APPENDIX U

APPENDIX U
NATIONAL MEDICAL SUPPORT NOTICE FORM

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PLEASE CAREFULLY READ ALL DOCUMENTS IMMEDIATE ACTION REQUIRED

The enclosed National Medical Support Notice (NMSN) has been sent to you in accordance with Title 45 of the Code of Federal Regulations, Part 303.32 because your employee is required to provide health care coverage for his/her dependent(s) if available at a reasonable cost. "Reasonable cost" to an obligor is defined by Rule 1910.16-6 (3)(i) as an amount that does not exceed 5% of the obligor's net monthly income and, when added to the amount of basic child support plus additional expenses the obligor is ordered to pay, does not exceed 50% of the obligor's net monthly income.

Enrollment shall not occur earlier than 25 days from the date of this notice to allow the employee time to object to the issuing court or Domestic Relations Section.

Please be advised that receipt of this NMSN constitutes legal process of service. The person or entity receiving this information is required to make every effort to ensure that these documents are submitted to the proper authority for completion. Failure of an employer or organization to comply with a NMSN may result in legal action.

Employer Requirements:
If dependent health care coverage **is not available** to the employee named in the NMSN, or the employee is no longer in your employ, complete the Employer Response and return it with Part A to the **Issuing Agency within 20 business days from date on the notice.**

If dependent health care coverage **is available** to the employee, complete and return the Addendum to Part A to the Issuing Agency. Forward Part B of the NMSN, Instructions to the Plan Administrator and the Addendum to Part B to the insurance Plan Administrator(s).

If you are the employer of an individual named herein who maintains or contributes to health care benefits that are administered through another organization or union, you must forward a copy of this letter, Part B, Instructions to the Plan Administrator and the Addendum to Part B, to the organization or union providing those benefits and/or acting as the Plan Administrator for completion.

Plan Administrators and unions providing benefits are required to:

Review and complete Part B of the NMSN and the Addendum to Part B. Return the completed documents to the **Issuing Agency within 40 business days from date on the notice.**

Note: * Part B of the Notice must be completed and submitted even if the health care benefits are already being provided.

The maximum amount of any attachment for child and medical support is set forth by the federal Consumer Credit Protection Act (Public Law 90-321, Section 303(b)). Priority of payment under any order for support shall be for cash support followed by medical support, which includes health insurance and related costs, capped at the maximum amount permitted by federal withholding law.

Employers should register on Pennsylvania's Child Support Program website at www.childsupport.state.pa.us to obtain more information about the form and its use. Select the "Employer" link from the center of the page and complete the registration screen. For assistance in completing these forms, please contact the Employer Maintenance Unit at 1-877-676-9580.

NATIONAL MEDICAL SUPPORT NOTICE - PART A
NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE

This Notice is issued under section 466(a) (19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998 (CSPIA). Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the employee. NOTE: For purposes of this form, the Custodial Parent may also be the employee when the State opts to enforce against the Custodial Parent.

Issuing Agency: _____ Issuing Agency Address: _____ _____ Notice Date: _____ CSE Agency Case Identifier: _____ Telephone Number:_____ FAX Number:_____	Court Authority: _____ Order Date: _____ Order Identifier: _____ Document Tracking Identifier: _____ Employer web site: www.childsupport.state.pa.us See NMSN Instructions: www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

RE:

_____
Employer/Withholder's Federal EIN Number

_____
Employer/Withholder's Name

_____
Employer / Withholder's Address

_____
Custodial Parent's Name (Last, First, MI)

_____
Custodial Parent's Mailing Address

_____

_____

_____
Child(ren)'s Mailing Address (if different from Custodial Parent's)

_____
Name and Telephone of a Representative of the Child(ren)

_____
Employee's Name (Last, First, MI)

_____
Employee's Social Security Number

_____
Employee's Mailing Address

_____
Substituted Official/Agency Name

_____
Substituted Official/Agency Address
(Required if Custodial Parent's mailing address is left blank)

_____
Mailing Address of a Representative of the Child(ren)

Child(ren)'s Name(s)	Gender	DOB	SSN	Child(ren)'s Name(s)	Gender	DOB	SSN

The order requires the child(ren) to be enrolled in ☒ all health coverages available;☐ or only the following coverage(s):
☐ Medical; ☐ Dental;☐ Vision; ☐ Prescription drug; ☐ Mental health; ☐Other(specify): _____

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. **OMB control number: 0970-0222 Expiration Date: 08/31/2019.**

PACSES Case Number:

EMPLOYER RESPONSE

If 1, 2, 3, 4 or 5 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If 1 through 5 does not apply, complete item 7 and forward **Part B** to the appropriate Plan Administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. This includes any organization or labor union that provides group health care benefits to the employee. Check number 5 and return this **Part A** to the **Issuing Agency** if the Plan Administrator informs you that the child(ren) would be enrolled in or qualify(ies) for an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization. You are required to respond to the Issuing Agency by returning this **Employer Response** regardless of whether you provide group health benefits or the employee named herein is no longer employed by your organization. Information for the Plan Administrator and the Employer Representative at the bottom of this section is required.

☐ 1. The employee named in this Notice has never been employed by this employer.

☐ 2. We, the employer, do not offer our employees the option of purchasing dependent or family health care coverage as a benefit of their employment.

☐ 3. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes. Do not check this box if the employee is only temporarily ineligible for health care coverage.

☐ 4. Health care coverage is not available because employee is no longer employed by the employer:

Date of termination: _____

Last known telephone number: _____

Last known address: _____

New employer (if known): _____

New employer telephone number: _____

New employer address: _____

☐ 5. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.

☐ 6. The participant is subject to a waiting period that expires _____ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period, which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____). At the completion of the waiting period, the Plan Administrator will process the enrollment.

☐ 7. Employer forwarded Part B to Plan Administrator on _____.
MM/DD/YY

CONTACT FOR QUESTIONS

Plan Administrator Name: _____
Contact Person: _____

FAX Number: _____
Telephone Number: _____

Employer Name: _____
Employer Representative Name/Title: _____

Telephone Number: _____
Federal EIN: _____
(if not provided on Page 1 of this Notice)

Employee Name: _____

Date: _____

NATIONAL MEDICAL SUPPORT NOTICE - PART B
MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998 (CSPIA). Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such law. The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the employee. NOTE: For purposes of this form, the Custodial Parent may also be the employee when the State opts to enforce against the Custodial Parent.

Issuing Agency: _____ Issuing Agency Address: _____ _____ Notice Date: _____ CSE Agency Case Identifier: _____ Telephone Number: _____ FAX Number:_____	Court Authority: _____ Order Date: _____ Order Identifier: _____ Document Tracking Identifier: _____ Employer web site: www.childsupport.state.pa.us See NMSN Instructions: www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

RE:

_____
Employer/Withholder's Federal EIN Number

_____
Employer/Withholder's Name

_____
Employer / Withholder's Address

_____
Custodial Parent's Name (Last, First, MI)

_____
Custodial Parent's Mailing Address

_____

_____

_____
Child(ren)'s Mailing Address (if different from Custodial Parent's)

_____
Name and Telephone of a Representative of the Child(ren)

_____
Employee's Name (Last, First, MI)

_____
Employee's Social Security Number

_____
Employee's Mailing Address

_____
Substituted Official/Agency Name

_____
Substituted Official/Agency Address
(Required if Custodial Parent's mailing address is left blank)

_____
Mailing Address of a Representative of the Child(ren)

Child(ren)'s Name(s)	Gender	DOB	SSN	Child(ren)'s Name(s)	Gender	DOB	SSN

The order requires the child(ren) to be enrolled in ☒ all health coverages available; ☐ or only the following coverage(s):
☐ Medical; ☐ Dental; ☐ Vision; ☐ Prescription drug; ☐ Mental health; ☐ Other (specify):_____

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. **OMB control number: 1210-0113 Expiration Date: 08/31/2019.**

PACSES Case Number:

PLAN ADMINISTRATOR RESPONSE

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

This Notice was received by the plan administrator on _____.

☐1. This Notice was determined to be a "qualified medical child support order," on _____.
Complete **Response 2 or 3, and 4**, if applicable.

2. The participant (employee) and alternate recipient(s) (child(ren)) are to be enrolled in the following family coverage.

- ○a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.
- ○b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.
- ○c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
- ○d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of __/__/___ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option (if plan is insured, identify provider, policy and group numbers): _____. Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

☐3. There is more than one option available under the plan and the participant is not enrolled. The County Domestic Relations Section must contact _____ (Plan Admin) at _____ (Plan Admin Phone Number) to determine next steps. Each child is to be included as a dependant under one of the available options that provide family coverage. The child(ren), and the participant if necessary, must be enrolled in the plan's default option if the Court does not reply within 20 business days of the date this Response is returned.

☐4. The participant is subject to a waiting period that expires __/__/____ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____). At the completion of the waiting period, the plan administrator will process the enrollment.

☐5. This Notice does not constitute a "qualified medical child support order" because:

- ○The name of the child(ren) or ○ participant is unavailable.
- ○The mailing address of the ○child(ren) (or a substituted official) or ○ participant is unavailable.
- ○The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan _____ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Address:_____

NATIONAL MEDICAL SUPPORT NOTICE

ADDENDUM to PART A - EMPLOYER RESPONSE

Use ONLY when enforcing a Pennsylvania medical support order

Employer/Withholder's Federal EIN	RE: Employee's Name (Last, First, MI)
Employer/Withholder's Name	Employee's Social Security Number
Employer/Withholder's Address	Employee's Mailing Address
Custodial Parent's Name (Last, First, MI)	Substituted Official/Agency Name
Custodial Parent's Mailing Address	Substituted Official/Agency Address

FOR COMPLETION BY THE EMPLOYER

Please provide the following information regarding the Plan Administrators, who you sent both **Part B - Medical Support Notice to Plan Administrator** and **Addendum to Part B - Plan Administrator Response**. Each administrator of each group health plan shall be sent both **Part B** and the **Addendum to Part B**. If more than one Plan Administrator is indicated, photocopy **Part B - Medical Support Notice to Plan Administrator** and **Addendum to Part B - Plan Administrator Response** and send both forms to each **Plan Administrator**.

NAME	ADDRESS	TELEPHONE #

Return this form to the ISSUING AGENCY named below within 20 business days of the date shown on the National Medical Support Notice to inform the ISSUING AGENCY about what action has occurred.

REMINDER: Report immediately to the ISSUING AGENCY any change in coverage availability that occurs in the future for any child(ren) named in **Part A.**

Employer Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

EIN (if not provided by Issuing Agency on Notice to Withhold for Health Care Coverage): _____

FOR OFFICIAL USE ONLY

Issuing Agency:	Court Authority:
Issuing Agency Address:	Order Date:
Notice Date:	Order Identifier:
CSE Agency Case Identifier:	Member ID:
Telephone Number:	
FAX Number:	

NATIONAL MEDICAL SUPPORT NOTICE

ADDENDUM to PART B - PLAN ADMINISTRATOR RESPONSE

Use ONLY when enforcing a Pennsylvania medical support order

Employer/Withholder's Federal EIN	RE: Employee's Name (Last, First, MI)
Employer/Withholder's Name	Employee's Social Security Number
Employer/Withholder's Address	Employee's Mailing Address
Custodial Parent's Name (Last, First, MI)	Substituted Official/Agency Name
Custodial Parent's Mailing Address	Substituted Official/Agency Address

FOR COMPLETION BY THE PLAN ADMINISTRATOR

If there is more than one coverage option, photocopy **Part B** before you forward it to the Issuing Agency. Complete and return this page with **Part B** when enrollment is completed. Keep a copy of the form for your records.

Child(ren)'s Name(s)	Gender	DOB	SSN	Child(ren)'s Name(s)	Gender	DOB	SSN

For all applicable coverages, provide the insurance company name, address, policy number, and group number for each type of coverage.

	Insurance Company Name and Address	Policy #	Group #
Medical:			
Dental:			
Vision:			
Prescription drug:			
Mental health:			
Other (specify):			

The child(ren) may not be disenrolled (or coverage eliminated) unless one of the conditions applies that is listed in the **Instructions to Plan Administrator** under the section **"Period of Coverage"** or the employee is no longer eligible for family health coverage due to a change in his her employment status.

Plan Administrator or Representative:

Name: _____ Address: _____

Title: _____ Telephone Number: _____

Date: _____

FOR OFFICIAL USE ONLY

Issuing Agency:	Court Authority:
Issuing Agency Address:	Order Date:
Notice Date:	Order Identifier:
CSE Agency Case Identifier:	Member ID:
Telephone Number:	
FAX Number:	

Dear Employer:

Please review the following instructions which are intended to assist you with completion of the National Medical Support Notice forms and to ensure that we can process the forms when you return them to us.

1. You will receive a form for each employee for whom a form must be completed. Please do not include information for more than one employee on each form.

2. DO NOT return any paperwork other than the NMSN forms. It is required that the original NMSN form be filled out. No other paperwork, forms, booklets etc. will be recognized.

3. Use blue or black ink only to complete the forms. Please do not use red or colored ink!

4. All information should be entered directly on the forms. Do not include business cards or post-it notes.

5. Please do not use staples on the forms.

6. Please do not include health insurance brochures, booklets, statements or rate sheets with your packet. If appropriate, these items will be separately requested by the County Domestic Relations Section that manages the employee's support case.

7. Please return the completed forms promptly. You may return the completed forms by mail to: EMU Group, P.O. Box 61197, Harrisburg, PA 17106

Or you may fax the completed forms to: (717) 930-1119

If you have any questions or require assistance in completing these forms, please contact the Employer Maintenance Unit at 1-877-676-9580. We are available to assist you M-F, 8:00 AM – 4:30 PM.

Thank you for taking the time to complete the National Medical Support Notice forms. Your cooperation is appreciated.

Employer Maintenance Unit
1-877-676-9580