Great Basin Physical Therapy and Performance Center

Medicare Questionaire

To assist with our Medicare billing, we need the following information:

1. Did you receive Home Health Care within the past year? ( ) yes ( ) no (Home Health Care is defined as anyone coming to your home doing therapy, cleaning, taking blood pressure, etc. from a health care agency).
   a) If yes, please list the name of the company who supplied the home health or the name of therapist who assisted you:

   ____

   b) Date Medicare released you from Home Health:________________

STOP: If you answered yes to the above question, Medicare must release you from Home Health in order to be seen in our office. Medicare will not pay for Home Health & Outpatient Physical Therapy at the same time.

2. Were you admitted to a Rehabilitation Center within the past year?
   ( ) yes ( ) no If yes, which center were you admitted?

   ____

   a) What date were you discharged?_____________________________

STOP: You must have been discharged from the Rehabilitation Center in order to be seen in our office.

3. Have you been hospitalized within the past year with this problem? If yes, when were you discharged from the hospital & which hospital were you in:____

4. When is your next Doctor's appointment?___________________________

_______________________________________ ____________________

Patient Signature or Representative Date

Thank you for your assistance,
Great Basin Physical Therapy and Performance Center, LLC.

CMS
Centers for Medicare & Medicaid Services

Medicare

Noridian Administrative Services
Medicare Part B Release of Information Request

This is an Authorization for Release of Information form. Your signature on this form authorizes Medicare to release information to the person, agency, company or organization that you name below to Act On Your Behalf. The form will be on file for future Telephone, Written Correspondence, of Appeal Requests. Please be aware, the form is not valid unless you sign and date it. An * indicates that fields that you are required to complete. Please complete all * fields before returning to our office.

Beneficiary Information (person with Medicare)

*Name:____ *Medicare #:__________________
From your red, white & blue Medicare Card

*Date of Birth:_________________________*Telephone #:______________________________

*Address:__________________________*City:_______________*ST:_______Zip:________

***Reason Why You are Filling Out This Request (please check one)**
( ) At Request of he Beneficiary
( ) Other (specify reason)____

***Type of Information to be released (please check one)**
( ) Release ALL Information
( ) Specific Information to be released____

***Time Frame (please check one)**
( ) On-going release
( ) Limited (give date range)_________________________to_____________________________

Person, agency, company or organization to which you are authorizing Medicare to disclose your personal medical information:

*Name: Great Basin Physical Therapy and Performance Center, LLC
*Address: 1701 County Road, Suite B, Minden, NV 89423
*Phone & Fax: Phone: (775) 782-4466 Fax: (775) 783-9708

I authorize the use of a copy (including electronic copy) of this form and the disclosure of my personal medical information described above. I understand refusal to authorize disclosure of my personal medical information will have no effect on my treatment, enrollment, eligibility for benefits, or the Medicare pay for the health service I receive.

____ ________________

*Signature of Beneficiary or Authorized Representative *Date

If you are signing as an authorized representative, please describe the basis for your authority to act for the beneficiary and attach appropriate documentation. (For example, Power of Attorney or Appointment of Representative)

Please Note:

This Release of Authorization Request allows Medicare to disclose information from your records to the requested person, agency, company or organization that you authorized. Therefore, the information disclosed pursuant to the authorization may be redisclosed by the recipient and may no longer be protected by law.
You also have a right to revoke this Release of Information Request by contacting our office in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to the address below.

If you have any questions regarding this form please contact us at:

AK, AZ, HI, NV, OR, WA: 1-800-444-4606
CO: 1-800-332-6681
IA: 1-800-532-1285
ND: 1-800-247-2267
SD: 1-800-437-4762
WY: 1-800-442-2371

Return To:
Noridian Mutual Insurance Company
A CMS Contracted Carrier/Intermediary
4305 – 13th Avenue South
Fargo, ND 58103

ABN Form Instructions

The Medicare ABN form is a requirement for Medicare patients to complete each calendar year. By signing this form, you are verifying that you have been informed about the cap that Medicare puts on each patient's combined physical therapy benefits and speech language services each calendar year. The cap for each calendar year is $2,080.00. By checking "Option 1" and signing the first form, you are acknowledging this cap and that once it is exceeded you or your secondary insurance may be responsible for all treatments that have exceeded the Medicare cap.

By Checking "Option 1" and signing the second form, you are allowing us to charge Medicare directly for all possible treatment codes that will be used over the course of your therapy at Great Basin Physical Therapy and Performance Center. If you would prefer to handle the claims yourself, and NOT allow us to bill Medicare for your treatment, then please check any of the other options.

These forms are kept in your chart for reference purposes, and as proof that you have acknowledged Medicare's cap and policies for this calendar year.

Notifier(s):

Patient Name: **Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:	Physical Therapy over the Medicare Cap AND Occupational Therapy over the Medicare Cap	**$2,080.00** **$2,080.00**	Per Calendar year Per Calendar year
Reason Medicare May Not Pay:	Effective January 1, 2020, Medicare has limited Outpatient Physical Therapy and Occupational Therapy To a cap of **$2,080.00** per calendar year	Great Basin Physical Therapy and Performance Center, LLC. Will note in each patient chart the amount Medicare will pay for each visit to insure	Great Basin Physical Therapy and Performance Center, LLC. Will also inform each patient when they are close to exceeding the Medicare Cap.
Estimated Cost:	Any charges over the Medicare Cap that does Not qualify for additional treatment	Patient does not exceed Medicare's cap.	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

❑ **OPTION 1.** I want the ______listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the ______listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTION 3.** I don't want the ______ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08)

Form Approved OMB No. 0938-0566

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ____________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** ____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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Medicare Therapy Cap

Medicare has an outpatient physical therapy cap of $2,080.00 **PER CALENDAR YEAR** (Jan 1st – Dec 31st). This encompasses all cases/incidents/body parts treated within the year. As of January 1, 2018, this is a hard cap (no more can be requested). After the $2,080.00 has been met the patient will then be financially responsible for 100% of further physical therapy charges. At our facility this typically equates to between 16 and 20 visits. While we do our best to monitor utilization of the Medicare cap, it is also the patient's responsibility to monitor utilization and inform staff if any future surgeries are planned for the year, or if they received therapy at another facility this year.

I understand that there is a $2,080.00 outpatient physical therapy cap and that if my physical therapy charges exceed this, I will be 100% responsible for the payment.

______________________________________ ____________________

Patient or Representative Signature Date