# Medicare Patient Information

AV Dermatology
ph: (661) 949-0004 fax: (661) 949-5286

**Patient Name:** ______________________________________ SS#:________________________________

Date of Birth: ______/______/______ Sex: ☐ Female ☐ Male email: __________________________

Address: ______________________________________________________________
Street

__________________________ _______________________ ___________
City State Zip Code

( )________________ ( )________________ ( )________________
Home Phone Work Phone Cell Phone

______________________________________________________________________________

**Please print your name as it appears on your Medicare Card**

______________________________________________________________________________

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

**Referred by**: ☐ Insurance ☐ Our Website ☐ Google ☐ Newspaper ☐ TV/Radio

☐ Doctor Name: __________________________ ☐ Other__________________________

Phone: ( )____________________

**Emergency Contact**
Name of Spouse or Close relative/friend: ____________________________________________
(In Case of Emergency)

Phone#: ( )____________________

## Please Sign So We May Have Your Medicare Authorization on File

I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

**Date:______/______/______ Signature:** ______________________________________________________

## Payment Policy

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

**Note:** If you have 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.

**-Continued-**

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 from 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 the 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: ______________________________________________
Explain

Policy Number: ______________________________ Group Number: ______________________________________

Name of Policy Holder (insured):___________________________________ ☐ Male ☐ Female

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

## Supplemental (MEDIGAP) 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. (MEDIGAP Coverage)

Name of Insurance Company: ____________________________________________________________

Policy Number: __________________________________ Group Number: ___________________________

Name 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 authoriaza 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: ___________________________________________________________