PATIENT INFORMATION   **MEDICARE**   **DATE:**_____

(Please Print, Black Ink Only)

Patient Name:_____Home Phone: _____

Address:_____ Cell/Pager#:_____

City & State: _____ Zip:_____ e-mail: _____

Date of Birth: _____ Sex: <u>M F</u>   Marital Status: <u>S M D W</u>   Soc. Sec#: _____

Employer: _____Bus. Phone: _____

Address: _____City & State: _____ Zip: _____

Occupation: _____

Emergency Contact:_____**Telephone**:_____

Physician's Name: _____UPIN#:_____   NPI#:_____

Address: _____City & State: _____Zip: _____

Telephone: _____ Fax:_____

Medicare Number:_____   Effective Date:_____

Deductible $_____ Met? Yes/No – How much has been met? $ _____ P.T. Cap Met? Yes/No $ _____   P.T. Paid at _____%

COPY OF Rx (CHECK ON LINE):_____   **Date of Rx:_____   **Railroad: Y / N**

Dx: _____Exception? Y/N Surgery? Yes/No   Date of Sx: _____

Secondary Ins:_____Telephone: _____

Address: _____City & State: _____Zip:_____

Insured's Name: _____ Date of Birth: _____

ID# / S.S.: _____   **Group** / Policy#_____

Deductible $_____ Met? Yes/No – How much has been met? $ _____ P.T. Paid at _____%

Policy Limits?_____   Effective Date: _____

Do you cover as primary carrier when Medicare benefits have been exhausted? YES / NO (supplemental only)

Policy Limits?_____ Benefits given by_____

*NOTE: If you do not have Secondary Insurance a $5 per visit payment on account will apply. _____

                                                                                                      (Patient Initials)

* HAVE YOU RECEIVED HOME HEALTH CARE WITHIN THE LAST 60 DAYS? Y / N   Date of Last Visit _____

Who referred patient / How did patient hear of our facility? _____

Therapist: _____   Appt. Date & Time: _____   Revised Sept 2008

Patient's Signature_____   CPRx Officer Signature_____

□ Billing Face Sheet □ Copy Rx □ Copy Ins Cards front/back □ Ins Coverage Info □ Staffing Sheet □ Make Labels □ Stamp Charts □ Doc's List