

# Medicare Patient Information

**Patient Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_  
Last First MI

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

Status:  Single  Married  Widowed  Divorced

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

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

\_\_\_\_\_  
Home Phone Work Phone Cell Phone

***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***

## Emergency Contact

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

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

## Primary Care Physician

**Name:** \_\_\_\_\_ **Phone# ( )** \_\_\_\_\_  
Last Name First Name

**Pharmacy** \_\_\_\_\_ **Phone# ( )** \_\_\_\_\_  
Name & Location

## 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: \_\_\_\_\_

**-Continued on Back-**

## 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 \$124.00 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.

**Are you in a Medicare HMO or other Senior Medicare Plan?**  Yes  No

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.

Name of Plan: \_\_\_\_\_

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

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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 #: \_\_\_\_\_

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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: \_\_\_\_\_