Inland Dermatology Skin Care Center

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Medicare Patient Form

Patient Name:_____ **Today's Date:**__/__/__

Date of Birth:__/__/__ **Sex: Male**____ **Female**____ **SS#:**_____

Address:_____ **City:**_____ **State:**____ **Zip Code:**_____

Home Phone: ( ) _____ **Work Phone:** ( ) _____

Cell Phone: ( ) _____

Please Print Your Name as it appears on your Medicaid Card:

Please enter you Medicare Health Insurance Claim Number *as it appears on your card. This is usually you Social Security Number. Be sure to include the letter after the nine-digit number.*
It is important that we have both the numbers and the letter.

Medicare Id #: _____

Referring Physician: *Name:*_____ *Phone Number:* ( ) _____

Emergency Contact: _____

Name of Spouse or Close Relative or Friend:_____

Phone Number: ( ) _____

Please Sign Below so that we may have your Medicare Authorization on File

Date:__/__/__ **Signature:** _____

Payment Policy

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $100.00 deductible and paying for the 20% copayment. We do file with Secondary / supplemental carriers. However, in the event that the secondary does not pay within 60days, patient will be balance billed.

Note: *If you recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.*

Please read each of the following and answer as they apply to you.

If it does apply to you, please check YES. If it does NOT apply to you, please check NO

YES	NO	
_____	_____	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
_____	_____	Are you covered by an HMO/PPO which makes Medicare secondary?
_____	_____	Are you coming to this office for an illness or accident that has been covered or is authorized for coverage for the VA (Veteran's Administration)?
_____	_____	Do you or your spouse work and have coverage through the insurance at your job?
_____	_____	Are you eligible for any benefits under the Federal Black Lung Program?
_____	_____	Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?
_____	_____	Are you coming to this office due to Medicare Disability Coverage?
_____	_____	Are you covered by the Federal End Stage Renal Disease Program?
_____	_____	Are you presently receiving Workers' Compensation?
_____	_____	Is the illness or injury you are coming to this office for a result of work-related causes?
_____	_____	Do you have medical assistance through Welfare or State-Aid?

If you answered YES to ANY of the above questions, please explain:_____

_____

Policy Number:_____ **Group Number:** _____

Name of Policy Holder (Insured):_____ **Male:**_____ **Female:**____

Date of Birth:___/___/___ **Policy Holder (Insured) SS#:**_____

Supplemental Insurance

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (Supplemental Medicare Insurance Information). Please fill out below if you are covered by a plan which covers the 20% **NOT** covered by Medicare.

Policy Number:_____ **Group Number:**_____

Name of Policy Holder (Insured):_____ **Male:**_____ **Female:**____

Date of Birth: / / Policy Holder (Insured) SS#:

Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP Carrier any information needed to determine these benefits or the benefits payable for related services.

Date:___/___/___ **Signature:**_____