Active Life & Sports
THERAPY FIT FOR YOU

MEDICARE AUTHORIZATION

I understand that Medicare will be billed for my services at **Active Life and Sports Physical Therapy**. I also understand that Medicare will pay 80% of the allowed amount. I will be responsible for the deductible, if not already met, and non-covered charges. I will not be responsible for non-allowed charges.

NOTE: Medicare requires that all patients be seen by their physician every **30 days** and obtain a new prescription for physical therapy each time. Failure to do this will result in nonpayment by Medicare. You will, therefore, be held responsible because this would be considered non-covered services.

Authorization to Release Information:

I request that payment of authorized Medicare and secondary Medicare benefits to be made on my behalf to **Active Life and Sports Physical Therapy** for any services furnished to me by that provider of care. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or of the benefits payable for related services.

Printed Beneficiary's Name: _____
Beneficiary's Signature: _____
Date: _____ **(SEAL)**

Medicare Secondary Payer Questionnaire

All questions must be answered completely per Medicare requirements.

	YES	NO
1. Are you a Veteran:	____	____
A) Did the VA refer you here?	____	____
B) Do you have a VA fee basis card?	____	____
2. Do you have a Federal Black Lung card?	____	____
3. Is this medical condition due to an accident of any kind?	____	____

If yes, was it: (circle) work related auto related injury at home other

4. Are you covered by an employers health insurance plan through your own employment or that of a family member: (not retiree coverage) ____ ____

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