MEDICARE ONE-TIME NOTIFICATION

______________________________ PATIENT NAME

______________________________ MEDICARE #

1) WHAT TYPE OF MEDICARE PLAN DO YOU HAVE?

- ☐ Medicare Part B (original Medicare)
- ☐ Railroad Medicare
- ☐ Medicare Advantage *(please check your plan from the list below)*:
  - ☐ Medicare Plus Blue (BCBSM)
  - ☐ Priority Medicare
  - ☐ BCN Advantage
  - ☐ Humana Choice
  - ☐ Aetna Advantage
  - ☐ Other ______________________

NOTICE: If you are enrolled in a Medicare HMO or PPO plan, please notify the receptionist immediately or contact our billing department at (616) 284-3674 prior to your appointment to ensure that your benefits are maximized.

2) AUTHORIZATION TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PHYSICIAN

I request that payment of authorized Medicare benefits be made on my behalf to West Michigan Orthopaedics for any services furnished to me by any physician of West Michigan Orthopaedics.

I authorize West Michigan Orthopaedics to release to the Centers for Medicare & Medicaid Services and its agents any medical information needed to determine these benefits or the benefits payable for related services.

PATIENT SIGNATURE: ______________________________ DATE: ____________________

3) Do you have a health insurance policy after Medicare that you purchased yourself from a private insurance company (a "Medigap" policy)? _____ Yes _____ No

If **no**, please stop. You have finished completing this form.
If **yes**, please continue.

4) AUTHORIZATION TO PERMIT PAYMENT OF MEDIGAP BENEFITS TO PHYSICIAN

I request that payment of authorized Medigap benefits be made on my behalf to West Michigan Orthopaedics for any services furnished to me by a physician of West Michigan Orthopaedics.

I authorize West Michigan Orthopaedics to release to my Medigap insurer any medical information needed to determine these benefits or the benefits payable for related services.

PATIENT SIGNATURE: ______________________________ DATE: ____________________

(REV 09-11)