rules that pertain to light or sedentary RFCs for a person age 50-54 will be displayed. Using the cursor, select the vocational rule you wish to use.

Vocational Rules

1. Is the rule to be applied strictly or as a framework? ☐ Unanswered ☒ Strictly ☐ As framework

The employee was 51 years and 1 months of age on the alleged onset date (6/2/2005) and is 51 years and 6 months now.

Apply vocational rule using Applicant age 51 years and 1 months.

Rule	Severity	Age	Education	Entry	Skill Level	Trans	Rlvnt	Decision
203.18	medium	50-54	11th grade (limited) or less	n/a	unskilled or none	n/a	n/a	not disabled
203.19	medium	50-54	11th grade (limited) or less	n/a	skilled or semiskilled	no	no	not disabled
203.20	medium	50-54	11th grade (limited) or less	n/a	skilled or semiskilled	yes	no	not disabled
203.21	medium	50-54	12th grade (high school graduate) or more	n/a	unskilled or none	n/a	n/a	not disabled
203.22	medium	50-54	12th grade (high school graduate) or more	no	skilled or semiskilled	no	no	not disabled
203.23	medium	50-54	12th grade (high school graduate) or more	no	skilled or semiskilled	yes	no	not disabled
203.24	medium	50-54	12th grade (high school graduate) or more	yes	skilled or semiskilled	no	yes	not disabled

The claimant has a high school education or more. The education does not provide for direct entry into skilled work. The work experience is skilled or semiskilled. Transferability of skills is not relevant to this decision. Vocational rules 203.22 and 203.23, applied strictly, both direct a finding of not disabled.

[Return to Disability Qualifications Window](#)

If the rule you select states that the claimant has transferable skills, boxes will appear in which to enter the 3 jobs to which the skills are transferable.

2. Cite 3 other jobs to which the claimant's skills are transferrable that are lighter work and/or not precluded by mental restrictions.

1.

2.

3.

The claimant's educational level is limited or less and the work experience is skilled or semiskilled. The skills are transferable to the following 3 jobs: . Vocational rule 202.03, applied as a framework, directs a finding of not disabled. The vocational rule was applied using the date 07/11/2005 (employee age 55) instead of the alleged disability onset date 05/11/2005 (employee age 54).

[Return to Disability Qualifications Window](#)

(NOTE: In the case of two rules that are exactly the same except for the transferability of skills, and both direct a finding of not disabled, select the rule in which skills are not transferable.) The text of the rule will appear in the lower part of the window.

Click on the red button labeled **Return to Disability Qualifications Window** on the bottom right.

To return to instructions for **Employee Occupational Qualifications** screen, click here: [DCM 12.5.5.1.](#)

To return to instructions for **Employee Total and Permanent Qualifications** screen, click here: [DCM 12.5.5.3](#).

To return to instructions for **Widow Qualifications** screen, click here: [DCM 12.5.5.4](#).

To return to instructions for the **Control** screen, click here: [DCM 12.5.4](#).

To go to instructions for the **Decision Summary** screen, click here: [DCM 12.5.6](#).

12.5.6 Decision Summary Screen

The **Decision Summary** screen contains **Disability Data Collected-Read Only** button and **Summary of Medical Findings** button. The **RFCs Narrative Read Only** button appears for employees and widows, but not for children. This screen also contains the claimant's name, annuity type, the SSA Number, the Claim number, DOB, filing date, the alleged onset, age at filing, age today, DOD and protected filing date if applicable, and employee information, as well as bold statements based on the information entered about the claimant.

Decision Summary			
Bene Paine - Male Employee			
SSA Number:	000-03-0003	Age at Filing:	61 Years, 9 Months
Claim Number:	A000-03-0003	Age Today:	62 Years, 0 Months
Date of Birth:	11/06/1943	Applicant DOD:	
Application File Date:	08/22/2005	Protected File Date:	
Alleged Disability Onset Date:	02/28/1990		
		RR Employee - Bene Paine	
		SSA#: 000-03-0003	
		CSM: 244	CC: Yes
		Last Worked RR:	02/28/1990
		Last Worked Non RR:	
		Employee Date of Death:	
Disability Data Collected - Read Only Summary of Medical Findings is Clear RFCs Narrative - Read Only		 The disability freeze is denied because the employee does not have a disability freeze insured status.	

After the **Summary of Medical Findings** is completed, additional questions and buttons will appear on the screen. For a complete description, see [DCM 12.5.6.4](#).

12.5.6.1 Disability Data Collected –Read Only- Button and Screen

Click on the gray **Disability Data Collected – Read Only** button. A text screen will appear containing a synopsis of the data collected up to this point. The information will appear under two or three headings: *General Case Information*, *Sequential Evaluation*, and *Exam Information*. The *Exam Information* heading will only appear in occupational cases. You cannot edit this screen. If any of this information is incorrect, go back to the appropriate screen (**Main**, **Control**, or **Qualifications**) and correct it. The **Disability Data Collected Screen** will

update itself to reflect the new information. After clicking on **Exit No Save** button, the **Decision Summary Screen** re-appears.

12.5.6.2 Summary of Medical Findings Button and Text Screen

Click on the green **Summary of Medical Findings is Clear** button. A text screen will appear.

Under the heading *Summary of Medical Findings*, fully describe the medical findings. Write your free form narrative discussion of the case here. Include case history, diagnosis, signs, symptoms, objective exam findings (range of motion in degrees, muscle spasm, sensory deficit, graded motor strength, etc.), prescribed treatment and their effects (surgery, physical therapy, etc.), failure to follow prescribed treatment, medications, prognosis, and any clinical and laboratory findings, as appropriate.

If this is an occupational disability ICE case and there is conflicting medical evidence in file, resolve the conflict by describing which evidence has greater weight and which has lesser weight. (In this instance, you would have answered Yes to item 8a on the **Qualifications** screen.) You will see two sentences: “*The following medical findings hold the greatest weight and are used to support the decision.*” and “*The following medical findings hold lesser weight and were not used to support the decision.*” These sentences will be followed by “xxxxxxx”. Replace the xxxxxx’s with your free form descriptions and explanations. Use the weight of evidence methodology to explain how these findings support or do not support the medical restrictions imposed by the impairment. (See [DCM 13.10.1.7](#) through DCM 13.10.1.11.) If you have a medical consultant’s opinion in file that addresses this issue, use the medical consultant’s language in your explanation.

Thoroughly proof read this entire screen and make any corrections to the free form text needed. When you are satisfied with the text on this screen, click on the **Exit and Save** button at the bottom of the text screen. You will get a pop up box asking if you want to spell check. Always select “yes”. When spell check is complete, click on **OK**. You will still be on the text screen. Since the spell-checker occasionally splits lines of text, check the screen and make any corrections necessary. Click on the **Exit and Save** button again. This time when the **Spell Check** box appears, click on **No**. The **Decision Summary** screen will re-appear. The green **Summary of Medical Findings Needs Edits** button will be changed to blue **Summary of Medical Findings is Saved**.

12.5.6.3. RFC Narrative Read Only Button and Screen

The text for all of the RFCs that you have entered will appear on this screen under the heading *RFC Information*. This screen cannot be edited. If you need

to make changes you must go back to the **Qualifications** screen, click on the **RFC Documentation** button, and edit the RFC you wish to change.

In occupational cases, a sentence as to whether or not a medical consultant's opinion has been ordered will be displayed. Occupational cases will also have a second heading: *RFC Work Restrictions Definitions*. If an RFC has been entered, the definition of that RFC (sedentary, light, medium, heavy, very heavy), as it appears in the federal regulations, will appear. These definitions are for the benefit of outside auditors.

12.5.6.4 Disability Summary Questions, and Disability Conclusion Button and Text Screen

Select the appropriate radio button (yes/no) after the question *"Is the medical criteria met?"*

The screenshot shows a software interface titled "Disability Annuity". It contains several input fields and radio buttons:

- "Is the medical criteria met?" with three radio buttons: "Unanswered", "Yes" (selected), and "No".
- "The occupational medical criteria was met as of" with a date input field containing "10/03/1991".
- "The disability annuity decision is" with three radio buttons: "Unanswered", "a grant" (selected), and "a denial".
- "CDR Diary callup is set at" with a dropdown menu showing "MINE - 6 years".

If you answer yes to this question, enter a date in the box following the phrase *"The medical criteria is met as of."* In death cases for employees and widows, the system will calculate whether the claimant died during the waiting period or the first month after. In widow cases, the system will calculate whether this date is before or after the prescribed period ending or date of remarriage. In child cases, the system will calculate whether this date is before or after age 22. Where appropriate, the annuity decision will be pre-filled as a denial.

In an occupational employee case in which the employee is at least age 60 and has 120-239 CSM, an additional question is asked: *If applicant qualifies for TP onset date more than 6 months prior to age 60 (month/year that is 6 months prior to age 60 will be shown), enter earlier date.* If a date is entered in this item, the case will be treated as a total and permanent rather than an occupational annuity on OLDDS and the G-325B headings will be those that pertain to a total and permanent annuity.

Disability Annuity

Is the medical criteria met? ☐ Unanswered ☒ Yes ☐ No

The occupational medical criteria was met as of 06/30/2003

If applicant qualifies for a TP onset date more than 6 months prior to age 60 (07/2003), enter earlier date. 06/30/2003

The disability annuity decision is ☐ Unanswered ☒ a grant ☐ a denial

Select the radio button corresponding to your decision (a grant or a denial) after the phrase: “*The disability annuity decision is.*”

If it is a grant, the established disability onset date is the date entered as the date the medical criteria was met..

In an employee case that is a simultaneous Single Freeze decision, you must complete the Disability Freeze section. Select the appropriate radio button (yes/no) after the question “*Is the medical criteria met?*” If you answer yes to this question, enter a date in the box following the phrase “*The medical criteria is met as of.*” These questions must be answered even if the employee does not have an insured status. For an employee who is not insured but meets the medical criteria, an additional question is asked: *Eligible for early Medicare based on 74 Act or government service? Yes/No.* (For additional information on special Medicare provisions based on 1974 Act or government service, see [DCM 6.8](#))

Disability Freeze

Is the medical criteria met? ☐ Unanswered ☒ Yes ☐ No

The medical criteria was met as of 10/03/1991

Eligible for early Medicare based on 74 Act or government service? [DCM 6.8](#) ☐ Unanswered ☒ Yes ☐ No

The disability freeze decision is ☐ Unanswered ☐ a grant ☒ a denial

Select either the *grant* or the *denial* radio button after *disability freeze decision is*. NOTE: If the employee is at least age 64 and 6/12 on the date the medical criteria is met, the disability freeze decision must be entered as a denial.

If it is a grant, the established disability onset date is the date entered as the date the medical criteria was met.

In some situations, radio buttons for annuity and /or for freeze will be pre-filled.

- If the question *Is the employee/widow/child in compensated railroad service?* on the **Control Center** screen is answered yes, the radio buttons for the annuity (and the disability freeze in employee cases) will be pre-filled as a *denial*.

- If the question *Is the impairment expected to last at least 12 months or result in death?* on the **Qualifications** screen is answered *no*, the radio buttons for the annuity (and the disability freeze in employee cases) will be pre-filled as a *denial*.
- If the employee annuity is a denial, the radio button for the disability freeze decision will be pre-filled as a *denial*.
- For an employee case that is not a simultaneous DF decision, the radio buttons for the disability freeze decision will be shown as *unanswered* and grayed out. .
- In employee cases, if the question *Does the employee have a Disability Freeze insured status?* on the **Employee Qualifications** screen is answered *no*, the disability freeze radio button will be pre-filled as a *denial*.
- If the question *Is the employee/widow/child still working in non-railroad service in Substantial Gainful Activity?* on the **Qualifications** screen is answered *yes*, the disability freeze radio button will be pre-filled as a *denial* for occupational employees and the annuity radio button will be pre-filled as a denial for all other types of cases.
- For widows whose alleged onset date or the date the medical criteria is met is after the prescribed period ending date, the radio button for disability annuity will be pre-filled as a *denial*.
- For widows who remarried before age 50 and are still married, the radio button for disability annuity will be pre-filled as a *denial*.
- For widows who remarried after age 50 and are still married and the alleged onset date or date the medical criteria is met is after the date of remarriage, the radio button for disability annuity will be pre-filled as a *denial*.
- For children whose alleged onset date or date medical criteria is met is after age 22, the radio button for disability annuity will be pre-filled as a *denial*.
- For employees or widows whose date of death is in the waiting period or in the first month after the waiting period (based on the alleged onset date or the date medical criteria is met), the radio button for disability annuity will be pre-filled as a *denial*.

For all of the above denial situations, a computer generated-sentence giving the denial reason will appear under the appropriate heading on the **Disability Conclusion** text screen.

In widow and child cases and all employee cases with simultaneous annuity and freeze decisions in which the annuity is granted, a **CDR Diary Callup Is Set At** window will appear. The window has a drop down menu with the following choices: *MINE, MIP, NONE-deceased, None- closed period of disability, and MIE choices of 6-18 months*. In death cases, the system will default to *NONE-deceased*. Select *None- closed period of disability* when a closed period of disability is being done. In all other cases, choose the appropriate *MINE, MIP, or MIE* diary. For cases in which the claimant is at least age 54 and for cases in which an occupational annuity is granted and a freeze is denied, the system will default to *MINE*. The system will calculate the diary expiration date and compare it to the date of birth and age at expiration date to determine if a CDR call-up is required. For information on setting CDR call-ups, see [DCM 8.5.3](#)

Click on the **Disability Conclusion is Clear** button. A text screen will appear. In occupational cases, the following headings will be included: *Comparison of Railroad Occupational Duties to Limitations, Occupational Disability Annuity Conclusion, Comparison of Past Relevant Work (PRW) to RFC, Disability Freeze Conclusion, and Diary*. In total and permanent employee cases, the following headings will be included: *Comparison of Past Relevant Work (PRW) to RFC, Disability Annuity Conclusion, Disability Freeze Conclusion, and Diary*. In widow cases, the following headings will be included: *Comparison of Past Relevant Work (PRW) to RFC, Disability Annuity Conclusion, and Diary*. In child cases, the following headings will be included: *Disability Annuity Conclusion, and Diary*.

Under the heading *Comparison of Railroad Occupational Duties to Limitations*, sentences concerning the G-251a/b will be displayed. If there are material differences between the G-251 Vocational Report and the G-251a/b, add a free form explanation of the differences and how they were reconciled.

Give a free form comparison of acceptable physical or mental restrictions to the job duties. You may include physical or mental restrictions from a G-250 or G-250a, a doctor's notes, or the consultative examiner here, even if you did not list them on the **RFC Documentation** Screen. Provide only the restrictions that you are using and why this precludes the claimant from performing his/her job duties.

Under the *Occupational Disability Annuity Conclusion* heading, a statement will appear as to whether the annuity is a grant or a denial.

In grant cases, a statement of the onset date will appear. If the established onset is different from that claimed, the statement will be followed by this sentence: "The established onset date differs from the claimed onset date because xxxxxxxx." Replace the "xxxxxxx" with an explanation of why a different onset date was chosen.

Under the *Comparison of Past Relevant Work (PRW) to RFC* heading, a statement regarding whether the claimant is able to do PRW will appear. Give a

free form comparison of acceptable physical or mental restrictions to the job duties. Provide only the restrictions that you are using and why this precludes the claimant from performing his/her PRW or not. (Note: In occupational cases with a simultaneous freeze, this heading will appear above the *Disability Freeze Conclusion* heading. In total and permanent employee and widow cases, this heading will appear above the *Disability Annuity Conclusion* heading.)

Under the *Disability Annuity Conclusion* heading, a statement will appear as to whether the annuity is a grant or a denial. In cases in which the decision was based on a medical-vocational rule, a sentence with that information will precede the grant/denial statement.

In grant cases, a statement of the onset date will appear. If the established onset is different from that claimed, the statement will be followed by this sentence: "The established onset date differs from the claimed onset date because xxxxxxx." Replace the "xxxxxxx" with an explanation of why a different onset date was chosen.

Under the *Disability Freeze Conclusion* heading, there are some situations in which you will have information that does not require any free form additions. These situations are:


- If this is a single DF decision that has been deferred, the following sentence will appear under the *Disability Freeze Conclusion* heading: "*The disability freeze decision is deferred because* (the sentence will be completed with the entry made in the text box on the **Employee Qualifications** screen.)"
- If this is a joint DF, the following sentence will appear under the *Disability Freeze Conclusion* heading: "*The disability freeze decision is deferred because it is a joint decision with the Social Security Administration.*"
- If the annuity has been denied, the following sentence will appear under the *Disability Freeze Conclusion* heading: "*The disability freeze is also denied.*"
- If the question *Does the employee have a Disability Freeze insured status?* on the **Employee Qualifications** screen is answered no, the following sentence will appear under the *Disability Freeze Conclusion* heading "*The disability freeze is denied due to a lack of insured status.*"

In all other simultaneous freeze decisions, a statement will appear as to whether the annuity is a grant or a denial. In cases in which the decision was based on a medical-vocational rule, a sentence with that information will precede the grant/denial statement. In grant cases, a statement of the onset date will appear.

If the disability freeze decision is a grant and the established onset is different from that claimed, the grant statement will be followed by this sentence: *"The established onset date differs from the claimed onset date because xxxxxxxx."* Replace the "xxxxxxx" with an explanation of why a different onset date was chosen.

In all decisions, the *Diary* heading will appear and information will be pre-filled. If a diary is not being set due to the employee's age at expiration date, a statement to that effect will appear. If the diary is not being set for another reason, a statement with the reason will appear.

Thoroughly proof read this entire screen and make any corrections to free form text needed. When you are satisfied with the text on this screen, click on the **Exit and Save** button at the bottom of the text screen. You will get a pop up box asking if you want to spell check. Always select "yes". When spell check is complete, click on OK. You will still be on the text screen. Since the spell-checker occasionally splits lines of text, check the screen and make any corrections necessary. Click on the **Exit and Save** button again. This time when the **Spell Check** box appears, click on No. The **Decision Summary** screen will re-appear. The **Disability Conclusion Is Clear** button will be changed to **Disability Conclusion is Saved**.

Decision Summary			
Ritchie Collards Male Employee		RR Employee Ritchie Collards	
SSA Number: 000-04-0004	Age at Filing: 56 Years, 9 Months	SSA#: 000-04-0004	
Claim Number: A000-04-0004	Age Today: 57 Years, 11 Months	CSM: 355	CC: Yes
Date of Birth: 01/17/1948	Applicant DOD:	Last Worked RR: 07/25/2004	
Application File Date: 10/20/2004	Protected File Date: 10/20/2004	Last Worked Non RR:	
Alleged Disability Onset Date: 07/25/2004		Employee Date of Death:	
Disability Data Collected - Read Only			
Summary of Medical Findings is Saved			
RFCs Narrative - Read Only			
<p>The disability freeze determination is not being made because it is a joint decision with the Social Security Administration.</p>			
Disability Annuity Is the medical criteria met? <input type="radio"/> Unanswered <input checked="" type="radio"/> Yes <input type="radio"/> No The occupational medical criteria was met as of 07/25/2004 The disability annuity decision is <input type="radio"/> Unanswered <input checked="" type="radio"/> a grant <input type="radio"/> a denial		Disability Freeze Is the medical criteria met? <input type="radio"/> Unanswered <input type="radio"/> Yes <input type="radio"/> No The disability freeze decision is <input checked="" type="radio"/> Unanswered <input type="radio"/> a grant <input type="radio"/> a denial	
There is no CDR callup because a freeze decision is not being made.			
Disability Conclusion is Saved		Not Concluded	
Reviewer/Authorizer is Clear - Read Only			
Please indicate Disability Exclusion Code		CDR Not Posted	OLDDS Not Posted
View Narrative Summary - Read Only		Decision Letters	Return to Control Center

12.5.6.5 Making Corrections to the Summary of Medical Findings and Disability Conclusion Text Screens

The text contained on the **Summary of Medical Findings, and Disability Conclusion** screens is a combination of free form and text. The screens are completely editable. However, if you make a change in a sentence, the corresponding question from the earlier screens will not change. Therefore, **never change a sentence**. Instead of changing text on a text screen, you **must** go back to the corresponding question on the **Main, Qualifications, or Decision Summary** screen and change it. The database that is used for statistical purposes is created from the **Main, Qualifications, and Decision Summary** screens (not the text screens) and it **must** be accurate. Once you have made your corrections to the questions, the buttons for the text screen will show: “Needs Edits” instead of “Is Saved”. Then go back and check your free form text. (Note: On the **Summary of Medical Findings** screen, the only sentences that would require a change are used in occupational ICE cases and have to do with conflicting medical evidence. The change would be made in question 8a on the general **Employee Qualifications** screen.)

In order to save and re-use your free form text, take the following steps:

- Step 1 Click on the button for the appropriate text screen. A split screen view will appear with your previous text in the upper window and the new text in the lower window.
- Step 2 Highlight the text you wish to save from the upper window.
- Step 3 From the **edit drop down** at the upper left of the screen, select *copy*.
- Step 4 Place your cursor in the spot in the lower window where you want your free form text to re-appear.
- Step 5 From the **edit drop down** at the upper left of the screen, select *paste*.
- Step 6 Repeat until all of the text that you wish to save is copied from the upper window to the lower window.
- Step 7 Delete xxxxxxx's.
- Step 8 If you are correcting the onset date and the new onset date that you have selected is different from the claimed onset date, a sentence ending with XXXXXX will appear. Replace the XXXXXX with an explanation of the difference in the onset date.

Step 9 When you are satisfied with the text on this screen, click on **Exit and Save** button and continue with the Spell Check procedure as before.


The **Decision Summary** screen will re-appear. The button that previously showed as green and “*Needs Edits*” will be changed to blue and “*is Saved*”.

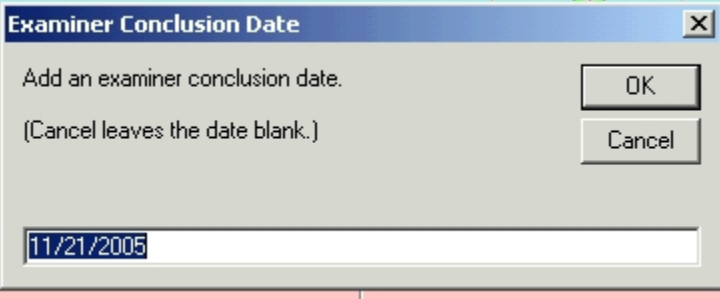
12.5.6.6 Narrative Summary Button and Screen

Click on the **View Narrative Summary – Read Only** button. The **Narrative Summary** screen appears. All of the information from all of the previous screens will appear here. Proofread the narrative summary for accuracy, spelling, and sentence structure. This screen cannot be edited. If corrections are necessary, they must be made to the questions screens and text screens.

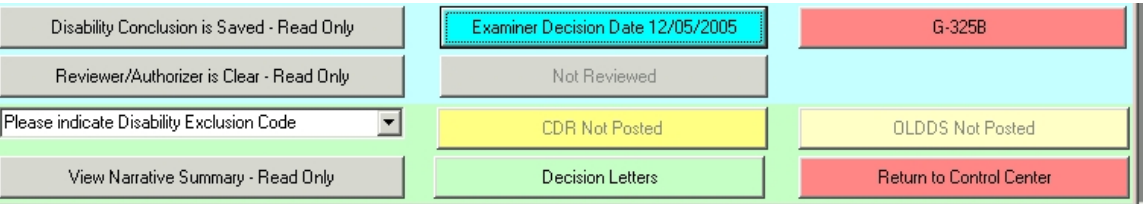
The **View Narrative Summary – Read Only** screen will update itself to reflect the new information. After clicking on **Exit No Save** button, the **Decision Summary** screen re-appears.

12.5.6.7 Examiner Decision, G-325B, and Disability Exclusion Code, and OLDDS Buttons and Self-Authorization

 Click on the *Not Concluded Button*. A pop-up box will appear with the following sentences: *Add an examiner conclusion date. (Cancel leaves the date blank.)*



Click **OK**. The green button labeled **Not Concluded** will now be blue and labeled **Examiner Decision Date** and show the date. The **G-325B** button will appear.



Click on the **G325B** button to access the **Disability Briefing Document**. The examiner's name and the date will appear at the bottom of the document. This document contains all the pertinent information gathered from all the screens that you have completed. Proof read the document. (NOTE: If you wish to make any changes on the G-325B, you must return to the screen which contains the information you wish to change and change it there first. This includes changes in spelling and grammar.) Close the document and return to the **Decision Summary** screen.

Select an entry from the drop-down *Please indicate Disability Exclusion Code* in the left column of buttons. (Note: You will not be able to complete this item unless there is an examiner conclusion date.) If you select *Not Excluded*, no entry will appear on OLDDS item 22B. For any other entry, a numeric code will appear in that item. The drop-down selections are:

- Not excluded
- Claimant caused a consultative examination to be delayed (Code1)
- Medical assessment delayed for recovery period (Code 2)
- Evidence needed was not submitted timely (Code 3)
- Protected or Deterred Filing Date (Code 4)
- Correctional confinement during case development (Code 5)
- Other (Code 6)

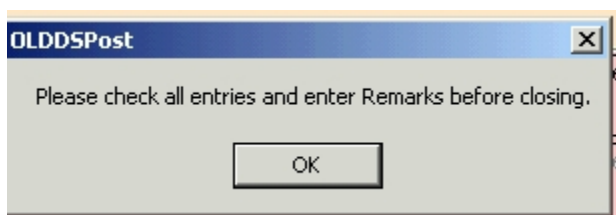
Tab out of the drop-down box.

Click on the **OLDDS** button in the right column of buttons at the bottom of the screen. (Note: You will not be able to open OLDDS unless you have completed the item for *Disability Exclusion Code*.) In occupational disability cases in which the railroad occupational title is not a covered job, a pop-up will appear with the following question: The applicant's job title was _____. What is the family group for this job?



Enter a number from 1-8 in the white box.

In all cases, a popup window will appear that instructs you to check all entries and enter remarks before closing.



Click **OK**.

If the OLDDDS screen does not appear on your screen, click on the mainframe (SESS) icon on the bottom of your screen.



The OLDDDS screen will appear. Check all items on the OLDDDS screen. Complete the OLDDDS screens as usual. Close the OLDDDS screen and return to the **Decision Summary** screen.

Click on the **Decision Letters** button. For instruction on completion of that screen, see [DCM 12.5.8](#). When the letters are completed, return to the **Decision Summary** screen.

If D-BRIEF has saved your name as an examiner, you will not be able to click on the **(Not) Review(ed)** button at the bottom of the screen, as it will be “grayed out.”

Self-authorization is not permitted in disability cases per [DCM 3.4.300](#). All disability cases must be authorized by disability post examiners, senior examiners, or supervisors.

When everything is completed on the **Decision Summary** screen, click on the **Return to Control Center** button. From the **Control Center** screen, click on the **Return to Main Screen** button. From the **Main** screen, click on the **Exit D-BRIEF** button.

12.5.7 Layout of Information on Text Screens and G-325B

D-BRIEF will use the information you entered and do two things:

- Create data tables from which statistical information can be extracted, and

- Produce full sentence narrative text based on the information entered into D-BRIEF.

The narrative will appear on text screens accessed by clicking on the following buttons on the **Decision Summary** screen:

- Disability Data Collected – Read Only,
- Summary of Medical Findings,
- RFC Narrative – Read Only
- Disability Conclusion, and
- View Narrative Summary – Read Only.

The **View Narrative Summary Screen** combines all of the information from these screens:

- Disability Data Collected,
- Summary of Medical Findings,
- RFC Narrative
- Disability Conclusion.

The **View Narrative Summary Screen** cannot be edited.

12.5.7.1 Revising the G-325B

The G-325B is created from the text, and in the order, that appears on the **View Narrative Summary Screen**. The G-325B itself is not saved. The G-325B is re-created from the text screens every time the G-325B is accessed. For this reason, corrections made directly on the G-325B by the examiner without making the corresponding changes on the text screens and the questions screens will not be saved on the G-325B that the reviewer sees. If a spelling error is corrected by the examiner on the G-325B without being corrected on the text screen, the correction will not be saved on the G-325B that the reviewer sees.

Therefore, all changes to sentences must be made on the questions screens (Main screen, Qualifications screen, Decision Summary screen.) All changes to free form text must also be correct on the text screens accessed by clicking on the following buttons on the **Decision Summary** screen:

- Disability Data Collected,

- Summary of Medical Findings,
- Disability Conclusion.
- Reviewer/Authorizer (This screen must be spell checked by the reviewer.)

(See [DCM 12.5.6.5](#) for further instruction on making corrections to text screens.) The **Summary of Medical Findings** screen, the **Disability Conclusion** screen, and the **Reviewer/Authorizer** screen can and should be spell checked. The G-325B that is imaged will be correct only if the information on the questions screens and the text screens is correct. The data table's information will be correct only if the information on the questions screen is correct.

12.5.7.2 Description of G-325B

The G-325B is taken from 5 text screens. The information on most of the text screens is divided into two or more headings. The text screens are:

1. **Disability Data Collected** (2 or 3 headings)
2. **Summary of Medical Findings** (1 heading)
3. **RFC Narrative** (1 or 2 headings)
4. **Disability Conclusion** (2 to 5 headings)
5. **Reviewer Comments** (Optional) (1 heading)

The following sections detail the information contained on each text screen.

12.5.7.3 Disability Data Collected Section

Information under Disability Data Collected includes data that was formerly collected on the Form G-253 and data needed on OLDDS and data gathered from answering the questions concerning sequential evaluation. The information is placed under three headings:

- General Case Information
- Sequential Evaluation
- *Exams Information.* (occupational cases only)

General Case Information

The information under this heading includes:

- Applicant's age at date of filing (from **Main** screen)

- Applicant's age at date of decision if it is relevant to his eligibility for an occupational disability annuity
- Annuity type (from **Main** screen)
- For employee cases, whether or not the employee has a disability freeze insured status (from **Employee Qualifications** screen)
- For employee cases, reason for disability freeze decision deferral, if applicable (from **Employee Qualifications** screen) or that this is a simultaneous freeze decision.
- 5 digit diagnostic code (from **Qualifications** screen)
- In occupational cases, 3 digit body code (from **Employee Qualifications Screen**.)

Sequential Evaluation

The information under this heading includes:

- Whether or not the applicant is in compensated railroad service (from **Control** screen)
- In employee cases, whether or not the applicant is earning more than \$850 per month in non-railroad service (from **Employee Qualifications** screen)
- In employee cases, the regular railroad occupation (from **Employee Qualifications** screen)
- Whether or not the applicant is in SGA (from **Qualifications** screen)
- List of medical impairments in order of severity (from **Qualifications** screen)
- Whether impairment is severe enough to last 12 months or result in death (from **Qualifications** screen)
- Whether or not impairment meets or equals listings and listing used, if applicable (from **Qualifications** screen)
- In occupational cases, whether or not employee has been carrier disqualified (from **Employee Qualifications** screen)
- In occupational cases, whether or not tables were used for occupational disability annuity decision and Table used, if applicable. If the tables were

not used, the reason for not using tables will also appear (from **Employee Qualifications** screen)

- Whether or not the claimant is able to do past relevant work (from **Qualifications** screen) for total and permanent employee cases, widow cases, and for occupational cases with simultaneous DF decision, in which the DF is not being denied due to SGA, lack of insured status, or annuity also being denied.
- Whether or not medical vocational rule was used (from **Qualifications** screen) for total and permanent employee cases, widow cases, and for occupational cases with simultaneous DF decision, in which the DF is not being denied due to SGA, lack of insured status, or annuity also being denied.

Exams Information (Occupational Cases Only)

The information under this heading includes:

- Whether or not medical evidence of record was sufficient to make determination (from **Qualifications** screen)
- If exams were ordered, code number and name of exam (from **Qualifications** screen).

This set of information is contained on the text screen accessed by clicking the **Disability Data Collected – Read It** button on the **Decision Summary** screen. It is the first three sections of information that appear on the text screen accessed by clicking on the **View Narrative Summary – Read It** button and the first three sections of information on the G-325B. All of the information under these headings is computer-generated. This screen cannot be edited. In order to change any of this information, the examiner must go back to the **Main** screen, the **Employee Qualifications** screen, or the **Control** screen to make the changes.

12.5.7.4 Summary of Medical Findings Section

Information under the *Summary of Medical Findings* heading includes:

- Free form text describing objective medical findings (see [DCM 12.5.6.2](#))
- A concluding sentence: All medical evidence in file was reviewed.

In occupational ICE cases in which there is conflicting medical evidence, the following sentences appear:

- The following medical findings hold the greatest weight and are used to support the decision.

- The following medical findings hold lesser weight and were not used to support the decision.

There is space under each of these sentences for a free form description of the medical findings pertaining to each sentence.

12.5.7.5 RFC Narrative

Information on the **RFC Narrative** screen includes the heading: *RFC information*. If this is an occupational decision in which RFCs are used, a second heading will also appear: *RFC Work Restriction Definitions*.

Information under *RFC Information* includes:

- In occupational cases, whether or not a consultative medical opinion was ordered (from **Qualifications** screen). Note: a consultative medical opinion does not always contain an RFC.
- Whether or not a G-250a from treating physician, RFC from medical exam contractor, RFC from SSA, or RFC from the medical consultant is in file (from **RFC Narrative**).
- In occupational cases, whether or not RFC information in file is fully acceptable, partially acceptable, or unacceptable (from **RFC Narrative** screen). For all RFCs that are not acceptable, a reason will be shown as to why it is not acceptable. In cases that are not occupational, only acceptable RFCs that are used for the decision are listed.
- Description of RFCs (from **RFC Narrative Screen**).

Definitions of severity (sedentary, light, medium, heavy, very heavy) of RFCs described will be shown under the *RFC Work Restrictions Definitions* heading.

12.5.7.6 Disability Conclusion Section

Information under *Disability Conclusion* heading includes comparison between work and physical or mental limitations, whether the decision is a grant or denial, and onset and diary information where applicable. The number of headings in the section for *Disability Conclusion* depends upon the annuity type:

- Comparison of Railroad Occupational Duties to Limitations (occupational cases only),
- Occupational Disability Annuity Conclusion (occupational cases only),
- *Disability Annuity Conclusion* (all cases other than occupational annuities),

- *Comparison of Past Relevant Work to RFC* (employee T&P, widows, and occupational cases with a simultaneous freeze in which the claimant has an insured status and is not in SGA),
- Disability Freeze Conclusion (employees only), and
- *Diary*. (all cases)

Comparison of Railroad Occupational Duties to Limitations

Information under this heading includes:

- G-251a/b information (from **Employee Qualifications** screen.) as to whether a G-251a/b was received and, if not, whether or not it has been at least 30 days since the G-251a/b was released.
- In ICE cases, whether or not the G-251a/b differed materially from the vocational report (from **Employee Qualifications** screen.) If it did differ materially, the examiner must type in a free form explanation of the difference and how it was resolved.
- In non-ICE cases, the following computer generated sentence will appear: *A comparison of job duties between the G-251 and the G-251a/b is not needed because the impairment meets/equals the listings/ the employee has been disqualified by the carrier/ the employee is found disabled under the tables* (from **Employee Qualifications** screen.)
- In non-ICE cases, one of the following 3 computer generated sentence will appear: 1). *The impairment meets/equals the listing, therefore, a comparison of limitations to job duties does not apply.* 2) *The employee has been disqualified by the carrier, therefore, a comparison of limitations to job duties does not apply.* 3) *The impairment meets the tables, therefore, a comparison of limitations to job duties does not apply.* (from **Employee Qualifications** screen.)
- In ICE cases, the examiner must provide a free form comparison between the occupational job duties and the limitations imposed by the impairment.

This set of information is the second section of information that appears on the text screen accessed by clicking on the **View Narrative Summary – Read It** button and it is the second section of information on the G-325B.

Occupational Disability Annuity Conclusion-

Information under this heading includes:

- Statement as to whether grant or denial (from **Decision Summary** screen)

- Onset date if grant (from **Decision Summary** screen)
- Free form explanation of any onset that is different from the one alleged. (The prompt for the explanation comes from the entries on the **Decision Conclusion** screen.)
- Free form explanation of any unsuccessful work attempt.

Comparison of Past Relevant Work (PRW) to RFC

Information under this heading includes:

- In cases in which the listings are met or equaled and an RFC is not used to provide an earlier onset date, the following sentence appears: *The comparison does not apply because the listings are met/equaled* (from **Employee Qualifications** screen).
- In cases in which the listings are not met or equaled or an RFC is used to provide an earlier onset date, the examiner must provide a free form comparison between the PRW and the RFC.
- When a RFC is entered, a sentence will appear as to whether the applicant can perform PRW (from **Qualifications** screen).

Disability Annuity Conclusion

Information under this heading includes:

- Medical Vocational rule information if applicable (from **Vocational Rule Documentation** screen.)
- Statement as to whether grant or denial (from **Decision Summary** screen)
- Onset date if grant (from **Decision Summary** screen)
- Free form explanation of any onset that is different from the one alleged. (The prompt for the explanation comes from the entries on the **Decision Conclusion** screen.)
- Free form explanation of any unsuccessful work attempt, if applicable.

Disability Freeze Conclusion

Information under this heading includes:

- Medical Vocational rule information if applicable (from **Vocational Rule Documentation** screen.)

- Statement as to whether grant or denial (from **Decision Summary** screen)
- Onset date if grant (from **Decision Summary** screen)
- Free form explanation of any onset that is different from the one alleged. (The prompt for the explanation comes from the entries on the **Decision Conclusion** screen.)
- Statement that DF decision is deferred, if applicable (from **Employee Qualifications** screen).
- Free form explanation of any unsuccessful work attempt, if applicable.

Diary

Information under this heading includes:

- Whether diary set (from **Decision Summary** screen.)
- Type of diary (MINE, MIP, MIE with months), if set (from **Decision Summary** screen)
- If not set, statement of the reason that diary is not set, such as applicant will be at least 61 ½ years old at diary expiration, or applicant is deceased, or no annuity entitlement, or freeze decision not being made (from **Decision Conclusion** screen.)

This set of information is contained on the text screen accessed by clicking the **Disability Conclusion** button on the **Decision Summary** screen. It is the third section of information that appears on the text screen accessed by clicking on the **View Narrative Summary – Read It** button and it is the third section of information on the G-325B.

There is information under all headings, however, the examiner may add free form text. This screen must be spell checked by the examiner.

12.5.7.7 Reviewer Comments (Optional)

This section is optional and consists entirely of free form text provided by the reviewer. This screen must be spell checked by the reviewer. If the reviewer does not make comments, this heading will not appear on the G-325B.

12.5.8 Decision Letters Button

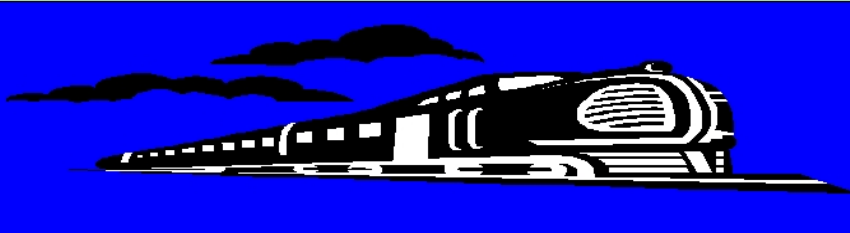
Use the **Decision Letters** in cases in which the annuity is allowed or in cases in which the annuity is denied because the claimant is in compensated railroad service

All disability allowances require RL-121f. Denials due to being in compensated railroad service require RL-216. A DF allowance will require RL-210 or RL-210d; a DF medical denial will require RL-260; a DF earnings denial will require a RL-260a or RL-260b.

Click on the *Decision Letters* button at the bottom of the middle row of buttons on the bottom of the **Decision Summary** screen.

Disability Conclusion is Saved - Read Only	Examiner Decision Date 12/05/2005	G-325B
Reviewer/Authorizer is Clear - Read Only	Not Reviewed	
Please indicate Disability Exclusion Code	CDR Not Posted	OLDDS Not Posted
View Narrative Summary - Read Only	Decision Letters	Return to Control Center

The **Letters and Forms** screen will appear.

Letters and Forms		
Applicant Address		Representative Payee Address
Applicant	Bene Paine	Payee
Line 1	1600 Hwy 3003	for
Line 2		Applicant
Line 3	Peace Branch, MS 38654	Bene Paine
Line 4		Line 2
Salutation	Dear Mr. Paine	Line 3
Phone No	(662)555-5555	Line 4
Fax No		Salutation
E-Mail		Phone No
		Fax No
		E-Mail
Send Letter To: <input type="radio"/> Applicant <input checked="" type="radio"/> Representative Payee <input type="radio"/> 3rd Party Contact		
		Annuity Allow
		RL-121F
		RL-121D
		Annuity Deny
		RL-216
		RL-218a
		RL-218b
		RL-218c
		RL-218d
		RL-218e
RL-218f		
Custom TP Denial		
Freeze Allow		
RL-210		
RL-210d		
Freeze Deny		
RL-260		
RL-260A		
RL-260B		
General Use		
Custom Disability		
Exit		

Name and address of the applicant and salutation will be pre-filled on the left side of the screen from the system from which you entered D-BRIEF (REQUEST or APPLE.) If a rep payee has been entered on the **Control** screen, the rep payee's name, and "for" and applicant's name will be entered on the right side of the **Letters** screen. Enter the rep payee's address and the salutation.

To complete a letter:

- Single click the button on the right for the desired letter. The letter will appear with name and address pre-fills. Complete inserts and/or dialogue

boxes as usual. (NOTE: Buttons for letters that are not appropriate to the case will be grayed out. For example, if you are doing a widow case, all buttons pertaining to disability freeze letters will be grayed out.)

- Click **auth icon** and send letter to auth as usual. Close the letter. You will be returned to the D-BRIEF **Letters and Forms** screen. If you need to do another letter, repeat the above process.
- Click on **exit**. You will be returned to the D-BRIEF **Decision Summary** screen.
- Do OLDDS screens and other disability decision-making procedures as described in [DCM 12.5.6.7](#). When everything is completed on the **Decision Summary** screen, click on the **Return to Control Center** button. From the **Control Center** screen, click on the **Return to Main Screen** button. From the **Main** screen, click on the **Exit D-BRIEF** button.

Note: Dialogue box questions for the RL-121f will be pre-filled from D-BRIEF. Item 4 *Has the Medical Evidence or other information been requested for possible establishment of an earlier onset date?* will show a default answer of *No*. When the established onset date is later than the alleged onset date, the following question will appear: *Does the difference in onset date have an adverse effect on the ABD?* The default answer to that question will be *Yes*. Check to be sure that the default answers are accurate and make changes when applicable.

12.5.9 Reviewing Decisions on D-BRIEF

There are several methods by which to access a case on D-BRIEF for review.

1. Follow the same instructions to access a case as the initial examiners used per instructions in [DCM 12.5.2](#). NOTE: It is not necessary to use the same system that the examiner used.

2. Or, access the case in the following manner:

Step 1 Access the **main** screen for RRAILS.

Step 2 Double click on *D-BRIEF* in the menu on the right.

Step 3 On the **Main** screen, click in the yellow **Get Case Saved** button.
The **Select Case** window will appear

Step 4 Using the scroll bar on the right side of the **Select Case** window, find the Applicant SSA number (*not* the RR claim number) you wish to access, or type the number in the white box at the top left.
Select the case by clicking in the box that contains the number.

Select Case

Applicant SSA No.	Application Date	Protected Date	Application Type	Updated
00234	2005/05/20		Employee Occupational	2005/06/06
00332	2005/04/20		Employee Occupational	2005/06/07
00452	2005/03/18		Employee Occupational	2005/05/14
00454	2003/02/25		Employee Occupational	2004/10/12
00460	2005/03/23		Employee Occupational	2005/04/28
00550	2004/09/25		Employee Occupational	2005/01/25
00554	2004/10/19		Employee Occupational	2005/02/09
00642	2004/09/05		Employee Occupational	2004/10/28
00752	2005/02/28		Employee Occupational	2005/03/17
0083C	2004/10/20		Employee Occupational	2004/11/16
01038	2004/10/13		Employee Occupational	2005/02/10
01042	2004/09/28		Employee Occupational	2005/02/18
01044	2004/09/09		Employee Occupational	2005/01/28
01332	2005/02/23		Employee Occupational	2005/04/11
01732	2004/09/25		Employee Occupational	2004/12/03
01834	2004/09/01		Employee Occupational	2004/11/04
01834	2005/02/02		Employee Occupational	2005/02/19
02038	2004/11/22		Employee Occupational	2005/03/15
0203E	2004/11/02		Employee Occupational	2005/01/03
02134	2005/01/11		Employee Occupational	2005/06/22
02640I	2004/07/07		Employee Occupational	2005/02/08
02640	2004/10/13	2004/07/07	Employee Occupational	2005/02/16
0293E	2004/10/14		Employee Occupational	2004/12/17
02936	2004/10/02		Employee Occupational	2005/01/15
02944	2004/11/22		Employee Occupational	2005/03/29

Select Cancel

Step 5 Click on the **Select** button at the bottom of the **Select Case** window. The **Main** screen will re-appear with the information pre-fills for the case.

Click on the **Open To Authorize** button on the bottom of the screen.


Decision 11/21/2005 Mary Hobein	Open to <u>A</u> uthorize	Open to <u>V</u> iew Only	<u>Q</u> ualifications and Reports	Exit DBrief
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If another reviewer has already worked on the case and it is being re-assigned, the following message will appear: *Do you want to change the authorizer from _____ to you?* Click on "Yes."

The **Control Center** screen will open. From the **Control Center** screen you can go to the **Qualifications** screen, the **Decision Summary** screen, or back to the **Main** screen by clicking on the appropriate button on the bottom of the screen.

You will be able to see the examiner entries, but you will not be able to change them, as the buttons for the examiner text screens and entries will be grayed out.

From the **Control Center** screen, Click on **Go to Decision Summary** button. This will take you to the **Decision Summary** screen.

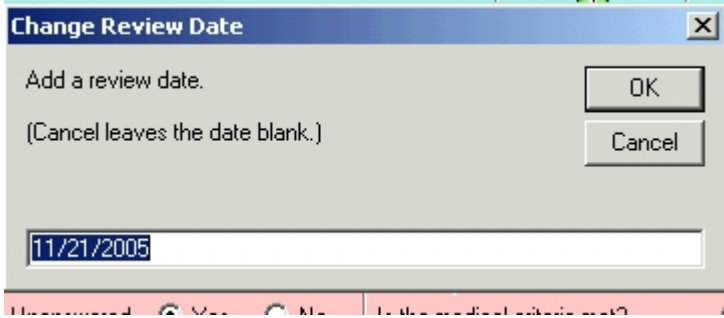
Decision Summary			
Joe D Fudge Male Employee		RR Employee Joe D Fudge	
SSA Number: 000-05-0005	Age at Filing: 58 Years, 8 Months	SSA#: 484	CC: Yes
Claim Number: A000-05-0005	Age Today: 61 Years, 0 Months	CSM: 484	CC: Yes
Date of Birth: 12/02/1944	Applicant DOD:	Last Worked RR: 04/30/2003	
Application File Date: 08/11/2003	Protected File Date:	Last Worked Non RR:	
Alleged Disability Onset Date: 04/30/2003		Employee Date of Death:	
			
Disability Data Collected - Read Only			
Summary of Medical Findings is Saved - Read Only			
RFCs Narrative - Read Only			
Disability Annuity: Is the medical criteria met? <input type="radio"/> Unanswered <input checked="" type="radio"/> Yes <input type="radio"/> No The occupational medical criteria was met as of 04/30/2003 The disability annuity decision is <input type="radio"/> Unanswered <input checked="" type="radio"/> a grant <input type="radio"/> a denial		Disability Freeze: Is the medical criteria met? <input type="radio"/> Unanswered <input checked="" type="radio"/> Yes <input type="radio"/> No The medical criteria was met as of 04/30/2003 The disability freeze decision is <input type="radio"/> Unanswered <input checked="" type="radio"/> a grant <input type="radio"/> a denial	
CDR Diary callup is set at MINE - 6 years			
CDR diary is not set as the employee will be at least age 61 1/2 years old on the expiration date.			
Disability Conclusion is Saved - Read Only		Examiner Decision Date 12/05/2005	G-325B
Reviewer/Authorizer is Clear		Not Reviewed	
Please indicate Disability Exclusion Code		CDR Not Posted	OLLDS Post Last Opened 09/13/2005
View Narrative Summary - Read Only		Decision Letters	Return to Control Center

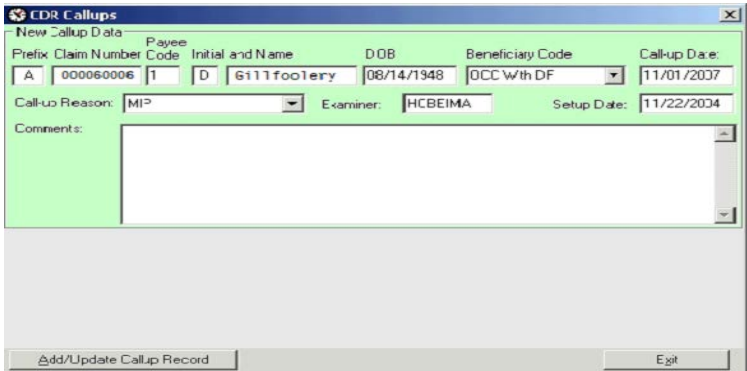
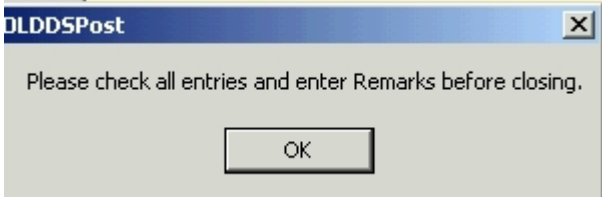

Click on **View Narrative Summary - Read It** button. This will bring up the rationale that the initial examiner saved on the system. See [DCM 12.5.7](#) for the proper layout of the information that appears on this screen and on the G-325B.

Review case as usual. If you do not agree with the examiner's decision or if you want the examiner to make changes, return to the main screen and exit program. Return the case to the examiner as you currently do. The examiner will be able to go back into the D-BRIEF program and make changes.

If you agree with the initial examiner's decision, take the following steps:

Step	Action
1	If you wish to add comments, click on the green Reviewer/Authorizer is Clear button. Type in your comments under the <i>Reviewer Comments</i> heading. Click on Exit and Save button. You will get a pop up box asking if you want to spell check. Always select "yes". When spell check is complete, click on OK . You will still be on the text screen. Since the spell-checker occasionally splits lines of text, check the screen and make any corrections necessary. Click on the Exit and Save button again. This time when the Spell Check box appears, click on No . The Decision Summary screen will re-appear. The button that was previously labeled " Reviewer/Authorizer is Clear " will now be

	labeled “Reviewer/Authorizer is Saved.”
2	<p>Click on the Reviewed button. The Review Date box will appear.</p>  <p>If you have accidentally clicked the Reviewed button and/or do not intend to complete the review at this time, click cancel. Otherwise, click OK. This will cause the review date to be shown as today's date for the G-325B, OLDDS, and CDR (if applicable.).</p>
3	<p>Click on G-325B button. (See DCM 12.5.6.7 for further information.) The G-325B with medical symbol will appear on your screen.</p>
4	<p>Print out a copy of the G-325B for the file. The examiner's name and job title and the date will appear above the appropriate label at the bottom of each page. The reviewer's name and job title and the date will appear above the appropriate label at the bottom of each page.</p>
5	<p>Send G-325B to imaging. Close G-325B and return to Decision Summary screen.</p>
6	<p>If a diary is being set, click on the CDR button in the middle row of buttons on the bottom of the Decision Summary screen. The CDR Callups window will open. Check the information on the screen. If the information is not correct, click on the exit button and give it back to the examiner for correction. Otherwise, add comments in the box provided if desired and click on the Add/Update Callup button. The CDR Callups window will close and the Decision Summary screen will reappear.</p>

	
7	<p>Unless the claimant is in compensated service, click on the OLDDS button in the right row of buttons on the bottom of the Decision Summary screen. A popup window will appear that instructs you to check all entries and enter remarks before closing. Click OK.</p>  <p>If the OLDDS screen does not appear on your screen, click on the mainframe (SESS) icon on the bottom of your screen.</p>  <p>The OLDDS screen will appear. Check all items on the OLDDS screen. Complete the OLDDS screens as usual. Close the OLDDS screen and return to the Decision Summary screen.</p>
8	<p>Complete all other actions (check auth file for letters, etc.) as usual. When all actions are complete, click on the Return to the Control Center button on the bottom of the right row of buttons on the Decision Summary screen. Click on the Return to Main Screen button on the bottom right of the Control screen. Click on the Exit D-BRIEF button on the bottom right of the Main screen.</p>

12.5.10 Re-Assignments, Examiner Corrections, and Browsing

Examiner Re-Assignments

The first examiner to work a particular case and to click on the **Open As Examiner** button on the bottom left side of the **Main** screen will be recognized by

D-BRIEF as the examiner who has been assigned to work the case, referred to as the examiner of record.

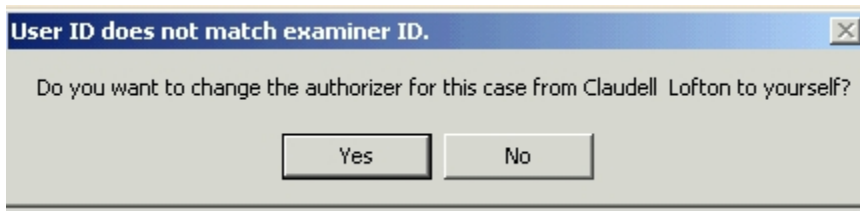
When an individual other than the examiner of record opens the case and clicks on the **Open As Examiner** button, a message box will appear which asks “Do you want to change the examiner name from _____ to your name?”



If the individual clicks on Yes, that individual becomes the examiner of record.

Reviewer/Authorizer Re-assignments

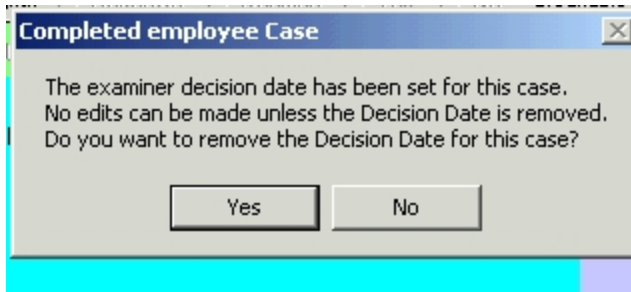
The first time a person opens the case and clicks on the **Open To Authorize** button, D-BRIEF will recognize that person as the authorizer of record. When an individual other than the authorizer of record opens the case and clicks on the **Open As Authorizer** button, a message box will appear which asks “Do you want to change the authorizer for this case from _____ to yourself?”



If the individual clicks on Yes, that individual becomes the authorizer of record.

Examiner Corrections

If the examiner wishes to make changes after an examiner date has already been entered on the **Decision Summary** screen, open the case by using one of the access methods previously described in [DCM 12.5.2](#) or [DCM 12.5.9](#). Click on the **Open As Examiner** button on the **Main** screen. A pop-up will appear with the following message: *The examiner decision date has been set for this case. No edits can be made unless the Decision Date is removed. Do you want to remove the Decision Date for this case?*



Click on yes.

Make your changes on the various screens. You will need to re-enter an examiner decision date on the **Decision Summary** screen.

Browsing

A supervisor or other individual who wishes to view data without becoming the examiner or authorizer of record may do so by clicking on the **Open to View** button. In this situation, all fields will be disabled (grayed out) for editing. That is, the supervisor will be able to look at those screens, but will not be able to change any data.

