JAYHAWK
FOOT & ANKLE CLINIC

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MEDICARE AUTHORIZATION FORM

PATIENT'S NAME _____ DATE OF SERVICE ___/___/___
Print

I hereby authorize payment of my Medigap benefits to _____ for all claims
Doctor/Supplier
filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

LIFETIME ASSIGNMENT OF BENEFITS

I hereby assign and authorize payment directly to the above named Doctor of all insurance, including Medicare benefits otherwise payable to me not to exceed the balance due of the regular charges for the services provided.

I understand that I am financially responsible to the above named Doctor for all charges not covered by this authorization.

Initials_____

BENEFICIARY/PHYSICIAN NOTICE

Medicare will only pay for services that it determines to be an allowable service under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would be otherwise covered, is not allowable under Medicare program standard, Medicare will deny payment for the service. If Medicare does not allow payment for your treatment on this date, you are ultimately responsible for these charges.

My physician has notified me that it is possible that in my case Medicare is likely to deny payment for the services rendered above. If Medicare does deny payment, I agree to be personally and fully responsible for payment to my physician of all charges.

Initials _____

If you clearly understand and agree to all of the terms above please initial in the spaces provided and sign below.

BENEFICIARY SIGNATURE: _____
MEDICARE NUMBER: _____
MEDIGAP NUMBER: _____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Custom Orthotics	Medicare does not cover durable medical equipment (DME)	$345
PowerStep Protec OTC Inserts		$35
CAM Walking Boot		$50
Lace-Up Ankle Brace		$30
Post-Operative Shoe		$20

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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