ARYA FOOT & ANKLE

MEDICARE PATIENT SCREENING

Medicare Patient Screening

Obtaining complete and accurate information from the patient is essential to ensuring the accuracy of a Medicare claim. Please complete the following questions in order to assist our office in filing your medical claims completely and accurately. To allow for greater access of care, Dr. Arya is available by appointment during posted hours and some weekends.

Patient Name (as it appears on your Medicare ID card): _____

If you go by something other than the name on your Medicare card, please note that our records must match the name on your Medicare card.

Date of Birth: _____ Medicare Claim #: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:	YES	NO
1. Are you enrolled in a Medicare HMO, such as Secure Horizon?	❑	❑
Please be aware that we are not providers for any Medicare HMO plans.		
2. Are you enrolled in COBRA while on Medicare?	❑	❑
If yes, Medicare Coordination of Benefits (COB) should be contacted for primary coverage. COBRA should be dropped, as they are NOT a secondary to Medicare.		
3. Is it your understanding that traditional Medicare Part B is your primary insurance coverage for outpatient services?	❑	❑
4. Are you currently employed by a company employing more than 20 employees?	❑	❑
If yes, please answer the following:		
a. Does your current employer offer group health insurance?	❑	❑
b. Are you covered by your employer's group health insurance?	❑	❑
c. Your employer: _____		
5. Is your spouse or other family member currently employed by a company with more than 20 employees?	❑	❑
If yes, please answer the following:		
a. Does your spouse's current employer offer group health insurance?	❑	❑
b. Are you covered by this employer's group health insurance?	❑	❑
c. Your spouse's employer: _____		
6. Do you or your spouse belong to a union?	❑	❑
If yes, do you have coverage through a union health plan?	❑	❑
7. Does the problem you are seeking treatment for relate to any of the following:		
a. Injury or illness sustained while at work?	❑	❑
b. Injury or illness resulting from an automobile accident?	❑	❑
If yes, we do not file to Worker's Comp, Third Party Liability, or Personal Injury Protection plans.		

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		YES	NO
8.	**Are you entitled to receive benefits for medical care through the Veterans Administration?** If yes, we will only file to Medicare, and you will be responsible for the patient portion at the time of service.	❑	❑
9.	**Is your Medicare entitlement due to End Stage Renal Disease?** If yes, what is your Medicare effective date: _____	❑	❑
10.	**Is your Medicare entitlement due to disability?**	❑	❑
11.	**Are your receiving care from a Home Health Agency?** If yes, what is the name of the agency: _____	❑	❑
12.	**Do you reside in a Skilled Nursing Facility or are you currently being treated at a Short Term Rehabilitation Facility?** If yes, what is the name of the facility: _____	❑	❑
13.	**Do you have a supplemental or secondary insurance?** If yes, what is the name of the insurance: _____	❑	❑
14.	**Do you have Medicaid?** If yes, we are not contracted with Medicaid, and you will be responsible for the patient portion at the time of service.	❑	❑
15.	**If you are a diabetic, have you received a pair of diabetic shoes this year?**	❑	❑

NOTE: If you have answered "Yes" to any of the questions numbered 4–10, it is possible that Medicare is not your primary insurance. It is imperative that Medicare is aware of any of these situations and is notified immediately if your status changes. We are not able to update this information with Medicare for you. Please contact Medicare as soon as possible at (800) 999-1118. If the information that Medicare has on file for you is not correct, they will not pay your medical claims, and you will be financially responsible for the entire billed amount.

I do hereby attest that the information provide on this Medicare Screening form is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Arya Foot & Ankle immediately of any changes to the above information and annually upon the office's request.

Patient or Legal Authorized Representative:

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

IF # 4–10 are answered yes, give copy to verification clerk. (MSP) If # 11–12 are yes, give copy to check out to update benefit note. (COBRA) Updated 1/2011

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