MEDICARE PART B SIGNATURE AUTHORIZATION

West Orange Orthopaedics & Sports Medicine

For Services Starting Date: _____

Circle the appropriate answer

Questions to determine Medicare status	Medicare is Primary if YES	Medicare is Secondary if YES
I am 65 or older - not employed - spouse not employed - no other insurance unless it is a Medicare supplement policy.	YES	NO
I am 65 or older - employed or my spouse is employed and I have group health insurance through that employer and that employer has more than 20 employees.	NO	YES
I am under 65 - Disabled - not employed - spouse not employed - no other insurance unless it is a Medicare supplement policy. ***DISABILITY DUE TO ILLNESS OF:*** _____	YES	NO
I am under 65 - Disabled - employed or my spouse is employed and I have group health insurance through that employer and that employer has more than 20 employees. ***DISABILITY DUE TO ILLNESS OF:*** _____	NO	YES
I have medical coverage from the Veterans Administration (VA).	NO	YES
I have medical coverage from the Public Health Service (PHS) or other Federal Agency.	NO	YES
My injury was related to an auto accident, a work comp accident or a liability accident and I have an open claim and guarantee of medical benefits from that carrier.	NO	YES

Circle the appropriate answer

YES	NO	I have signed up for a Medicare HMO or Medicare Replacement policy. I no longer file my medical claims to Medicare Part B. The primary insurance is determined by the questions above.
YES	NO	I have signed up for a Medicare Part A/Hospitalization only. *If you or your spouse has an Employer/Retiree Policy, you may penalized for not purchasing Medicare Part B.

YES	NO	I currently reside in a Skilled Nursing Facility/Rehabilitation Center (SNF). If yes, please list the name of the SNF _____ The SNF is responsible for primary payment of all x-rays (TC) and casting materials.

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration, its intermediaries, carriers, or the billing agent of West Orange Orthopaedics, which is 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. My physician advised me that based on Medicare guidelines these services may be denied. Therefore, I acknowledge and accept liability for payment of these services. I request that payment of authorized Medigap/Crossover benefits be made on my behalf to West Orange Orthopaedics. I authorize any holder of information about me to be released to the questioning party if needed to determine these benefits or the benefits payable for related services.

Patients Signature:_____

Print Patients Name As Listed on Medicare ID Card: _____

Medicare ID#: _____Medicare Part B Effective Date As Printed on Medicare ID Card: _____