Name: ____________________ Date: ____________

Account #: ____________________

| Name of Medication | | Dosage | Frequency | Route Taken please mark X | | | |
|---|---|---|---|---|---|---|---|
| | | | | By Mouth | IM | IV | Other |
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |
| 11 | | | | | | | |
| 12 | | | | | | | |
| 13 | | | | | | | |
| 14 | | | | | | | |
| 15 | | | | | | | |

Patient refused: ____________ Date: ____________

(Please initial)

# Did You Know Before You Go? Medicare Part B

*Patient is to fill out the first two sections, the Employee is to fill out the "Your benefits" section on Traditional MC patients. Patient is to sign the form and the form is scanned into the patients EMR.*

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Patient Name: ______________________________ DOB: ______________

Medicare Policy#: ______________________________ Dx: ______________________

Part B effective date: ________________ DOS: ______________ Acct#: ________________

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**Patient portion - Please Mark Appropriately:**

Are you currently receiving:

| | | |
|---|---|---|
| Home Health | Yes | No |
| Hospice | Yes | No |

Or residing in:

| | | |
|---|---|---|
| Skilled Nursing Facility | Yes | No |
| Intermediate Care Facility | Yes | No |

Have you been seen for therapy at another facility at any time this year? Yes No

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**Care Coordinator Portion - Your benefits:**

- The annual deductible is $203.00; the remaining deductible amount is $ ____________
- Medicare Primary: YES NO
  - Medicare will pay 80%; you will be billed 20% of the allowable.
- Your therapy benefits allowed: $2110.00 therapy threshold PT/SPT combined for 2021
  $2110.00 therapy threshold OT for 2021
  - Medicare Therapy benefits used this year: PT: ______________ OT: ______________
- Currently receiving Home Health: YES NO
- Special instructions ______________________________________________

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If your deductible has not been met, you will be responsible for the outstanding charges in addition to any other co-insurance and/or co-pays. Medicare only pays for covered benefits; ALL BENEFITS ARE SUBJECT TO MEDICAL NECESSITY. This verification is performed by a Confluent Health staff member as a courtesy and DOES NOT represent a guarantee of payment by your insurance company.

I fully understand that I am financially responsible for any services not covered by my insurance.

______________________________________________ ________________

**Patient or Authorized Representative Signature** **Date**

______________________________________________

Print name and relationship to the patient

Verified By - CC Initials: Date:

ProRehab

# Medicare Secondary Payer (MSP) Form

Patient Name: ______________________________________________Acct#: ______________________

*Medicare requires us to identify if Medicare is the primary or secondary payer, please answer all the required questions below.*

1. Do you receive Veteran's benefits? ☐ Yes ☐ No

2. Are the services to be paid by a government research program? ☐ Yes ☐ No

3. Are you receiving benefits under the Black Lung Program? ☐ Yes ☐ No
   If yes, date benefits began ______________________
   *Black lung is primary payer only for claims related to black lung*

4. Was this injury/illness due to a work-related accident/condition? ☐ Yes ☐ No
   If yes, date of injury/illness _________________________; *Please provide the WC Information*

5. Was the injury/illness related to an automobile accident? ☐ Yes ☐ No
   If yes, date of accident _______________________; *Please provide the MVA Information*

6. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? ☐ Yes ☐ No *If yes, please provide the Attorney's information*

*(If answered YES to any of the questions above Medicare is the secondary payer)*

7. Are you entitled to Medicare based on:
   ☐ Age (65 & over) - go to question 8
   ☐ Disability - go to question 9
   ☐ End Stage Renal Disease - **if yes to both questions below - group health plan (GHP) is primary**
   1. Do you have group health plan coverage? ☐ Yes ☐ No
   2. Are you within the 30-month coordination period? ☐ Yes ☐ No

8. Are you currently employed? ☐ Yes ☐ No - Date of retirement _________________________
   a. Is your spouse employed? ☐ Yes ☐ No - Date of retirement __________________________
   b. Do you have a GHP as primary coverage based on your own or spouse's current employment?
      ☐ Yes ☐ No
   c. Does the employer that sponsors the GHP employ <u>20 or more</u> employees? ☐ Yes ☐ No

**If you OR your spouse is currently employed and answered YES to BOTH b and c, GHP is primary, please provide your insurance information.**

9. Are you currently employed? ☐ Yes ☐ No Date of retirement ________________________
   a. Is your spouse/family member employed? ☐ Yes ☐ No
   b. Do you have a GHP as primary coverage based on your own or spouse's or family member's current employment? ☐ Yes ☐ No
   c. If you have group health coverage, does employer that sponsors the GHP employ <u>over 100 or more</u> employees? ☐ Yes ☐ No

**If you have GHP coverage based on your or spouse's or family member's current employment and answered YES to BOTH b and c, GHP is primary, please provide your insurance information.**

_____________________________________________________________________________

Signature of Patient/Representative Date

_____________________________________________________________________________

Relationship to patient