Duke Lightner Dermatology, CPDC Patient Label Here
Medicare MSPQ Form

*Name as it appears on your Medicare card:*_____ *Today's Date* _____/_____/_____

*Medicare Health ID Number as it appears on your card:*_____

(This is usually your social security number. Be sure to include the letter after the nine digit number. It is important that we have both number and letter.)

Do you reside in a nursing home/assisted living facility? [ ] yes [ ] no

*If yes, name of facility*_____

Does someone other than yourself make the decisions regarding your health care? [ ] yes [ ]yes, but only in emergencies [ ] no If yes, name of person/facility*_____

**This person must be present for every visit.*

Does someone other than yourself have Power of Attorney for you? [ ] yes [ ]yes, but only in emergencies [ ] no*

*If yes, name of person & their relationship to you*_____

** Your Power of Attorney must be present to sign your forms for you.*

*Please read each of the following and answer as they apply to you. If it does apply to you, please check **YES**. If it does not apply to you, please check **NO**.*

YES	*NO*	
_	_	*Have you recently joined a Medicare HMO or Medicare Advantage Plan?*
		If yes, identify: _____
_	_	*Are you on Medicare disability coverage?*
_	_	*Is this illness covered by the VA (Veteran's Administration)?*
_	_	*Are you eligible for benefits under the Federal Black Lung or End Stage Renal Disease Programs?*
_	_	*Is this illness related to an automobile accident? If yes, Date of accident:*_____
_	_	*Is this illness due to an injury at work? If yes, Date of injury:*_____
_	_	*Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job, which would make Medicare your secondary plan?*
_	_	*Are you covered by an HMO/PPO plan which makes Medicare secondary?*
_	_	*Are you receiving Medicaid?*

The information on this form is complete and accurate to the best of my ability.

Signature of Patient/Guardian/Power of Attorney *Date*

-OVER-

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare card Date / /

If you have a supplemental policy we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on supplemental card Date / /

*Our office does not file secondary claims for plans we do not participate in or are not MEDIGAP plans.