

Medicare Part B Patient Intake Form

In order for us to submit your claims to Medicare for reimbursement, the following information is required. Please complete the following information in its entirety and hand it to the pharmacist.

Last Name: _____ First: _____

Middle Initial: _____ Generation, example, Jr., Sr., III, etc: _____
(ONLY IF it appears on your Medicare Card) (ONLY IF it appears on your Medicare Card)

Medicare Card #: _____ Part B Effective Date: _____
(EXACTLY as it appears on your Card)

Patient SSN: _____ D.O.B: _____ Sex: _____

Address: _____ City: _____
Permanent Address on file with Medicare

State: _____ Zip Code: _____ Telephone: _____

DO YOU HAVE CURRENT MEDICAID COVERAGE? Yes No

If Yes, Which State Issued Your Medicaid Card: _____

Medicaid Card I.D. # _____

DO YOU HAVE SECONDARY INSURANCE COVERAGE - Such as a MediGap Plan? Yes No

If Yes, Insurance Name _____ Card I.D. # _____

Primary Physician Name: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip _____

Medical Release Authorization for Claims

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (supplier) _____ for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____