ORENTREICH MEDICAL GROUP

MEDICARE PART B
SIGNATURE ON FILE AUTHORIZATION

David S. Orentreich, MD Catherine A. Orentreich, MD Jodi A. LoGerfo, FNP-BC Sorayah G. Kaschak, NP-BC

"I request that payment of authorized Medicare benefits be made on my behalf to Orentreich Medical Group, LLP for any services furnished to me by David Orentreich, MD, Catherine Orentreich, MD, Jodi LoGerfo, FNP-BC, or Sorayah Kaschak, NP-BC. Furthermore, I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services."

Patient Name: _____

Patient Signature: _____

Medicare ID Number: _____

Date: _____

Affix Patient label here.

Patient ID #: _____

First and Last Name: _____

Dear Patient:

In our capacity as a **MEDICARE PART B** provider, Orentreich Medical Group, LLP (OMG) submits all Medicare claims electronically which results in a more efficient and faster payment of benefits. Medicare, in turn, automatically submits unpaid portions of claims to your secondary insurance carriers.

If your primary insurance is **MEDICARE** and you are unsure whether Medicare has an automatic crossover agreement with your secondary insurance carrier, you must contact Medicare. If there is no automatic crossover, you will be responsible for submitting unpaid portions of claims to your secondary carrier.

In any circumstance, you are responsible for payment of any unpaid deductibles, co-insurance and treatments or services for which **MEDICARE** does not reimburse OMG.

Please read the following descriptions of Medicare insurance categories **BEFORE** you sign under the appropriate statement. The four categories are explained on the back of this page. Then sign your name (only once) and fill in the date on the appropriate line that describes your type of insurance coverage.

DESCRIPTIONS OF MEDICARE COVERAGE Please check **ONE** statement that applies, then sign and date accordingly.

☐ **A. MEDICARE** is my **ONLY** insurance:

As Medicare is my only insurance carrier, I understand that I am responsible for any co-insurance, deductible and medications, as well as any services that Medicare determines **NOT** "medically necessary".

Signature: _____ Date: _____

☐ **B. MEDICARE** is my **PRIMARY INSURANCE,** and I have a **SECONDARY INSURANCE CARRIER:**

After processing, Medicare will automatically forward my "Explanation of Medicare Benefits" (EOMB) to my **SECONDARY** carrier if there is an "automatic crossover" agreement with this carrier. If there is no "automatic crossover", I understand that I am responsible for sending a copy of the Medicare EOMB to my **SECONDARY** insurance carrier for possible reimbursement of any co-insurance. I further understand that I am responsible for payment of any still outstanding charges not reimbursed by my **SECONDARY** insurance carrier.

Secondary Insurance Carrier: _____ Policy #: _____

Signature: _____ Date: _____

☐ **C.** My **SECONDARY INSURANCE CARRIER** is **MEDICARE,** and I have a **PRIMARY INSURANCE CARRIER:**

OMG will send my claim to my private insurance carrier. When I receive their Explanation of Benefits (EOB) for the date of service (DOS) in question, I will immediately send a copy to OMG, along with the reimbursement check endorsed over to OMG. Information for that DOS will then be forwarded to Medicare. I understand that I am responsible for payment of any outstanding charges not reimbursed by either my **PRIMARY** or **SECONDARY** insurance carriers.

Primary Insurance Carrier: _____ Policy #: _____

Signature: _____ Date: _____

☐ **D. MEDICARE HMO** or **MEDICARE ADVANTAGE** is my **PRIMARY INSURANCE CARRIER:**

As OMG does not participate in any **MEDICARE HMO** / **MEDICARE ADVANTAGE** plan, I understand that OMG will charge me Medicare rates for any Medicare reimbursable procedures, and that I must pay in full for these services at time of visit.

Insurance Carrier: _____ Policy #: _____

Signature: _____ Date: _____

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