A Service Of
FLORIDA HOSPITAL
MEMORIAL MEDICAL CENTER
HealthCare Partners

CO-INSURANCE NOTICE TO MEDICARE PATIENTS
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305 Memorial Medical Parkway, Suite 205
Daytona Beach, FL 32117

Dear Medicare Patient:

We would like to take this opportunity to inform you that this physician practice is a provider-based clinic. This provides increased continuity of care and improved reimbursements, thus allowing Florida Hospital Memorial Medical Center to continue to provide quality medical care and services.

Your visits to this office are billed by a Central Billing Office(CBO), which is a service of Florida Hospital Memorial Medical Center. You will be registered in this office as an outpatient of Florida Hospital Memorial Medical Center. Any services you receive will still be billed by Florida Hospital Memorial Medical Center to Medicare and any secondary insurance companies. If you have any questions regarding your service provided at this office, please call 386-671-4500 to speak to a Billing Representative.

In accordance with Medicare's laws and regulations, you will incur a co-insurance liability to Florida Hospital Memorial Medical Center that you would not have incurred if this office were not provider-based. Your actual co-insurance liability will depend upon the actual services furnished by this office. For example, co-insurance balances for an average follow up visit for an established patient (99213) would be approximately $13.02 for the hospital charge and $ 8.97 for the physician charge.

After the hospital and physician have been reimbursed by Medicare, co-insurance balances will be billed to secondary insurers. If co-insurance is still owed to Florida Hospital Memorial Medical Center and/or physician, you will be billed. If you have no secondary insurance you will be required to pay your portion at time of service. You may request an estimate of this amount of co-insurance liability by contacting your physician's office.

As required by policy, for this physician's office, you will be required to read and sign this letter at every visit.

I have read and understand that I will incur a liability to Florida Hospital Memorial Medical Center for Medicare coinsurance as permitted by law.

_____ _____

Signature of Patient or Authorized Representative Date

FLORIDA HOSPITAL
Memorial Medical Center
HealthCare Partners

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

Patient Name:_____ Date of Birth_____

Physician: BIRKEDAL_____ Medical Record #:_____

I AM ENTITLED TO MEDICARE BENEFITS:

[ ] NO - RETURN FORM TO THE FRONT DESK

[ ] YES - PROCEED TO SECTION I.

SECTION I

Select the ONE statement that is true for you:

[ ] I am over 65 and married… **Proceed to section II**

[ ] I am over 65 and not married (includes widowed)… **Proceed to section III**

[ ] I am under 65, Disabled and currently employed… **Proceed to section IV**

[ ] I am under 65, Disabled and unemployed…

Disability Date: _____ **IV Proceed to section**

SECTION II

Select the one statement that is true for you:

[ ] My spouse and I are both fully retired

The date of my retirement: _____

The date of my spouse's retirement: _____ …**Proceed to section V**

[ ] I work full or part-time (my spouse is retired) for a company with:

[ ] LESS than 20 employees… **Proceed to section V**

[ ] MORE than 20 employees… **Proceed to section IV**

[ ] My spouse works full or part-time (I am retired) for a company with:

[ ] LESS than 20 employees… **Proceed to section V**

[ ] MORE than 20 employees… **Proceed to section IV**

SECTION III

Select the one statement that is true for you:

[ ] I am fully retired…

The date of my retirement: _____ ….**Proceed to section V**

[ ] I work full or part-time for a company with:

[ ] LESS than 20 employees… **Proceed to section V**

[ ] MORE than 20 employees… **Proceed to section IV**

SECTION IV

Select the one statement that is true for you: *(This does not apply to supplemental plans or employer plans offered during retirement.)*

I have health care coverage through my employer. [ ] NO [ ] YES

I have health care coverage through someone else. [ ] NO [ ] YES

IF YES, list name of guardian and relationship:_____

Proceed to Section V

Patient Name: _____ Date of Birth_____

SECTION V

Is this visit related to an injury due to a fall?

[ ] YES - Did the accident occur in… [ ] your home [ ] public location [ ] other

Date of Accident:_____

OR

Is this visit related to an illness/injury due to an automobile accident?

[ ] YES - Date of Accident:_____

RETURN TO FRONT DESK AND PRESENT YOUR AUTOMOBILE INSURANCE CARD.

[ ] NO **Proceed to Section VI**

SECTION VI

Indicate which statements apply to you.

[ ] I am entitled to Worker's Compensation for this service.
[ ] I am entitled to Black Lung benefits.
[ ] I am entitled VA benefits.
[ ] I am entitled ESRD benefits.
[ ] I am entitled COBRA benefits.
[ ] I am entitled to other Federal benefits. (UMWA, Gov't research programs, Hospice) Please Explain: _____

_____

Patient Signature _____ Date _____

Staff Signature _____ Date _____