

**Medicare Patient Information**

**Patient Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Female  Male

Address: \_\_\_\_\_  
Street

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HomePhone WorkPhone

**Please print your name as it Appears on Your Medicare Card**

**Medicare Health Insurance Claim Number as it appears on your card.** This is usually your Social Security number. Be sure to include the letter after the nine-digit number. It is important that we have both the numbers and letter)

**Referring Physician**

Name: \_\_\_\_\_ Phone# ( ) \_\_\_\_\_

**Emergency Contact**

Name of Spouse or Close Relative or Friend: \_\_\_\_\_  
(In Case of Emergency)

Phone# ( ) \_\_\_\_\_

**Please Sign So We May Have Your Medicare Authorization On File**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_

**Payment Policy**

**Medicare:** We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual \$110.00 deductible and paying for the 20% copayment. We do file with secondary /supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

**Note:** If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

**-Continued on Back-**

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does NOT apply to you, please check NO

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by a HMO/ PPO which makes Medicare secondary?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work and have coverage through the insurance at your job?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you eligible for any benefits under the Federal Black Lung Program?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you coming to this office due to Medicare disability coverage?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by the Federal End Stage Renal Disease Program?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently receiving Workers' Compensation?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the illness or injury you are coming to this office for the result of work-related causes?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have medical assistance through Welfare or state-aid?   |

If you answered YES to ANY of the above questions: \_\_\_\_\_  
Explain

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name Policy Holder (Insured): \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Policy Holder (Insured) SS# \_\_\_\_\_

#### Supplemental (MEDIGAP) Insurance

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare. (MEDIGAP Coverage)

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name Policy Holder (Insured): \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Policy Holder (Insured) SS# \_\_\_\_\_

#### Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: \_\_\_/\_\_\_/\_\_\_ Signature: \_\_\_\_\_