CENTERS for MEDICARE & MEDICAID SERVICES

Medicare & Your Mental Health Benefits

This official government booklet has information about mental health benefits for people with Original Medicare, including:

- ★ **Who's eligible**
- ★ **Outpatient & inpatient benefits**
- ★ **Prescription drug coverage**
- ★ **Help for people with limited income & resources**
- ★ **Where to get help**

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

This booklet gives you information about mental health benefits in Original Medicare. If you get your Medicare benefits through a Medicare Advantage Plan or other Medicare health plan, check your plan's membership materials, and call the plan for details about how to get your Medicare-covered mental health benefits.

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

"Medicare & Your Mental Health Benefits" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

This product was produced at U.S. taxpayer expense.

Table of contents

Mental health care & Medicare 5

Section 1: Outpatient mental health care 7
- What Original Medicare covers 7
- Opioid use disorder treatment services 8
- Alcohol misuse screening & counseling 9
- Partial hospitalization 9
- What you pay for outpatient mental health care & services 10
- What isn't covered 10

Section 2: Inpatient mental health care 11
- What Original Medicare covers 11
- What you pay for inpatient mental health care & services 11
- What isn't covered 12

Section 3: Medicare drug coverage (Part D) 13
- Medicare drug plans have special rules 13
- Learn more about Medicare drug coverage (Part D) 14

Section 4: Help, rights, & resources 15
- Help if you have limited income & resources 15
- Your Medicare appeal rights 17
- Mental health resources 18

Section 5: Definitions 19

If you or someone you know is struggling or in crisis and would like to talk to a trained crisis counselor, call or text **988**, the free and confidential Suicide & Crisis Lifeline. You can also connect with a counselor through web chat at 988lifeline.org.

The 988 Suicide & Crisis Lifeline is a national network of local crisis centers that provides free and confidential emotional support if you or someone you know is having thoughts of suicide or experiencing a mental health or substance use crisis. You can talk to a counselor 24 hours a day, 7 days a week in the U.S. Call, text, or chat:

- To talk to someone who cares
- If you feel you might be in danger of hurting yourself
- If you're concerned about a family member or friend
- To find referrals to mental health treatments and services in your area

Call 911 if you're in an immediate medical crisis.

Mental health care & Medicare

Mental health conditions, like depression and anxiety, can happen to anyone at any time. If you think you may have problems that affect your mental health, you can get help. Talk to your doctor or other health care provider if you have:

- Thoughts of ending your life (like a fixation on death or suicidal thoughts or attempts)
- Sad, empty, or hopeless feelings
- Loss of self-worth (like worries about being a burden, feelings of worthlessness, or self-loathing)
- Social withdrawal and isolation (like you don't want to be with friends, engage in activities, or leave home)
- Little interest in things you used to enjoy
- A lack of energy
- Trouble concentrating
- Trouble sleeping (like difficulty falling or staying asleep, oversleeping, or daytime sleepiness)
- Loss of appetite or weight loss
- Increased use of alcohol or other drugs

Mental health care includes services and programs to help diagnose and treat mental health conditions. These services and programs may be provided in outpatient and inpatient settings. Medicare helps cover outpatient and inpatient mental health care, as well as prescription drugs you may need to treat a mental health condition.

Words in red are defined on pages 19–20.

Section 1: Outpatient mental health care

What Original Medicare covers

Medicare Part B (Medical Insurance) helps pay for mental health services you generally get outside of a hospital (like in a clinic, doctor's office, or therapist's office) and services a hospital provides in its outpatient department. Part B also covers visits with these providers:

- Psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician assistant

NEW: Starting January 1, 2024, Medicare will also cover mental health care services provided by marriage & family therapists and mental health counselors.

Doctors or other health care providers who participate in Part B must accept assignment. An assignment is an agreement by your doctor, provider, or other supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance. Ask your doctor or other health care provider if they accept assignment before you schedule an appointment. Some health professionals, like clinical social workers and clinical nurse specialists, must always accept assignment. Deductibles and coinsurance may apply.

If your doctor or other health care provider accepts assignment, Part B helps pay for these outpatient services:

- One depression screening each year. The screening must be done in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals. Visit Medicare.gov/coverage/depression-screening for more information.
- Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state where you get the services.

Words in red are defined on pages 19–20.

- Family counseling, if the main purpose is to help with your treatment.
- Testing to find out if you're getting the services you need and if your current treatment is helping you.
- Psychiatric evaluation.
- Medication management.
- Certain prescription drugs that aren't usually "self-administered" (drugs you would normally take on your own), like some injections.
- Diagnostic tests.
- Partial hospitalization.
- A one-time "Welcome to Medicare" preventive visit within the first 12 months you have Part B. This visit includes a review of your potential risk factors for depression. Visit Medicare.gov/coverage/welcome-to-medicare-preventive-visit for more information.
- A yearly "Wellness" visit. This is a good time to talk to your doctor or other health care provider about changes in your mental health, so they can evaluate your changes year to year. Visit Medicare.gov/coverage/yearly-wellness-visits for more information.

Note: If you have a Medicare Advantage Plan, it may offer extra benefits, like certain types of mental health counseling not covered by Original Medicare. Contact your plan for details.

Opioid use disorder treatment services

Medicare covers opioid use disorder treatment services in opioid treatment programs. The services include:

- Medication (like methadone, buprenorphine, naltrexone, and naloxone)
- Counseling
- Drug testing
- Individual and group therapy
- Intake activities
- Periodic assessments

Medicare covers counseling, therapy services, and periodic assessments both in person and, in certain circumstances, by virtual delivery (using audio and video communication technology, like your phone or a computer). Talk to your doctor or other health care provider to find out where you can go for these services. Visit Medicare.gov/coverage/opioid-use-disorder-treatment-services for more information.

Alcohol misuse screening & counseling

Medicare covers one alcohol misuse screening each year for adults (including pregnant individuals) who use alcohol, but don't meet the medical criteria for alcohol dependency. If your primary care doctor or other health care provider determines you're misusing alcohol, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling). You must get counseling in a primary care setting (like a doctor's office).

If you have a substance use disorder or a co-occurring mental health disorder, you can get telehealth services from home.

Visit Medicare.gov/coverage/alcohol-misuse-screenings-counseling for more information.

Partial hospitalization

In some cases, Part B may cover partial hospitalization services given by a community mental health center or by a hospital to outpatients if you meet certain requirements and if your doctor certifies that you would otherwise need inpatient treatment. Partial hospitalization is a structured day program that offers outpatient psychiatric services as an alternative to inpatient psychiatric care.

NEW: Starting January 1, 2024, Medicare will cover intensive outpatient program services provided by hospitals, community mental health centers, federally qualified health centers, and Rural Health Clinics.

Partial hospitalization and intensive outpatient services are more rigorous than care you'd get in a doctor's or therapist's office.

Medicare may also cover:

- Occupational therapy that's part of your mental health treatment
- Individual patient training and education about your condition

Visit Medicare.gov/coverage/mental-health-care-partial-hospitalization for more information.

What you pay for outpatient mental health care & services

In general, after you pay your yearly Part B deductible, you pay 20% of the Medicare-approved amount for visits to diagnose or treat your condition, if your health care provider accepts assignment.

Screenings

Medicare will pay for:

- One depression screening per year if your health care provider accepts assignment.
- Alcohol misuse screening and counseling if your primary care doctor or other primary care provider accepts assignment.

Opioid use disorder treatment services

After you pay the Part B deductible, you pay nothing for opioid use disorder treatment services if you get them from a provider who's enrolled in Medicare.

Partial hospitalization

For partial hospitalization (and starting January 1, 2024, for intensive outpatient program services), after you meet the Part B deductible, you pay:

- A percentage of the Medicare-approved amount for visits to your doctor or other health care provider if they accept assignment.
- Coinsurance for each day of partial hospitalization services you get in a hospital outpatient setting or community mental health center.

If you get your services in a hospital outpatient clinic or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.

Note: If you have a Medicare Supplement Insurance (Medigap) policy or other health coverage, tell your health care provider so your bills get paid correctly. Visit Medicare.gov/coverage/mental-health-care-outpatient for more information on outpatient mental health services.

What isn't covered

- Meals.
- Transportation to or from mental health care services.
- Support groups that bring people together to talk and socialize. (**Note:** This is different from group psychotherapy, which is covered.)
- Testing or training for job skills that isn't part of your mental health treatment.

Section 2: Inpatient mental health care

What Original Medicare covers

Medicare Part A (Hospital Insurance) helps pay for mental health services you get in a hospital when you're admitted as an inpatient. You can get these services either in a general hospital or in a psychiatric hospital that only cares for people with mental health conditions. No matter which type of hospital you choose, Part A will help cover inpatient mental health services.

Part A covers your:

- Semi-private rooms
- Meals
- General nursing
- Drugs (including methadone to treat an opioid use disorder)
- Other hospital services and supplies as part of your inpatient treatment

Visit Medicare.gov/coverage/mental-health-care-inpatient for more information.

What you pay for inpatient mental health care & services

Medicare measures your use of hospital services (including services you get in a psychiatric hospital) in benefit periods. A benefit period begins the day you're admitted as an inpatient in a general or psychiatric hospital. The benefit period ends after you haven't had any inpatient hospital care for 60 days in a row. If you're admitted to a hospital again after 60 days, a new benefit period begins, and you must pay a new deductible for any inpatient hospital services you get.

Words in red are defined on pages 19–20.

There's no limit to the number of benefit periods you can have when you get mental health care in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital, but there's a lifetime limit of 190 days. Part A only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime.

As a hospital inpatient, you pay these amounts in 2023:

- $1,600 deductible for each benefit period
- Days 1–60: $0 coinsurance per day of each benefit period
- Days 61–90: $400 coinsurance per day of each benefit period
- Days 91 and beyond: $800 coinsurance per each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime)
- Beyond lifetime reserve days: all costs
- 20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you're a hospital inpatient

Visit Medicare.gov/basics/costs for the most up-to-date costs.

Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services. This includes mental health services provided by doctors and other health care professionals if you're admitted as a hospital inpatient. You pay 20% of the Medicare-approved amount for these mental health services while you're a hospital inpatient.

Note: If you have a Medicare Supplement Insurance (Medigap) policy or other health coverage, tell your doctor or other health care provider so your bills get paid correctly.

What isn't covered

- Private duty nursing
- A phone or television in your room
- Personal items, like toothpaste, socks, or razors
- A private room, unless medically necessary

Section 3: Medicare drug coverage (Part D)

To get Medicare drug coverage (Part D), you must join a Medicare-approved plan that offers drug coverage, like a Medicare drug plan. Medicare drug plans are run by private insurance companies that follow rules set by Medicare. Each plan can vary in cost and in the specific drugs it covers. However, nearly all antidepressants and antipsychotics are required on drug formularies of every Medicare drug plan. It's important to know your plan's coverage rules and your rights.

Medicare drug plans have special rules

Will my plan cover the drugs I need?

Most Medicare drug plans have a list of drugs that the plan covers, called a formulary. Medicare drug plans aren't required to cover all drugs, but they're required to cover all (with limited exceptions) antidepressant, anticonvulsant, and antipsychotic medications.

Medicare reviews each plan's formulary to make sure it has a wide range of drugs and that it doesn't discriminate against certain groups (like people with disabilities or mental health conditions).

If you take prescription drugs for a mental health condition, it's important to find out if a plan covers your drugs before you enroll. You can write down the names of your current prescriptions and doses on page 21.

Visit Medicare.gov/plan-compare to find out which plans cover your drugs. Each time you shop for plans, you can enter the prescription drugs you're currently taking to get a better idea of what your out-of-pocket drug costs would be in each plan.

Words in red are defined on pages 19–20.

Can my drug plan's formulary change?

Your Medicare drug plan may change its drug list during the year because drug therapies change, new drugs are released, or new medical information becomes available. Plans can also, in certain cases, immediately remove a brand name drug from their formularies if the plan adds a new generic in place of the brand drug, or plans can change the cost or coverage rules for a brand name drug when adding the new generic drug.

If the formulary status of a drug you're currently taking changes, your plan will send you information about the specific changes. For other changes involving a drug you're currently taking that will affect you during the year, your plan must do **one** of these:

- Give you notice at least 30 days before the effective date of the change
- At the time you request a refill, provide notice of the change and a month's supply of the drug under the same plan rules as before the change

What if my prescriber thinks I need a certain drug that my plan doesn't cover?

If you're in a Medicare drug plan, you have the right to ask for a coverage determination (including an exception). You can appoint a representative to help you. Your representative can be a family member, friend, advocate, attorney, financial advisor, doctor, or someone else who will act on your behalf. You, your representative, or your doctor or other prescriber must contact your plan to ask for a coverage determination.

For more information on your appeal rights, go to page 17.

Learn more about Medicare drug coverage (Part D)

To find out more about Part D:

- Visit Medicare.gov/part-d.
- Visit Medicare.gov/publications to view the booklet "Your Guide to Medicare Prescription Drug Coverage."
- Visit Medicare.gov/plan-compare to find and compare plans in your area. Have your Medicare card, a list of your drugs and their dosages, and the name of the pharmacy you use available.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP) to get personalized help. Visit shiphelp.org, or call 1-800-MEDICARE to get the phone number.

Section 4: Help, rights, & resources

Help if you have limited income & resources

Extra Help paying your Medicare drug costs

If you have limited income and resources, you may qualify for Extra Help from Medicare to help pay the costs of Medicare drug coverage (Part D). You should apply even if you aren't sure if you qualify.

Visit secure.ssa.gov/i1020/start to apply for Extra Help online. You can call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. You can apply for Extra Help by phone or ask for a paper application.

For more information:

- Visit Medicare.gov/basics/costs/help/drug-costs.
- Contact your State Medical Assistance (Medicaid) office. To get their phone number, visit Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Words in red are defined on pages 19–20.

State Pharmaceutical Assistance Programs (SPAPs)

Many states have State Pharmaceutical Assistance Programs that help certain people pay for prescription drugs. Each program makes its own rules on how to help its members. To find out if there's a State Pharmaceutical Assistance Program in your state and how it works, visit Medicare.gov/pharmaceutical-assistance-program/#state-programs.

Pharmaceutical Assistance Programs

Many major drug manufacturers offer assistance programs for people with Medicare drug coverage (Part D) who meet certain requirements.

For more information, visit Medicare.gov/pharmaceutical-assistance-program.

Medicare Savings Programs

If you have limited income and resources and meet certain conditions, you may be able to get help from your state to pay your Medicare costs (like premiums, deductibles, and coinsurance).

For more information, visit Medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs.

- Contact your State Medical Assistance (Medicaid) office, and ask for information on Medicare Savings Programs. Call even if you aren't sure if you qualify. To get their phone number, visit Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu. You can also call 1-800-MEDICARE. TTY users can call 1-877-486-2048.
- Visit Medicare.gov/publications to view or print the brochure "Get Help With Your Medicare Costs: Getting Started."
- Call your State Health Insurance Assistance Program (SHIP) for free personalized health insurance counseling. Visit shiphelp.org, or call 1-800-MEDICARE to get the phone number.

Medicaid

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and (in some cases) resources. Medicaid also offers some benefits that Medicare doesn't normally cover, like custodial nursing home care and personal care services. Each state has different rules about eligibility and applying for Medicaid.

For more information:

- Visit Medicare.gov/basics/costs/help/medicaid.
- Call your State Medical Assistance (Medicaid) office to find out if you qualify. To get their phone number, visit Medicaid.gov/about-us/beneficiary-resources/index.html#statemenu. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit Medicare.gov/publications to view the brochure "Medicaid: Getting Started" to learn more about the Medicaid program.

Your Medicare appeal rights

An appeal is an action you can take if you disagree with a coverage or payment decision by Medicare, your Medicare health plan, or your Medicare drug plan. If you decide to file an appeal, ask your doctor, health care provider, or supplier for any information that may help your case. Keep a copy of everything you send to Medicare or your plan as part of the appeal.

For more information:

- Visit Medicare.gov/appeals.
- Visit Medicare.gov/publications to view the booklet "Medicare Appeals."
- Call 1-800-MEDICARE.

All people with Medicare have certain rights and protections. For more information, visit Medicare.gov/basics/your-medicare-rights.

Mental health resources

If you or someone you know is struggling or in crisis:

Call or text 988, or chat 988lifeline.org, the Suicide & Crisis Lifeline. You can talk to a trained crisis counselor 24 hours a day, 7 days a week in the U.S.

For more information about Medicare mental health benefits and coverage:

- Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized health insurance counseling. Visit shiphelp.org, or call 1-800-MEDICARE to get the phone number.

If you're in an immediate medical crisis, call 911.

Talk to your doctor or other health care provider if you have questions or concerns about your mental health, to find out more about mental health, or to find mental health treatment. You can also visit mentalhealth.gov, or one of these resources:

National Institute of Mental Health (NIMH), National Institutes of Health (NIH)

- Visit nimh.nih.gov.
- Call 1-866-615-6464. TTY users can call 1-301-443-8431.
- Email nimhinfo@nih.gov.

Substance Abuse and Mental Health Services Administration (SAMHSA)

- Visit samhsa.gov. To find treatment facilities in your area, visit findtreatment.samhsa.gov.
- Call 1-877-SAMHSA-7 (1-877-726-4727). TTY users can call 1-800-487-4889.

Mental Health America

- Visit mhanational.org.
- Call 1-800-969-6642.

National Alliance on Mental Illness (NAMI)

- Visit nami.org.
- Call or text the Information Helpline at 1-800-950-NAMI (1-800-950-6264).

National Council for Mental Wellbeing

- Visit thenationalcouncil.org.
- Call 1-202-684-7457.
- Email Communications@thenationalcouncil.org.

Section 5: Definitions

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

Copayment—An amount you may be required to pay as your share of the cost for benefits after you pay any deductibles. A copayment is a fixed amount, like $30.

Coverage determination—The first decision made by your Medicare drug plan (not the pharmacy) about your drug benefits, including:

- Whether a particular drug is covered.
- Whether you've met all the requirements for getting a requested drug.
- How much you're required to pay for a drug.
- Whether to make an exception to a plan rule when you request it.

The drug plan must give you a prompt decision (72 hours for standard requests, 24 hours for expedited requests). If you disagree with the plan's coverage determination, the next step is an appeal.

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

Exception—A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's on its non-preferred drug tier. You or your prescriber must request an exception, and your doctor or other prescriber must provide a supporting statement explaining the medical reason for the exception.

Formulary—A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Lifetime reserve days—In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Medicare-approved amount—The payment amount that Original Medicare sets for a covered service or item. When your provider accepts assignment, Medicare pays its share and you pay your share of that amount.

Medicare health plan—Plans offered by private companies that contract with Medicare to provide Part A, Part B, and in many cases, Part D benefits. Includes Medicare Advantage Plans and certain other types of coverage (like Medicare Cost Plans, PACE programs, and demonstration/pilot programs).

Medicare drug plan (Part D)—Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare drug plans.

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

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

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

My current prescriptions & dosages

CMS Accessible Communications

Medicare provides free auxiliary aids and services, including information in accessible formats like braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

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

1. **Call us:**
   For Medicare: 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048
   For Marketplace: 1-800-318-2596 TTY: 1-855-889-4325
2. **Email us:** altformatrequest@cms.hhs.gov
3. **Send us a fax:** 1-844-530-3676
4. **Send us a letter:**

   Centers for Medicare & Medicaid Services
   Offices of Hearings and Inquiries (OHI)
   7500 Security Boulevard, Mail Stop DO-01-20
   Baltimore, MD 21244-1850
   Attn: Customer Accessibility Resource Staff (CARS)

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

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

Nondiscrimination Notice

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

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

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

1. **Online:**
   hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
2. **By phone:**
   Call 1-800-368-1019. TTY users can call 1-800-537-7697.
3. **In writing:** Send information about your complaint to:

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

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

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

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