**MEDICARE PAYMENT INFORMATION SHEET**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Alt #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Place of work**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Insured:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name exactly as on card:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this Medicare (**choose one) HMO\_\_\_\_ Straight Medicare\_\_\_\_\_

Is there an insurance that is primary to Medicare? Y N // Are you a Veteran? Y N //

Is your condition related to Employment, Auto accident, Other accident? Y N //

Do you have Medi-gap, Group Health Plan Y N (# employees\_\_\_\_, is it for disability Y N //)

ESRD or black lung? Y N // Are you (circle): Single Married Other

Are you (circle) Employed Full time student Part time student // Do you have Medi-Cal? Y N.

**Secondary insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Billing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name exactly as on card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; ID #:\_\_\_\_\_\_\_\_\_\_\_\_; Grp #\_\_\_\_\_\_\_\_\_

**BILLING MEDICARE**:

Therapy In Your Home – OT, PT, ST is a Medicare Provider of **OUT PATIENT** services which we provide IN THE HOME. These are NOT Home Health Services. If you receive ANY home health during our visits you will need to pay for our visits yourself. Medicare will not pay. Tell us immediately if you receive a visit from a Home Health Agency.

- If you qualify for Home Health, under Medicare part A, use those services first.

- There is a limit on the amount of Outpatient services Medicare will cover.

- Medicare will pay for 80% of allowed amount, and bill your secondary IF they know who the secondary is. Otherwise you are responsible for the 20% even if you have Medi-Cal unless your are QMB.

**Referring MD and Specialty:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAX** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address of Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other MD and Specialty**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAX** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address of Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Information We Need: (Please submit as directed above.)**

1. Prior therapy this year: # Out Patient visits: PT\_\_\_\_\_ OT\_\_\_\_\_\_ ST\_\_\_\_\_

2. Dates of Any Home Health Agency care: \_\_\_\_\_\_\_\_\_\_\_\_\_ Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Prescription: Please ask your doctor to **fax it to 877-334-0714**.

4. Medication list and update us on all changes

5. ABN (Advance Beneficiary Notice), if needed

**I agree to the Rights and Responsibilities, HIPPA document on website, and to pay for services:**

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***DATE:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8-31-19