Attention Medicare Patients with other Health Insurance or coverage:

If you have Medicare and other health insurance or coverage, it is important that we work together to identify which coverage should be billed first. To ensure claims for the services you receive from Richmond Family Medicine are processed efficiently, please review the following questions:

(1) Are you 65 or older and covered by a group health plan because you or your spouse is still working?

(2) Are you disabled and covered by a large group health plan from your work, or from a family member that is working?

(3) Do you have End Stage Renal Disease and group health plan or COBRA coverage?

(4) Have you been in an accident where no-fault or liability insurance is involved?

(5) Do you have black lung disease and are covered under the Federal Black Lung program?

If you have answered **yes** to any of these questions, please complete the following questionnaire. If you have any questions, a member of our office staff as we can provide you with a questionnaire to properly determine your coordination of benefits.

ATTENTION ALL MEDICARE PATIENTS

Effective, January 1, 2016, you are responsible for an annual $166.00 deductible. (Medicare will only pay for services after expenses exceed $166.00).

Medicare will pay 80% of the allowable charges. You are responsible for the remaining 20%. If you have secondary insurance coverage and provide us with that information, we will bill your secondary insurance as a courtesy for you. If you do not have secondary coverage or your secondary coverage fails to pay for your services, you are responsible for the payment of the 20%.

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient Name: _____ **Account #:** _____

Responses Section I

☐ Yes ☐ No 1. Are you currently receiving <u>any</u> Home Health Services (including nursing, bathing or dressing, injections or respiratory services)?

☐ Yes ☐ No 2. Are you covered under a Medicare Part C (Medicare Advantage/Medicare+Choice) program? If YES, enter the name of the health plan:
_____

☐ Yes ☐ No 3. Was your illness or injury due to a <u>work-related</u> accident or condition?
If YES, enter the date of illness or injury: _____

☐ Yes ☐ No 4. Was your illness or injury due to a <u>non-work-related</u> accident?
If YES, enter the date of illness or injury: _____
If NO, enter your retirement date: _____

☐ Yes ☐ No 5. If you are entitled to Medicare based upon Age or Disability, are you currently employed?
If YES, provide your employer's information on the Patient Registration form
If NO, enter your retirement date: _____ ☐ Never employed

☐ Yes ☐ No 6. Do you have a spouse who is currently employed?
If YES, provide your spouse's employer's information on the Patient Registration form
If NO, enter your spouse's retirement date: _____ ☐ Never employed

☐ Yes ☐ No 7. Do you have group health plan coverage based upon your own or your spouse's employment?
If YES, enter your and/or your spouse's group health plan information in Section II

☐ Yes ☐ No 8. Are you entitled to Medicare due to End Stage Renal Disease (ESRD)?
If YES, enter the date of the kidney transplant: _____ ☐ No Transplant
If YES, enter date that dialysis began: _____ ☐ No Dialysis

☐ Yes ☐ No 9. Are you receiving Black Lung (BL) Benefits?
If YES, enter date benefits began: _____

Section II (Please provide us with your insurance card.)

Type of Insurance Coverage: ☐ Worker's Compensation ☐ No-fault, Auto or Liability ☐ Group Health Plan

Insurance Name: _____
Street Address: _____
City, State, ZIP: _____
Phone Number: _____
Policy Number: _____
Group Number: _____
Name of Policy Holder: _____
If group health plan, approximate # of employees: ☐ 1-19 ☐ 20-99 ☐ 100 or more

I certify that all of the information provided herein is true and correct.

_____

Signature of Patient/Representative **Date**

Medicare Financial Responsibility Disclosure

Thank you for choosing our clinic for your therapy needs. As a Medicare provider, we are required to inform you about your responsibilities as a Medicare beneficiary. Please read this notice carefully. If you have any questions, please contact one of our staff.

Patient Financial Responsibilities

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If Medicare denies charges because you have other insurance that is considered your primary insurance, you will be responsible for all incurred charges. It is your responsibility to inform us of any other insurance coverage that you may have.

Medicare as the Secondary Payer

There may be situations where Medicare is not your primary payer. Medicare law requires that we investigate all possible situations where other insurance, besides Medicare, might be the primary payer.

If any of the following items below apply to you, Medicare may not be the primary payer.

- Black Lung Benefits
- Veterans Administration (VA)
- Workers' Compensation
- Automobile Accident, No Fault or Other Liability Insurance
- Employer Group Health Plan (EGHP)
- End Stage Renal Disease Benefits (ESRD)
- Disabled and covered by a Large Group Health Plan (LGHP)

Medicare Part C (Medicare Advantage or Medicare+Choice)

Please notify one of our office staff if your Medicare coverage is Medicare Part C Coverage. Medicare Part C Coverage is also known as Medicare Advantage Program or Medicare+Choice. Medicare Part C coverage is purchased and administered through a private insurance company and includes HMO, PPO, PFFS, PSO and MSA products. Medicare Part C beneficiaries pay premiums that typically provide them with more coverage than the "traditional Medicare programs" (Medicare Part A and B) at a lower cost. Failure to provide us with this information may result in non-payment of your health claims.

Medicare Home Health Services

Medicare has required that patients receiving certain Home Health Services must have outpatient therapy services consolidated with the Home Health Agency. Failure to provide us with this information may result in non-payment of your health claims by Medicare.

You will be asked to complete a **Medicare Secondary Payer Questionnaire** to ensure that we properly determine whether Medicare is the Primary or Secondary Payer in your case or if Medicare will not allow payment for our services.

Thank you for reviewing this important information regarding your Medicare coverage. If you have any questions, please contact a member of our office staff.