MAHONEY
DERMATOLOGY SPECIALISTS, P.A.

Medicare Patient Information

Patient Name: _____

Social Security Number: _____

Patient Date of Birth: _____/_____/_____ Gender: ❒ Female ❒ Male

Address: _____
Street

_____
City State Zip Code

( ) _____ ( ) _____
Home Phone Cell Phone

E-mail Address_____

May we leave you a voice mail on your phone? ❒**Yes** ❒**No** May we send you an e-mail? ❒**Yes** ❒**No**

_____
Please print your name as it appears on your Medicare card

_____
Medicare Health Insurance Claim Number as it appears on your card. *This is usually your Social Security number. Be sure to include the letter after the nine-digit number. It is important that we have both the numbers and letter)*

Pharmacy (Name or Corner Location): _____

Pharmacy Phone Number: _____

Primary Care Physician: _____

Referring Physician:: _____

Emergency Contact: _____ Relationship:_____

Phone #_____

Do you give our office permission to discuss your medical information with family members? If yes please provide their name and phone number.

Name: _____ Relationship: _____

Phone #:_____

Please Sign So We May Have Your Medicare Authorization On File

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature: _____ Date: ____/____/____

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Payment Policy

***Medicare*:** **We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $155.00 deductible and paying for the 20% co-insurance. We do file with secondary /supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed for any remaining balances.**

Are you in a Medicare HMO or other Senior Medicare Plan? ❒ Yes ❒ No

If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

Name of Insurance Company: _____

Policy Number: _____ Group Number: _____

Name Policy Holder (Insured):_____

Gender: ❒ Male ❒ Female Policy Holder Date of Birth: ____/____/____

Supplemental Insurance or Medicare Advantage Plans

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% co-insurance, which is ***not*** covered by Medicare.

Name of Insurance Company: _____

Policy Number: _____ Group Number: _____

Name Policy Holder (Insured):_____

Gender: ❒ Male ❒ Female Policy Holder Date of Birth: ____/____/____

Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above carrier any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____ Date: ____/____/____

Please present your Medicare and insurance card(s) and a photo ID to the receptionist along with this completed form. Thank you.