Attention Medicare Patients!!!!!!

HAVE YOU HAD PRIOR HOME HEALTH PHYSICAL THERAPY???????

IF SO, <u>HAVE YOU BEEN DISCHARGED?</u>

Please provide our office with a copy of your discharge papers or have Home Health provider to fax us a copy of your discharge to (806) 353-5445 **BEFORE YOUR FIRST VISIT WITH US.**

MEDICARE SECONDARY PAYER QUESTIONAIRE

Person Giving Information: _____ Relationship to Patient _____

Patient Name: _____

HIC Number: _____ Patient Age: _____ Patient Sex: _____

Basis for Patient Entitlement to Medicare (circle one)

Age Disability End Stage Renal Disease (ESRD)

Group Health Plan Information

1. Is the patient or patient's spouse currently employed? **Yes** or **No**

If No: Retirement date of patient: _____

Retirement date of spouse: _____

If Yes, continue.

Is patient or spouse employed? **Yes** or **No**

Are There: _____ 1. Less than 20 employees

_____ 2. More than 100 employees

Is employee actively working? **Yes** or **No**

Insurance Company: _____

Policy Number: _____ Claim Number: _____

Insurance Plan Name: _____

Plan ID Number: _____

Is the patient employed? **Yes** or **No** Full Time ___ Part Time

Employer Name: _____

Employer Address: _____

City _____ State _____ Zip _____

Employer ID Number: _____

Automobile, No Fault, or Liability Insurance Information

2. Is the illness / injury due to an accident (auto included)? **Yes** or **No**

If Yes continue.

Type of non-work-related accident: **Auto** Other: _____

Date of Accident: _____

Insurance situation: **Liable** **Not Liable**

Name of Policy Holder: _____

Address of Policy Holder: _____

Policy or Claim ID Number: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Name of Patient's Legal Representative for the case, if any? _____ _____

Phone Number of Legal Representative: _____

Workers Compensation Insurance Information

3. Was the patient involved in a work-related accident? **Yes** or **No**
   If Yes, continue.

Date of Accident: _____

Is the patient working? (circle one) **Yes** **No** **Full Time** **Part Time**

Employer Name: _____

Employer Address: _____

City _____ State _____ Zip _____

Employer ID Number: _____

Name of Insurance Company: _____

Name of Person or Company Insured: _____

Insurance Company Claim or Policy Number: _____

Workers Compensation Claim Number: _____

Name of Workers Compensation Agency where claim is filed: _____

Address of Agency: _____

Has the case been settled? **Yes** - Date _____ **No**

Name of Patient's Legal Representative for the case, if any? _____ _____

Phone Number of Legal Representative: _____

Veteran's Administration (VA) Authorization Information

Does the patient have a VA fee service card? (circle one) **Yes** or **No**

Has the VA issued a special authorization for these sevices? (circle one) **Yes** or **No**

Does the patient authorize you to bill the VA? (circle one) **Yes** or **No**

Black Lung Insurance Information

Is the patient entitled to benefits under the Department of Labor's Black Lung Program? **Yes** or **No**

Are the services provided on the Department of Labor's list of approved procedures for the treatment of Black Lung Disease? **Yes** or **No**

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

DO NOT EMAIL FORM. This electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be hand delivered to the clinic.

Notice of Exclusion From Medicare Benefits (NEMB)
Services Beyond Medicare Financial Cap for Outpatient Therapy Services

THERE ARE ITEMS AND SERVICES FOR WHICH MEDICARE WILL NOT PAY

Note: This form is to be completed at the time therapy services are estimated to reach the annual financiat limitation imposed by CMS for outpatient physical therapy/speech and occupational therapy.

Patient:

Medicare does not pay for all of your health care costs and only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them. When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may may.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them if there is no other insurance you have that will cover the services. In summary, if Medicare does not pay, you will be responsible for payment.

Before you make a decision, you should read this entire notice carefully.

Ask us to explain, if you don't understand why Medicare won't pay.

The estimated cost to you for services received after hitting your Medicare annual maximum is ***$70.00*** per visit. The estimated number of visits in excess of your Medicare annual maximum is ***0*** of an estimated total of ***12.***

Patient Signature (Date) _____ Reviewed with patient by (Clinic Employee) _____

This is only a general summary of exclusions based on the annual maximum Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations and rulings.

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(A)Notifier(s): *West Texas Physical Therapy, 1901 Medi-Park, Suite 1010, Amarillo, TX 79106*

(B) Patient Name: (C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D)_____ below.

(D)_____.	(E) Reason Medicare May Not Pay: _____	(F) Estimated Cost:
Theraband	Non-covered Charges	Up to $10.00
Electrodes	Non-covered Charges	$15.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D)_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

□ **OPTION 1.** I want the (D)_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

□ **OPTION 2.** I want the (D)_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

□ **OPTION 3.** I don't want the (D)_____listed above. I understand with this choice. I am not responsible for payment, and I cannot appeal to see if Medicare would pay. I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date:

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