ORENTREICH MEDICAL GROUP, LLP

DAVID S. ORENTREICH, MD CATHERINE A. ORENTREICH, MD
JODI A. LOGERFO, FNP-C

MEDICARE PART B SIGNATURE ON FILE AUTHORIZATION

"I request that payment of authorized Medicare benefits be made on my behalf to the Orentreich Medical Group, LLP for any services furnished to me by David Orentreich, MD, Catherine Orentreich, MD or Jodi LoGerfo, FNP-C. 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:_____

Patient Label:

Dear Patient:

In our capacity as a MEDICARE Part B provider, OMG submits all MEDICARE claims electronically which results in a more efficient and faster payment of benefits. Medicare, in turn, now 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.

On the back of this page is a questionnaire. Please read the following descriptions of Medicare insurance categories BEFORE you sign under the appropriate statement. Then, sign your name only once on the appropriate line that describes your type of insurance coverage.

Descriptions of Medicare coverage:

A)MEDICARE is my ONLY insurance:
As Medicare is my only insurance carrier, I understand I am responsible for payment of any co-insurance, deductible and medications, as well as any services that Medicare determines NOT "medically necessary."

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.

C)My SECONDARY INSURANCE CARRIER is MEDICARE. I have a private 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.

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.

Please fill in, sign and date the appropriate description of your type of insurance coverage.

A. MEDICARE is my ONLY insurance:

_____

Signature Date

B. MEDICARE is my PRIMARY insurance. I have a SECONDARY INSURANCE whose name and Policy # are:

Insurance Carrier: _____ Policy #:_____

_____

Signature Date

C. My SECONDARY INSURANCE CARRIER is MEDICARE. My PRIMARY INSURANCE name and Policy # are:
Insurance Carrier: _____ Policy #:_____

_____

Signature Date

D. MEDICARE HMO or MEDICARE ADVANTAGE is my PRIMARY INSURANCE CARRIER.

Insurance Carrier: _____ Policy #:_____

_____

Signature Date