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 _____

11) Is this illness/injury covered by a non worker related accident? ( ) Yes ( ) No

12) If you answered yes on question #11, what type of accident caused the illness/injury?

_____ Automobile

_____ Non-Automobile

_____ Other

Name of no-fault or liability insurer: _____

Address: _____ City:_____ State: _____Zip:_____

Phone Number: _____

Name of insured party: _____

Policy/ID number: _____ Insurance claim number: _____

13) Are services covered by a Public Health Service or Research Program? ( ) Yes ( ) No

Information Supplied by _____ Relationship to patient _____

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Patient's Representative (If Patient is unable to sign) Date

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 of Legal Representative

If signed by legal representative, relationship to patient: _____

Delivered by: _____ Date: _____

DOCUMENATION 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*

360 TOTAL REHAB
MID SOUTH REHAB OUTPATIENT CLINIC, LLC
PHYSICAL • SPEECH • OCCUPATIONAL THERAPY

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 */f 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	☐	☐	☐

360 TOTAL REHAB
MID SOUTH REHAB OUTPATIENT CLINIC, LLC
PHYSICAL • SPEECH • OCCUPATIONAL THERAPY

CONSENT FORM FOR TREATMENT, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

Location: _____ Date: _____

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

BILLING INFORMATION: A l EGIBLE COPY OF ALL CARDS A LONG 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".*

360 TOTAL REHAB

MID SOUTH REHAB
OUTPATIENT CLINIC, LLC

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