How To Apply For Medicare

By Amy Kennedy

You become eligible for Medicare health insurance in the United States when you turn 65. (Some younger people with disabilities also qualify for the federally sponsored program.) If you are approaching age 65, there is a seven-month period during which you can apply for Medicare. You may apply three months before your 65th birthday, the month of your birthday, or three months after your birthday by visiting the Social Security Administration office near you.

Part A Medicare helps pay for hospital bills, and Part B helps pay for doctor bills. (Part D is the prescription drug insurance program that went into effect in 2006 and it requires a separate application process.) Most people do not have to pay a monthly premium for Part A, which covers hospital bills. The Medicare taxes you or your spouse paid while working cover the cost.

Whether you sign up for Part B, which covers doctor bills, is your choice. You will have to pay a deductible and monthly premium for Part B coverage. You may sign up when you first go on Medicare, decline the coverage, or sign up in the future. If you are still working or have group health insurance from your employer or your spouse's employer, you might not have an immediate need for Part B. However, if you postpone signing up, the premium could go up by 10 percent each year.

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If you are 65 or older when you sign up for Part B, you have six months to buy any Medicare Supplemental (Medigap) policy you choose no matter what your state of health. (This open enrollment period occurs only once.) If you are 65 or older and working and you have group health insurance from your employer or a spouse's employer, you can postpone your open enrollment period.

The Original Medicare Plan is available throughout the United States while Medicare Advantage Plans (HMO, PPO, PFFS plans) are available only in certain parts of the country. If you have other plans besides the Original Medicare Plan available to you, compare the costs and benefits, then choose the plan that suits your needs best.

The amount you pay for Medicare depends on which plan you choose and whether you have other insurance. If you choose a Medicare HMO or PPO, you won't need to purchase a Medicare Supplemental (Medigap) policy. (Medigap is insurance that helps pay some of your uncovered costs in the Original Medicare Plan.)

In the Original Medicare Plan you can go to any doctor or hospital in the United States that accepts Medicare. In a Medicare HMO or PPO you will pay more if you go to doctors outside the plan network, and with a PFFS plan you can choose any doctor or hospital that accepts the Medicare plan. (If you need emergency care, you can go any doctor or hospital no matter which Medicare plan you have.)

If you are on a limited budget, costs in a Medicare HMO or PPO are typically lower. You may be able to get help from your state to pay some of your health care costs if you qualify.

All Medicare plans pay for your health care costs away from home if you have an emergency or need urgent care. If you travel outside the country frequently you should choose a plan that covers health care outside the United States.

As we get older many of us have medical concerns that require the services of a specialist. With the Original Medicare Plan, PFFS plans, and PPO's you can go directly to any specialist. With a Medicare HMO you can only see a specialist after your primary care doctor makes a referral.

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In January 2005 Medicare expanded coverage to include a one-time comprehensive physical exam after enrolling in Medicare Part B, plus screening tests for heart disease and diabetes. The exam must take place within the first six months that you have coverage. It includes an overall evaluation of your health, information about preventive care, and referrals for additional care if needed. The exam includes a review of your medical history, blood pressure check, vision test, and evaluation of drugs you take.

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