BodyBalance
physical therapy

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# MEDICARE PATIENT & PAYOR INFORMATION FORM

***All* Patients or Patients' Legal Representative, please complete all Sections**

## (1) Patient: (Full Legal Name or as on Insurance Card)

**Name:** ______________________________________________________________
Last First Initial Sr. Jr.

**Address:**____________________________________________________________
Street Apt# City State Zip Code

**Phone**: (_____) ______-________ (_____) ______-________ (_____) ______-________ (_____) ______-_________
Home Mobile Work Emergency

**Email:** __________________________________________

**Sex: M F** **Birthdate:** _____/_____/______ **S.S #** ______/______/_______

## (2) Condition to be treated in Physical Therapy:____________________________________________

Did this Condition Result in Surgery? No Yes If Yes Date of Surgery ____/____/____

Did this Condition Result from a Work Injury? No Yes If Yes Date of Accident ____/____/____

Have You Had PT Anywhere this Year? No Yes If Yes Where?_____________________________

Are You Currently Receiving Home Health? (i.e. any healthcare worker, aide assisting or doing something to or for you?) No Yes If Yes From Who?_______________________

Do You Live in a Nursing Home? No Yes If Yes What Is Its Name?
______________________

Are You Covered:

a. Under Black Lung Disease? No Yes
b. End Stage Renal Disease? No Yes
c. Large Group Insurance? No Yes If Yes Name/Group #___________________
d. Veterans Affairs No Yes

## (3) Patient's Doctor

**Referring Doctor**: ___________________________________

**Primary Doctor**:_____________________________________

**All Patients or Patients' Legal Representative Please Sign Section 8 on Page 3**

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## (4) Payor Information Primary:

**Primary Insurance Company: Medicare**

**Insured's Name:**________________________________________ **Patient ID #** _______________ **Group #** _________

**Regular Medicare:** **Yes** **No** **Rail Road Medicare:** **Yes** **No**

## (5) Payor Information Secondary/Supplemental Insurance Company: (If YES, please complete)

**Ins. Co. Name:** __________________________ **Insured's Name:** ______________________ **Ins. Ph#**_______________

**Insured is:** _____**Patient** _____**Spouse** _____**Parent**

**Patient ID #:** _______________**Group. #** _______________**Policy/Plan #:** _____________________________________

**Claims Mailing Address:**_____________________________________________________________________________

Street City State Zip Code

**Employer Name:** ______________________________________________ **Employer Phone # (      )** ______- _______

**Address:**

## (6) Employer Information (Please complete if the insured person's employer is the source of benefits)

**Employer Name:** ________________________________________________**Employer Phone # (      )** ______- _______

**Address:** ____________________________________________________________ _________________________

Street City State Zip Code

**Name of Employer Contact:** ____________________________________ **Contact's Phone # (      )** ______- _______

**All Patients or Patients' Legal Representative Please Sign Section 8 on Page 3**

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# MEDICARE PATIENT & PAYOR INFORMATION FORM

**(7) Payment Authorization:** ***(Initials required for all 3 statements)***

__________ **Assignment of Insurance Benefits**

Initials

**I authorize that the payment of my insurance benefits be made directly to Body Balance Physical Therapy for any services that are reimbursable by Medicare or any other insurance company my insurance company, if I have one.**

__________ **Guarantee of Payment**

Initials

**I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

__________ **Certification of Information**

Initials

**I certify that the information I have provided Body Balance Physical Therapy for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

**(8) Signature/ Date:**

______________________________________________ ____________________

**Patient or Legal Representative's Signature** **Today's Date**

**All Patients or Patients' Legal Representative Please Sign Section 8 on Page 3**