

Medicare Patient Screening

Updated 7/2006

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
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
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
8. **Are you entitled to receive benefits for medical care through the Veterans Administration?** Yes No
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 you 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?** Yes No
If yes, what is the name of the facility: _____

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.

By signing below, I certify that the information that I have provided is true and complete and that I have updated this information with the Medicare Coordination of Benefits (COB) Contractor.

Patient/Rep Name: _____ Signature: _____ Date: _____

FAANT Rep Signature: _____

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)