Cardiology & Arrhythmia Consultants, Inc.
Medicare

Name: _____

Medicare or Medicare Replacement Plan No: _____ Medicare Effective Date: _____

ATTENTION MEDICARE RECIPIENTS

Medicare has put forth guidelines for Health Care Providers to follow in determining whether services rendered are to be billed as a primary or secondary to Medicare. To ensure compliance with these guidelines from Medicare, we have included a brief questionnaire as part of your registration information packet. We ask that you complete the brief questionnaire below and return this form to the front desk staff. This questionnaire will be kept on file in your chart and reviewed for any changes. Thank you for your cooperation.

MEDIGAP (Secondary) BENEFIT AUTHORIZATION

I request that payment of authorized Medigap benefits be made to me or on my behalf to Cardiology & Arrhythmia Consultants, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information
(name of secondary policy)
needed to determine these benefits or the benefits payable for related services.

MEDICARE BILLING QUESTIONNAIRE

1) Do you have any Medical Insurance other than Medicare? YES ☐ NO ☐
If yes, what Insurance are you covered by?

Insurance Name: _____ Group / Plan No.: _____

Name of Policyholder: _____ Relationship to Policyholder: _____

2) Are you / your spouse working / employed and receiving employee health insurance benefits? YES ☐ NO ☐

3) Is your Medicare eligibility based solely on a disability? YES ☐ NO ☐
If yes, please specify the date the disability began: _____

4) Is your Medicare eligibility based solely on End Stage Renal Disease? YES ☐ NO ☐
If yes, please specify the date dialysis or disability began: _____

PATIENT'S SIGNATURE	DATE

FOLLOW- UP REVIEW (OFFICE USE ONLY)

Initial	Date	Initial	Date	Initial	Date	Initial	Date
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____