



There may be situations where Medicare is “Not the primary payer” or Medicare coverage policies vary. Medicare law requires that we investigate all possible situations where other insurance besides Medicare might be the primary payer.

MSPQ Medicare Secondary Payer Questionnaire

Patient's Name _____ MRN _____

Spouse Name _____

1) Are you employed? () Yes () No

Name of employer: _____

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

2) Is your spouse/other family member employed? () Yes () No

Name of employer: _____

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

3) Are you covered by employer group health plan (EGHP)

from own or family member's current or former employment?

() Yes, covered by former employer's EGHP

() Yes, covered by current employer's EGHP

() No

- If you marked yes, does your employer sponsoring EGHP

have 20 or more employees? () Yes () No

Name of GHP: _____

Phone Number: _____

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

Policy ID number: _____ Group ID number: _____

Name of insured: _____ Relationship to patient: _____

4) Are you or your spouse retired?

Yes No - Your retirement date _____

Yes No - Spouse retirement date _____

5) Are you entitled to Medicare because of end stage renal disease (ESRD)? Yes No

6) Are you entitled to Medicare because of disability, other than ESRD? Yes No

- If you marked yes, does your employer sponsoring EGHP have 100 or more employees? Yes No

7) Are you entitled to benefits through the Department of Veterans Affairs? Yes No

8) If your answer was yes on question #7, would you like the VA to be contacted for authorization? Yes No

9) Are you entitled to benefits under the Federal Black Lung Program? Yes No

Federal BL Program: _____

Phone Number: _____

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

Policy/ID number: _____ Date benefits began: _____

10) Is this illness/injury covered by a workers' compensation claim? Yes No

Name of WC Plan: _____ Policy/ID number: _____

Phone Number: _____

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

Name and address of employer _____



**Mid South Rehab
Services & Affiliates
Joint Notice of Privacy Practice Acknowledgement Page**

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

Patient Name (Print)

Date

Signature of Patient or Legal Representative

If signed by legal representative, relationship to patient: _____

Delivered by: _____ Date: _____

**DOCUMENTATION OF THE ATTEMPT TO OBTAIN WRITTEN
ACKNOWLEDGEMENT OF THE DELIVERY OF THE JOINT NOTICE OF PRIVACY
PRACTICES**

I, _____, delivered Mid South Rehab Services and Affiliates' Joint Notice of Privacy Practices to _____ on _____. I attempted to obtain an acknowledgment of receipt of Mid South Rehab Services and Affiliates' Joint Notice of Privacy Practices but was unable to do so because _____

- Joint Notice of Privacy Practices was mailed to patient/patient representative.
- Joint Notice of Privacy Practices was left in the patient's room.

Patient Name: _____

Therapist Signature: _____

*Effective Date: February 7, 2017
Distribution: Original to MSRS; copy to patient
Rev 0210*



NAME: _____ DATE: _____

Height: _____ ft. _____ in Weight: (approximate) _____ lbs. Do you smoke: No Yes _____ ppd

Is your injury or illness work-related? Yes No *if yes, what was date of injury?* _____

Have you ever had a previous work-related injury or illness? Yes No *if yes, when?* _____

Are you: working full-time working part time in vocational re-training in vocational re-education
 not working retired *If you are not working, do you desire to return to work?* Yes No

If you are not working, how long have you been off work? _____ wks _____ months _____ years

How many surgeries have you had related to this injury or illness? None Yes I have had surgery. *Please list:*

How many surgeries have you had in your lifetime? None Yes I have had surgery. *Please list:*

What procedures or medical tests have you had for this injury or illness? Bone Scan CT Scan EMG
 MRI Myelograms Nerve Block Nerve Conduction studies X-rays

Do you currently take any medication, including over the counter? None Yes *Please list them with dosage*

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

If extra space is needed, please continue on the back.

Please list any allergies you have (to food, seasonal, meds, etc.): _____

Are you currently being treated by any of the following? Chiropractor Dentist Osteopath Doctor
 Psychiatrist/Psychologist other Physical Therapist *If yes, for what?* _____

Place a check mark beside any past or present medical condition.

CONDITON	PRESENT	PAST	NO	CONDITION	PRESENT	PAST	NO
Anxiety				HIV/AIDS			
Arthritis				Hyperthyroidism			
Asthma				Hypothyroidism			
Bladder/Urinary Disorder				Liver Disease			
Cancer				Lung Disease/Emphysema			
Chemical Dependency				Obesity			
Chronic Pain				Osteoporosis/ Osteopenia			
Congestive heart Failure				Peptic Ulcers/ Reflux Disease			
Heart Disease or Heart Attack				Renal or Kidney Disease			
Depression				Seizure Disorder			
Diabetes				Spinal Fusion			
Headaches or Migraines				Stroke			
Hepatitis				Tuberculosis			
High Blood Pressure				Vertigo			



CONSENT FORM FOR TREATMENT, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

Location: _____ Date: _____

Patient Name: _____ DOB: _____
 (LAST) (FIRST) (MIDDLE INITIAL)

BILLING INFORMATION: A LEGIBLE COPY OF ALL CARDS ALONG WITH A PICTURE I.D. IS REQUIRED

NOTE: Outpatient or ALF treatment may be delayed until Valid I.D. and/or Medicare & Insurance data is verified.

Copy of the back & front of all cards have been uploaded into Casamba.

***** HOSPICE:** Is the patient under Hospice Care? Yes No *^If Yes, STOP & contact the Hospice agency for*

written approval to evaluate.

*****HOME HEALTH:** Has the patient received any Home Health Services in the last 60 days?

Yes & DC date is _____ No **^If DC Date is not known, contact the Agency to verify DC date prior to evaluation.**

*****MEDICARE:** Does the patient have a Medicare Advantage / HMO / PPO Policy? Yes No *If Yes, contact the agency (find the phone number on the back of the card) for instructions prior to evaluation.*

MEDICARE AND INSURANCE: BENEFITS WILL VARY ACCORDING TO THE PATIENT'S INDIVIDUAL PLAN

Under the original Medicare Part B program:

- Medicare will pay 80% of the Medicare allowable fees after the patient's deductible has been satisfied.
- The remaining 20% will be billed to the patient's secondary insurance (if they have one). If no supplemental policy information is given to us, the balance will be billed to the patient or the person responsible for paying the bills.
- This form must be signed by the patient or a representative authorized by the patient giving MSRS /360 Total Rehab permission to (a) bill the patient for the deductible (if applicable) (b) bill Medicare and (c) bill the supplemental insurance policy.

CONSENT IS GIVEN BY: PATIENT GUARDIAN RESPONSIBLE PARTY VERBAL CONSENT
 For the following therapy service(s): PT OT SLP

I authorize treatment and payment of medical benefits for services rendered as ordered by my physician. I further authorize the provider to furnish medical or other information for any claims incurred under Title XVIII of the Social Security Act to its intermediary or carrier when such information is requested for payment, utilization review, or coverage determination. Charges are available upon request. The undersigned hereby agrees that

Initial

he/she is financially responsible to the provider for all charges not covered by this Assignment, and hereby assumes full responsibility for payment. **NOTICE:** Patients under Hospice or Home Health Care are not eligible for Part B benefits separate from the Hospice & Home Health Benefit. I acknowledge that I am not a Hospice or Home Health patient. In the event I am found to be receiving Hospice or Home Health Benefits at the time I am receiving this Outpatient Therapy treatment, I

understand that I may be responsible for payment of this therapy treatment should the Hospice or Home Health Agency not agree to pay for this therapy.

GUARANTOR INFORMATION: NAME: _____

Home Phone #:() _____ Work Phone #:() _____ Email: _____

Address: _____
 (Street) (City / State) (Zip)

 (Signature of Patient or Authorized Representative) (Relationship to Patient) (Date) (Time)

Witness: _____ Witness: _____
 (Name) (Title) (Date /Time) (Name) (Title) (Date/Time)

NOTE: This form must be witnessed by a staff member. If the signature is by mark, it must have two witnesses. The party obtaining Verbal Consent must sign as a "Witness".

Please indicate below where your symptoms are located. Please describe your symptoms beside the body diagram. (burning, aching, cramping, shooting, numbing, tingling, etc.)

