

## 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 deductible and copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

***Are you in a Medicare HMO or other Senior Medicare Plan?***  Yes  No

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.

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name Policy Holder (Insured): \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Supplemental Insurance or Medicare Advantage Plans

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.

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name Policy Holder (Insured): \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_

***Please present your Medicare and insurance card(s) and a photo ID to the receptionist along with this completed form. Thank you.***