

Name _____ Age _____ Birthdate _____

Address _____ ZIP _____

Home Phone # _____ SS# _____ Marital Status --- S M D W

Spouse's Name _____ Work Phone # _____

Relative/Friend Name _____ Relationship _____ Phone# _____

MEDICINE ALLERGIES _____

REFERRING DOCTOR: _____ *You may call my cell phone & leave msg: Y N* Cell# _____

We will bill your MEDICARE & 2ndary INSURANCE for you. Please provide COMPLETE & ACCURATE INFORMATION

MEDICARE # _____ Is Medicare Billed First? _____

SUPPLEMENTAL INSURANCE POLICY OR MEDIGAP INSURANCE POLICY INFORMATION

#1 Insurance Co _____ Address _____ ZIP _____

Subscriber Name _____ B/D _____ ID# _____ Group# _____

Preauthorization Phone# _____ Ins Company Phone # _____

Is insurance through your former employer? _____ Employer _____

#2 Ins Company _____ Address _____ ZIP _____

Subscriber Name _____ B/D _____ ID# _____ Group# _____

Preauthorization Phone# _____ Ins Company Phone # _____

Is insurance through your former employer? _____ Employer _____

MEDICARE LIABILITY QUESTIONNAIRE - NEEDED TO PROVE THAT MEDICARE IS PRIMARY

1. Are you or your spouse **currently** employed with a company that provides you with health insurance? _____
If YES list insurance company and address _____

2. Are you entitled to Medicare because of DISABILITY or END STAGE RENAL DISEASE? _____

3. Is this illness or injury a result of an AUTOMOBILE ACCIDENT or OTHER INJURY? _____

4. Is this illness or injury a result of accident or illness that OCCURRED AT WORK? _____

5. Is this illness or injury covered by V.A. _____ (if so is it authorized?) _____

I authorize release of Medical Information necessary to process my claim and assign PAYMENT OF MEDICAL BENEFITS to NEUROLOGICAL ASSOCIATES. Any phone numbers provided for means of contact may be used and shared with third party collection agencies. This information is not sold. I agree to pay any and all charges that exceed or are not covered by insurance. I am aware finance charges of .8% may be assessed on overdue accounts over 90 days, that a \$25 minimum charge will be assessed to my account for insufficient funds on personal checks. If this is a Medicare claim, and Medicare should deem this service "not reasonable or necessary," I agree to be personally and fully responsible for payment.

SIGNED _____ DATE _____