Medicare Verification Form

Patient Account #: ______________________

Provider Data

Provider NPI: ______________________

Provider PTAN: ______________________

Provider Tax ID or SS: ______________________

Section A - Patient Data

Patient Name on Card: ______________________

Patient's DOB: ______________ Patient's ID: ______________

Section B - Identify Coverage

Auto Accident? ◯Yes ◯No Work Injury? ◯Yes ◯No Personal Injury? ◯Yes ◯No

If any Yes responses above, Medicare is secondary. Use related Verification Form, such as PI or WC first and verify other insurance as primary.

Patient is working aged? ◯Yes ◯No Patient's spouse is working aged? ◯Yes ◯No

If any Yes responses above, Medicare may be secondary. If so, use Major Medical Insurance Verification Form to verify primary insurance.

Patient has Medicare Advantage Card (This is Part C Coverage)? ◯Yes ◯No

If Yes, Go to Section D - Medicare Advantage Verification.

Patient has Medicare card? ◯Yes ◯No Railroad Medicare card? ◯Yes ◯No

If Yes, Go to Section C - Medicare Coverage Verification

Section C - Medicare Coverage Verification

Method Used: ◯ Phone ◯IVR ◯Online Portal/HETS

Part B Effective Date: ______________

Part B Expiration date? ______________ *This may mean the patient is enrolled in a Medicare Advantage Plan. Please confirm with patient.

◯Name and Address Match Confirmed

◯Automatic Crossover Established

◯Confirmation of QMB Status

Part B Deductible Remaining This Year? ______________

Supplement/Secondary Information available? ◯Yes (Go to Section E) ◯No

Section D - Medicare Advantage Verification - Part C Coverage

Carrier Name: ______________________

Phone Number: ______________ Contact Person: ______________

Subscriber Name: ______________________

Subscriber ID#: ______________ Group: ______________

Participating? ◯Yes ◯No

If No, use caution about accepting assignment. You could become deemed participating.

Deductible: $ ________ Year Met: $ ________ Co-pay: $ ________ or

Coinsurance: ________ % Maximum per day if any $ ________

Follows Medicare guidelines? ◯Yes ◯No Visit Limits per year/occurrence: ________

Covers statutorily non-covered service? ◯Yes ◯No If yes, use Major Medical Insurance form to verify coverage.

Use traditional ABN? ◯Yes ◯No Own ABN Required? ◯Yes ◯No

Section E - Secondary/Supplement Coverage:

Carrier Name: ______________________

Phone Number: ______________ Contact Person: ______________

Subscriber Name: ______________________

Subscriber ID#: ______________ Group: ______________

Relationship to Patient: ◯Self ◯Spouse ◯Other: ______________

Deductible: $ ________ Year Met: $ ________ Co-pay: $ ________ or

Coinsurance: ________ % Maximum per day if any $ ________

Follows Medicare guidelines? ◯Yes ◯No Covers Medicare Deductible? ◯Yes ◯No

Covers statutorily non-covered service? ◯Yes ◯No

If Yes on Statutorily non-covered, use Commercial Health Insurance Verification Form to complete verification.

Section F - Custom

Notes

Number Called: ______________ Date: ______________

Time: ______________ Staff completing form: ______________

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