ProRehab

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)

ProRehab

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.

Patient Name: _____ DOB: _____

Medicare Policy#: _____ Dx: _____

Part B effective date: _____ DOS: _____ Acct#: _____

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 $233.00; 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: $2150.00 therapy threshold PT/SPT combined for 2022 ☐ $2150.00 therapy threshold OT for 2022
  - Medicare Therapy benefits used this year: PT: _____ OT: _____
- Currently receiving Home Health: YES NO
- Special instructions _____

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 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/guardian signature: _____ **Date**:_____

Question about your bills, statements or claims? Just give us a call at 812.759.7476, we can help!

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.

Part I - INFORMATION ABOUT BLACK LUNG, WORKERS' COMPENSATION (WC), NO-FAULT AND LIABILITY

1. 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.
2. Was this injury/illness due to a work-related accident/condition? ☐ Yes ☐ No
   If yes, date of injury/illness _____; *Please provide the WC information.*
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile?
   ☐ Yes ☐ No
   If yes, date of accident _____
   Is no-fault insurance available? ☐ Yes ☐ No
   If yes, please provide no-fault insurance information.
4. 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 and you do NOT need to fill out Part II or III

Part II - INFORMATION ABOUT MEDICARE ENTITLEMENT AND GROUP HEALTH PLANS

1. Are you entitled to Medicare based on:
   ☐ Age (65 & older) – go to question #2
   ☐ Disability – go to question #2
   ☐ End Stage Renal Disease— Go to Part III
2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? ☐ Yes ☐ No
   If yes, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage:
   ☐ Aged (65 & over) - If you are aged and there are 20 or more employees, your GHP is primary.
   ☐ Disability - If you are disabled and your employer, spouse, or family member employer, has 100 or more employees, your GHP is primary.

Part III - INFORMATION ABOUT THE PATIENT IF ESRD (End Stage Renal Disease) MEDICARE ENTITLEMENT APPLIES

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.

1. Do you have group health plan coverage? ☐ Yes ☐ No
2. Are you within the 30-month coordination period? ☐ Yes ☐ No
   If yes to both questions, GHP is primary during the 30-month coordination period.

_____ _____
Signature of Patient/Representative Date

Relationship to patient: _____