THIS PAGE TO be FILLED OUT BY MEDICARE PATIENTS ONLY!

MEDICARE NOTICE

Lake Health Care Center, Inc.
910 Mt. Homer Road Eustis, Fl 32726

Medicare Patient Name _____ Medicare Number _____

Medicare requires Medicare patients to be aware and sign this notice. Medicare only pays for care that is absolutely not covered under any other program, such as auto injury, on the job injury (WC), black lung disease, liability/ personal injury with attorney, VA (DVA), disability paid for by carrier other than Medicare, end stage renal disease and any other possible special case. Of course, Medicare will allow you use your Medicare approved supplemental, Medigap and/or secondary coverage.

If you and/or your spouse have a group policy and your spouse is working, you may be covered by another insurance. We are asking you to please discuss this with the front desk and the physician treating you to make sure Medicare is the only choice for your treatment or care. This saves the Medicare system money. The Federal Government requires us to make sure that Medicare is the **only** source of coverage.

To the best of my knowledge and understanding, Medicare is the ONLY insurance available to pay for my care.

SIGNATURE OF PATIENT _____ **DATE** _____

LIFETIME AUTHORIZATION FOR MEDICARE

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made to me or on my behalf to Lake Health Care Center for any services furnished me by Lake Health Care Center. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I request that payment of authorized MEDIGAP benefits be made on my behalf to _____ for any services furnished me by _____. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for the related services.

*** If you have changes of coverage relating to Medicare please let use know immediately. ***

SIGNATURE OF PATIENT _____ **DATE** _____