Greenwood Orthopaedics, P.C.

Patients Name:
DOB: Date:

1.	Is the illness/injury covered by Workman's Compensation? If yes, note employer/insurer name, address and claim number (if available) in #9 and file claims with them. If no, go to #2.	□ YES □ NO
2.	Is this illness/injury covered under the Federal Black Lung Program? If yes, file the claim with them. If no, go to #3.	□ YES □ NO
3.	Is this illness/injury the result of an auto accident? If yes, enter the responsible auto insurer in #9 and file them claim with them. If no, go to #4.	□ YES □ NO
4.	Is another party's liability insurance, non-liability insurance, or no-fault insurance liable for this illness/injury? If yes, enter information in #9 and file the claim with them, If not, go to #5.	□ YES □ NO
5.	Is this patient covered by an employer health plan (EGHP), including the Federal Employee Health Benefits? If yes, go to #6. If no, Medicare is primary.	□ YES □ NO
6.	Is this patient or his/her spouse actively employed by an employer of 20 or more employees? If yes, enter information in #9 and file the claim with them. If no, go to #7.	□ YES □ NO
7a.	Is the patient under 65 and entitled to Medicare due to a disability? If yes, go to #7b. If no, go to #8.	□ YES □ NO
7b.	Is the patient or his/her spouse or parent actively employed by, or is the patient considered an employee of an employer having 100 or more employees? If yes, enter the LGHP date in #9 and file the claim with them. If no, to #8a.	□ YES □ NO
8a.	Is patient entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)? If yes, go to #8b. If no, Medicare is primary.	□ YES □ NO
8b.	Has the patient completed ERSD coordination period? If yes, Medicare is primary. If no, enter EGHP date in #9 and file the claim with them.	□ YES □ NO
9.	Name of insurance company:_____ Name of insured:_____ Patient's relationship to insured:_____ Insured's policy number:_____ Insurer's address:_____ Employer's name: _____ Employer's address:_____ Name of attorney(s) involved_____	

Authorization Statement and Payment Agreement

*I declare under penalty of perjury that I do not have another primary insurance carrier to pay for medical care rendered to me by _____, and that all information regard to residence, employment, and income is correct to the best of my knowledge.

*I request that payment of authorized Medicare Benefits be made to Greenwood Orthopaedics for any services furnished to me by physicians or suppliers.

*I understand that my signature requests that payment be made and it authorizes release of medical information necessary to pay the claim(s). If a secondary insurance carrier is involved my signature also authorizes releasing information to the insurer or agency shown.

*In Medicare assigned cases, the physician or supplier agrees to accept the allowed amount determined by the Medicare Carrier, and the patient is responsible only for the deductible, co-insurance and non-covered services.

Co-insurance and deductible are based upon the allowed amount determined by the Medicare Carrier.

_____ _____

Signature of Patient or Authorized Representative Date

Greenwood Orthopaedics, P.C.

Name:

DOB:

Date:

This page is to be completed by the patient and witnessed on all subsequent visits.

Patient_____ Medicare #_____

Date of Visit	Patient Signature	Witness Signature