**MEDICARE PAYMENT INFORMATION SHEET**

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

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

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

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

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

**Email address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

**Is this Medicare (**choose one) HMO\_\_\_\_ PPO\_\_\_\_ 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 qualify for Home Health, under Medicare part A, use those services first.

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

- Medicare will pay for 80% of allowed amount.

- We will bill Medicare and they will bill your secondary insurance.

- Keep track of your Medicare payments on-line at MyMedicare.gov.

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