Fort Dodge Health and Rehabilitation

Outpatient Therapy Insurance Verification

(This section to be completed at time appointment is made)

Patient Name: _____ Appointment Date: _____ Time: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Social Security #: _____ Birth Date: _____

Primary Insurance Co.: _____ ID #: _____

Subscriber Name: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Secondary Insurance Co.: _____ ID #: _____

Subscriber Name: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

(To be completed prior to first appointment or attached with insurance authorization)

Primary Ins. Co.: _____ Date contacted: _____

Name of Contact: _____ Policy Effective Date: _____

Policy in force? Yes No

Annual Deductible: $ _____ Already met? Yes No

Co-Payment Due: $ _____ # of Visit or CPT codes Authorized: _____

Contract Required? Yes No _____

Type of Coverage: PT OT ST

In-network: PT Yes No OT Yes No ST Yes No

Authorization Required? Yes No

Authorization #: _____ Authorization Through Date: _____

Continued Authorization Required? Yes No

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Outpatient Therapy Insurance Verification
(continued)

Send claims to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Required billing format: _____

Required billing frequency: _____

Required billing attachments: _____

Secondary Ins. Co.: _____ Date contacted: _____

Name of Contact: _____ Policy Effective Date: _____

Policy in force? Yes No

Annual Deductible: $_____ Already met? Yes No

Co-Payment Due: $ _____ # of Visits Authorized: _____

Contract Required? Yes No

Type of Coverage: PT OT ST

In-network: PT Yes No OT Yes No ST Yes No

Authorization Required? Yes No

Authorization #: _____ Authorization Through Date: _____

Continued Authorization Required? Yes No

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Send claims to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Required billing format: _____

Required billing frequency: _____

Required billing attachments: _____

OUTPATIENT REHABILITATION
PATIENT INFORMATION AND BRIEF MEDICAL HISTORY

Federal and State Regulations require a medical history must be included in the patient's medical records in this office.

Date: _____ Birthdate: _____ OP Med Rec #_____

Patient Name: _____ Patient Phone #_____

Reason For Therapy Referral: _____

Date of Onset/Injury/Surgery_____ Physician: _____

MEDICAL HISTORY:

Do you have/or have you had any of the following:

Diabetes	Yes	No	Sensitivity to heat	Yes	No
High Blood Pressure	Yes	No	Sensitivity to cold (ice)	Yes	No
Circulatory Disorders	Yes	No	Dizziness	Yes	No
Heart Disease	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Headaches	Yes	No
Stroke/TIA	Yes	No	Cancer	Yes	No
Pacemaker	Yes	No	Visual Problem	Yes	No
Metal Implants	Yes	No	Allergies	Yes	No
Kidney Problems	Yes	No	Previous Surgeries	Yes	No
Hernia	Yes	No	Back Injuries	Yes	No
Nervous Disorders	Yes	No	Other Injuries	Yes	No
Are you pregnant?	Yes	No	Other Illnesses	Yes	No
Breathing Difficulties	Yes	No	Difficulty Sleeping	Yes	No
Osteoporosis	Yes	No	Neurological Problems	Yes	No
Weight Loss	Yes	No	DVT/Pulmonary Embolism	Yes	No

If Yes on any of the above, please explain and give approximate dates:_____

_____

_____

MEDICATIONS:

Yes No Are you presently taking medications?

If Yes, please list what medications, dosage and for what condition:

Medication Dosage Condition

_____

_____

_____

_____

_____

OTHER INFORMATION:

Yes No Have you had previous therapy for the present condition for which you are to receive treatment here?

Yes No Is this a work related injury or condition?

Yes No Has this injury been reported to your employer?

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient Name: _____ **Medicare ID:** _____

INSTRUCTIONS:
Ask the following questions to Medicare beneficiaries upon **each inpatient** and **outpatient admission**. Answer the questions in sequence. The instructions will direct you to the next appropriate question to determine MSP situations.

PART I

1. Are you receiving Black Lung (BL) Benefits?
   - ☐ Yes. Date began: MM/DD/CCYY _____ **BL IS PRIMARY** ONLY FOR CLAIMS RELATED TO BL
   - ☐ No.

2. Are the services to be paid by a government research program?
   - ☐ Yes. **GOVERNMENT RESEARCH PROGRAM IS PRIMARY**
   - ☐ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?
   - ☐ Yes. **DVA IS PRIMARY**
   - ☐ No.

4. Was the illness/injury due to a work-related accident/condition?
   - ☐ Yes. Date of injury/illness: MM/DD/CCYY _____ GO **to PART III**

If YES, OBTAIN NAME & ADDRESS OF WC PLAN, POLICY NUMBER, AND NAME & ADDRESS OF YOUR EMPLOYER

WORKERS' COMPENSATION(WC) IS PRIMARY ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS

- ☐ No. GO **to PART II**

PART II

1. Was illness/injury due to a non-work-related accident?
   - ☐ Yes. Date of accident: MM/DD/CCYY _____
   - ☐ No. GO **to PART III**

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident) NO-FAULT INSURER IS PRIMARY for services related to accident.
   - ☐ Yes.
     Name & address of no-fault insurer(s) and no-fault insurance policy owner: _____
     Insurance claim number(s): _____
   - ☐ No.

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property) LIABILITY INSURANCE IS PRIMARY for services related to settlement.
   - ☐ Yes.
     Name & address of liability insurer(s) and responsible party: _____
     Insurance claim number(s): _____
   - ☐ No.

GO **to PART III**

PART III

Are you entitled to Medicare based on:

- ☐ Age. GO **to PART IV**
- ☐ Disability. GO **to PART V**
- ☐ End-Stage Renal Disease (ESRD). GO **to PART VI**

Note that both **Age** and **ESRD** – OR - **Disability** and **ESRD** may be selected simultaneously. An individual **CANNOT** be entitled to Medicare based on **Age** and **Disability** simultaneously

PART IV – AGE

Are you currently employed?

☐ Yes.

Name & address of your employer: _____

☐ No. If applicable, date of retirement: MM/DD/CCYY _____

☐ No. Never Employed.

2. Do you have a spouse who is currently employed?

☐ Yes.

Name & address of your spouse's employer: _____

☐ No. If applicable, date of retirement: MM/DD/CCYY _____

☐ No. Never Employed.

IF NO TO BOTH 1 AND 2, MEDICARE IS PRIMARY STOP DO NOT PROCEED FURTHER

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

☐ Yes, both.

☐ Yes, self.

☐ Yes, spouse.

☐ No. STOP **MEDICARE IS PRIMARY**

4. If the GHP coverage is based on **your own** current employment, **your spouse's** current employment - Does the employer that sponsors or contributes to the GHP **employ 20 or more employees**?

☐ Yes. **GHP IS PRIMARY**

If YES, OBTAIN NAME & ADDRESS OF GHP, POLICY NUMBER, NAME OF POLICY HOLDER/NAMED INSURED, AND RELATIONSHIP TO PATIENT

☐ No. STOP **MEDICARE IS PRIMARY**

PART V – DISABILITY

1. Are you currently employed?

☐ Yes.

Name & address of your employer: _____

☐ No. If applicable, retirement date: MM/DD/CCYY _____ STOP **MEDICARE IS PRIMARY**

☐ No. Never Employed. STOP **MEDICARE IS PRIMARY**

2. Do you have a spouse who is currently employed?

☐ Yes.

Name & address of your spouse's employer: _____

☐ No. If applicable, retirement date: MM/DD/CCYY _____ STOP **MEDICARE IS PRIMARY**

☐ No. Never Employed. STOP **MEDICARE IS PRIMARY**

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

☐ Yes, both.

☐ Yes, self.

☐ Yes, spouse.

☐ No. STOP **MEDICARE IS PRIMARY**

4. Are you covered under the GHP of a family member other than your spouse?

☐ Yes.

Name & address of your family member's employer: _____

☐ No. STOP **MEDICARE IS PRIMARY**

5. If you have GHP coverage based on **your own** current employment, **your spouse's** current employment, or **family member's** current employment - Does the employer that sponsors or contributes to the **GHP employ 100 or more employees**?

☐ Yes. **GHP IS PRIMARY**

If YES,** OBTAIN NAME & ADDRESS OF GHP, POLICY NUMBER, GROUP NUMBER, MEMBER NAME, NAME OF POLICY HOLDER/NAMED INSURED, AND RELATIONSHIP TO PATIENT

☐ No. STOP **MEDICARE IS PRIMARY**

PART VI – ESRD

1. Do you or your spouse have group health plan (GHP) coverage?

☐ Yes.

If YES,** OBTAIN NAME & ADDRESS OF GHP, POLICY NUMBER, GROUP NUMBER, MEMBER NAME, NAME OF POLICY HOLDER/NAMED INSURED, RELATIONSHIP TO PATIENT, AND EMPLOYER NAME & ADDRESS (if GHP through spouse)

☐ No. STOP **MEDICARE IS PRIMARY**

2. Have you received a kidney transplant?

☐ Yes. Date of transplant: MM/DD/CCYY _____

☐ No.

3. Have you received maintenance dialysis treatments?

☐ Yes. Date dialysis began: MM/DD/CCYY _____

If you participated in self-dialysis training program, date training started: MM/DD/CCYY _____

☐ No.

4. Are you within the 30-month coordination period that starts MM/DD/CCYY?

☐ Yes.

☐ No. STOP **MEDICARE IS PRIMARY**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

☐ Yes.

☐ No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

☐ Yes. STOP **GHP CONTINUES TO PAY PRIMARY** DURING THE 30- MONTH COORDINATION PERIOD

☐ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY**

7. Does the working aged or disability MSP provision apply (is the GHP already primary based on age or disability entitlement)?

☑ Yes. **GHP CONTINUES TO PAY PRIMARY** DURING THE 30-MONTH COORDINATION PERIOD

☐ No. **MEDICARE CONTINUES TO PAY PRIMARY**

Beneficiary/Responsible Party Signature _____

Facility Witness Signature _____

Date: _____