Medicare Patient Screening

Obtaining complete and accurate information from the patient is essential to ensuring the accuracy of a Medicare claim. Please complete the following questions in order to assist our office in filing your medical claims completely and accurately.

Patient Name (as it appears on your Medicare ID card):_____

** If you go by something other than the name on your Medicare card please note that our records must match the name on your Medicare card.**

Date of Birth: _____ Medicare Claim Number: _____

1. **Are you enrolled in a Medicare HMO, such as Secure Horizon? ..... Yes No**
   Please be aware that we are not providers for any Medicare HMO plans.
2. **Are you enrolled in COBRA, while on Medicare?.....Yes No**
   If yes, Medicare Coordination of Benefits (COB) should be contacted for primary coverage. COBRA should be dropped, as they are NOT a secondary to Medicare.
3. **Is it your understanding that traditional Medicare Part B is your primary insurance coverage for outpatient services?..... Yes No**
4. **Are you currently employed by company employing more than 20 employees?..... Yes No**
   If yes, please answer the following
   a. Does your current employer offer group health insurance?**..... Yes No**
   b. Are you covered by your employer's group health insurance? **..... Yes No**
   c. Your employer _____
5. **Is your spouse or other family member currently employed by a company with more than 20 employees? ..... Yes No**
   If yes, please answer the following
   a. Does your spouse's current employer offer group health insurance?**..... Yes No**
   b. Are you covered by this employer's group health insurance?**..... Yes No**
   c. Your spouse's employer _____
6. **Do you or your spouse belong to a union?..... Yes No**
   If yes, do you have coverage through a union health plan?..... **Yes No**
7. **Does the problem you are seeking treatment for relate to any of the following:**
   a. Injury or illness sustained while at work?..... **Yes No**
   b. Injury or illness resulting from an automobile accident?..... **Yes No**
   ****** If yes, we do not file to Worker's Comp, Third Party Liability, or Personal Injury Protection plans******
8. **Are you entitled to receive benefits for medical care through the Veterans Administration? ..... Yes No**
   ****** If yes, we will only file to Medicare and you will be responsible for the patient portion at the time of service**
9. **Is your Medicare entitlement due to End Stage Renal Disease? ..... Yes No**
   If yes, what is your Medicare effective date: _____
10. **Is your Medicare entitlement due to disability?..... Yes No**
11. **Are your receiving care from a Home Health Agency? ..... Yes No**
    If yes, what is the name of the agency: _____
12. **Do you reside in a Skilled Nursing Facility or currently being treated a Short Term Rehabilitation facility? ……..Yes No**
    If yes, what is the name of the facility: _____
13. **Do you have a supplemental or secondary insurance?.....Yes No**
    If yes, what is the name of the insurance _____
14. **Do you have Medicaid?.....Yes No**
    ** If yes, we are not contracted with Medicaid and you will be responsible for the patient portion at the time of service**
15. **If you are a diabetic, have you received a pair of diabetic shoes this year? …….Yes No**

NOTE: If you have answered "Yes" to any of the questions numbered 4 - 10, it is possible that Medicare is not your primary insurance. It is imperative that Medicare is aware of any of these situations and is notified immediately if your status changes. We are not able to update this information with Medicare for you. Please contact Medicare as soon as possible at (800) 999-1118. If the information that Medicare has on file for you is not correct, they will not pay your medical claims and you will be financially responsible for the entire billed amount.

I do hereby attest that the information provide on this Medicare Screening form is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Foot and Ankle Associates immediately of any changes to the above information and annually upon the office's request.

_____ _____ _____

Print Name of Patient Legal Authorized Representative Signature Date

IF # 4 -10 are answered yes – give copy to verification clerk. (MSP) If # 11 - 12 are yes – give copy to check out to update benefit note. (COBRA)
Updated 1/2011