

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____
 Social Security # _____ - _____ - _____ Sex M F Home # () _____ Work # () _____
 Address _____
 City, State _____ Zip Code _____
 Marital Status: *Single Married Divorced Widowed Separated Other*
 Employer Name _____ Address: _____
 Referring Physician _____ Phone: () _____
 In Case of Emergency, Contact _____ Phone () _____
 Please let us know with whom we may discuss your care. _____
 Name of Pharmacy: _____ Pharmacy Phone # () _____

Insured Information

Insured Party _____ Social Security # _____
 Date of Birth _____ Sex M F
 Insured Party Address (if different from above) _____
 City, State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Ext. _____
 Employer Name _____ Address _____
 City, State _____ Zip Code _____ Relationship to Insured _____

Insurance

Primary Insurance Company _____
 Address _____
 Group # _____ Policy # _____
 Subscriber/Policy holder (as listed on card) _____
 Patient's Relationship to Subscriber/Policyholder Self _____ Spouse _____ Child _____ Other _____
 Secondary Insurance Company _____
 Address _____
 Group # _____ Policy # _____
 Subscriber/Policy holder (as listed on card) _____
 Patient's Relationship to Subscriber/Policyholder Self _____ Spouse _____ Child _____ Other _____

IF YOUR CARE IS A RESULT OF AN AUTO ACCIDENT OR WORKMEN'S COMPENSATION, PLEASE NOTIFY US

CONSENT FOR TREATMENT / RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

I consent to the treatment necessary for the care of the patient indicated on this form. I hereby authorize Center for Infectious Diseases, P.A. to furnish information to my physician and insurance carriers concerning my illness (including mental disorders, drug or alcohol abuse and sexually transmitted diseases) and treatment. I assign to the physician(s) all payments for medical services rendered to me, if I have not already paid for such services.

I understand I am financially responsible for charges. In addition, understand I am responsible for charges not covered by insurance plans in which Center for Infectious Diseases, P.A. participates and any applicable co-pays and deductibles.

SIGNATURE: _____ **DATE:** _____

Patient or Guardian

Determination of Primary Insurance When Patient is Entitled to Medicare Part B

Medicare will be primary when a patient with Medicare part B has no other insurance, has Medigap Supplemental insurance, has Medicaid in addition to Medicare, and/or is in one of the following situations:

Please place a checkmark next to **ONE** statement of the following that is true for you:

- _____ 1 I am 65 or over, fully retired, and my spouse is also fully retired. Medicare is primary. Date of Retirement _____ Date of Spouse’s Retirement _____
- _____ 2 I am 65 or over, fully retired and my spouse works for a company with LESS than 20 employees. Medicare is primary for me.
- _____ 3 I am 65 or over, and work full-time or part-time for a company with Less than 20 employees. Medicare is primary.
- _____ 4 I am under 65, am disabled, and I do not have primary coverage with a large Group Health Plan because I do not have nor does a family member have “current employment status”. Medicare is Primary.
- _____ 5 I am a Veteran entitled to Medicare, and I may choose either the VA or Medicare to be responsible for payment of services covered by both programs.
 - _____ A If I choose Medicare, Medicare is primary for me. It is not necessary to submit a claim to the VA for denial before sending to Medicare.
 - _____ B If I choose the VA, Medicare is secondary and All hospital services must be pre-authorized by the VA.

Medicare will be Secondary Payer for a Patient with Medicare Part B when:

- _____ 1 I am 65 or over, fully retired, and my spouse works for a company with MORE than 20 employees. Medicare is secondary for me.
- _____ 2 I am 65 or over and work full-time or part-time for a company with MORE than 20 employees. Medicare is secondary for me.
- _____ 3 I am under 65, disabled, and I have primary coverage through a large Group Health Plan. Medicare is secondary for me.
- _____ 4 I have End Stage Renal Disease. My Medicare coverage began _____. Medicare is secondary for me for the first 18 month or 30 month coordination period.
- _____ 5 I am entitled to Black Lung benefits. Medicare is secondary for me only for treatment of lung conditions caused by mining.
- _____ 6 I was injured in an accident. ___ Auto ___ Work ___ Home ___ Other
Detailed billing information will be requested separately. Medicare is second for me.

* “Current Employment Status” means that an individual is actively working as an employee, is the employer, or is associated with the employer in a business relationship.

CENTER FOR INFECTIOUS DISEASES, P.A.

Patient Registration

By completing this questionnaire and signing below, I acknowledge that CID has made a good faith effort to determine whether any other insurance is primary to any Medicare I may have.

Beneficiary's (PRINTED) Name

Date

Beneficiary's Signature