



MIDWEST PHYSICAL THERAPY AND SPORTS CENTER BILLING INFORMATION

Moving you to wellness.

Please print clearly. To insure that the proper parties are billed- please answer the following questions and sign. Thank you!

Patient's name: \_\_\_\_\_

What will we be treating you for? \_\_\_\_\_

Have you received any other Physical Therapy or Speech Therapy this year? Yes [ ] No [ ] If yes, please list where you received treatment and approximate number of visits \_\_\_\_\_

MEDICARE SECONDARY PAYER QUESTIONNAIRE (TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

1. Are you a veteran? Yes [ ] No [ ]

If 'Yes' do you authorize us to bill the VA? Yes [ ] No [ ]

Did the VA refer you here for treatment? Yes [ ] No [ ]

Do you have a VA "fee basis ID Card? Yes [ ] No [ ]

2. Do you have a federal black lung card? Yes [ ] No [ ]

Submit claims to: Federal Black Lung Program P.O. Box 740 Lanham, Maryland 20706

3. Is this medical condition due to an accident of any kind? Yes [ ] No [ ]

If yes, was it: Work Related [ ] Auto accident [ ] Injured at home [ ] Other [ ]

If 'Other' please explain: \_\_\_\_\_

Do you have an attorney working on your case? Yes [ ] No [ ]

Do you know of any insurance we should bill before Medicare? Example: Home owners insurance or a business's liability insurance. Yes [ ] No [ ]

4. Are you covered by an employer's health insurance plan through your own employment or that of a family member? (Not retiree coverage) Yes [ ] No [ ]

If 'Yes' insurance name: \_\_\_\_\_ Card copied [ ]

Is Medicare your Primary [ ] Secondary [ ] Other \_\_\_\_\_

Medicare card copied [ ] All other insurance cards copied [ ]

Have you been receiving home health care? Yes [ ] Date of last visit \_\_\_\_ / \_\_\_\_ / \_\_\_\_ No [ ]

If 'Yes' has your doctor informed Medicare of your release? Yes [ ] No [ ] Unknown [ ]

Name of hospital or agency that provided the home health care: \_\_\_\_\_

NOTE: Medicare requires you to be under a Plan of Treatment which is coordinated by your physical therapist and certified by your physician. For this reason, we require that you have a prescription or referral from your physician for physical therapy. If we do not have a prescription and are unable to obtain physician certification for the Plan of Treatment, Medicare may deny payment and the full amount billed will become the responsibility of the patient. Medicare requires physician certification of the Plan of Treatment every 30 days.

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_