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)

MEDICARE SECONDARY PAYER (MSP) FORM

Name:

Part I

1. Are you receiving benefits under the Black Lung Program? If yes, date benefits began: _____	☐ Yes	☐ No
2. Was this injury/illness due to a work-relatedaccident/condition? If yes, date of injury/illness: _____	☐ Yes	☐ No
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? If yes, date of accident: _____ Is no-fault insurance available?	☐ Yes ☐ Yes	☐ No ☐ No
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? If yes, please provide: Attorney's Name: _____ Address: _____ Phone Number: _____ If you answered **NO** to all questions, go to Part II. If you answered **YES** to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information.	☐ Yes	☐ No

Part II

1. Are you entitled to Medicare based on? *Check the box that applies*
   - ☐ Age (65 & older) – go to question #2
   - ☐ Disability – go to question #2
   - ☐ End Stage – 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? If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage:	☐ Yes	☐ No
☐ Aged (65 & over) - If you are aged and there are 20 or more employees, <u>your GHP is primary.</u>	☐ Yes	☐ No
☐ Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, <u>your GHP is primary</u>.	☐ Yes	☐ No

Part III

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

Please provide a copy of your group health insurance if determined to be primary.

Signature of Patient/Representative:	Date:
Relationship to Patient:	

Did You Know Before You Go? Medicare Part B

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

Your benefits:

- The annual deductible is $240.00; 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: ☐ $2330.00 therapy threshold PT/SPT combined for 2024
  ☐ $2330.00 therapy threshold OT for 2024
  - 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 of benefits 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, we can help!

Verified By: Date: