Rupp Urology Clinic

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Medicare Lifetime Signature on File

One Time Authorization: I request that payment of authorized Medicare benefits be made to Rupp Urology Clinic for any services furnished me by Dr. Rupp. I authorize any holder of medical information about me to be released to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Our office accepts assignments on fees for Medicare eligible patients. If you have Medicare Part B Coverage we will file any claims for you at no charge. If you have not met your deductible for the year, the charges will be applied to your deductible. You will receive an explanation of benefits in the mail that will inform you have this amount. You are responsible for any Medicare approved charges not paid by Medicare or supplemental insurance.

Signature: _____ Date: _____

Medicare Secondary Payer Questionnaire

(To Be Completed For ALL Medicare Patients)

Patient Name: _____

Date of Service: _____

1. Is the patient a Veteran? Yes No
    a. Did the VA refer you here for treatment? Yes No
    b. Does the patient have a VA "fee basis ID card"? Yes No
2. Do you have a Federal Black Lung? Yes No
3. Is this medical condition die to an accident of any kind? Yes No
    a. If yes, was it: (Please circle response. If other, please explain)
        i. Work Related
        ii. Auto
        iii. Injured in own home
        iv. Other: _____
        _____
4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (Not retiree coverage) Yes No