

Professional Medical

Application for Medicare Co-Insurance Waiver

MEDICARE LAW REQUIRES A HEALTH CARE PROVIDER (SUCH AS A PHARMACY OR MEDICAL EQUIPMENT COMPANY) THAT ACCEPTS AN ASSIGNMENT FOR SERVICES BILLED TO THE MEDICARE PROGRAM, TO BILL THE BENEFICIARY FOR A PORTION OF THE COST OF THESE SERVICES. THIS IS CALLED MEDICARE CO-INSURANCE. THE HEALTH CARE PROVIDER MAY, HOWEVER, ELECT TO WAIVE ALL OR A PORTION OF THE MEDICARE CO-INSURANCE IF THE HEALTH CARE PROVIDER DETERMINES THAT THE BENEFICIARY DOES NOT HAVE THE ABILITY TO PAY THE MEDICARE CO-INSURANCE. IN ORDER TO ASSIST US IN DETERMINING IF YOU HAVE THE ABILITY TO PAY THE MEDICARE CO-INSURANCE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

NAME: _____ PHONE NUMBER: _____

ADDRESS: _____ DATE OF BIRTH: ___/___/___ SEX: _____

_____ MEDICARE # _____

1) ARE YOU RECEIVING ANY TYPE OF ASSISTANCE FROM LOCAL, COUNTY, STATE, OR FEDERAL GOVERNMENT AGENCIES? IF SO, DESCRIBE THIS ASSISTANCE: _____

2) IF NOT, DO YOU QUALIFY FOR ASSISTANCE FROM LOCAL, COUNTY, STATE, OR FEDERAL GOVERNMENT AGENCIES? IF SO, WHAT TYPE OF ASSISTANCE ARE YOU QUALIFIED TO RECEIVE? _____

3) DO YOU HAVE OTHER HEALTH INSURANCE THAT COVERS HEALTH RELATED PRODUCTS OR SERVICES? YES No If "YES", LIST THE COMPANIES AND POLICY NUMBERS: _____

4) IS A GUARDIAN OR ANYONE ELSE LEGALLY RESPONSIBLE FOR YOUR MEDICAL BILLS? YES No If "YES", GIVE THE NAME, ADDRESS AND PHONE NUMBER OF THIS PERSON: _____

5) ARE YOU EMPLOYED? YES No
If "YES", WHAT IS YOUR PAY PERIOD (E.G., WEEKLY, EVERY OTHER WEEK, 1ST & 15TH)? _____
HOW MUCH DO YOU GROSS PER PAY PERIOD? _____
HOW MUCH DO YOU NET PER PAY PERIOD? _____

6) DO YOU OWN YOUR OWN HOME? YES No
If "YES", IS IT PAID FOR OR ARE YOU STILL MAKING PAYMENTS ON IT? YES No
HOW MUCH IS EACH MONTHLY PAYMENT? _____

7) HOW MUCH DO YOU HAVE IN SAVINGS TO WHICH YOU HAVE IMMEDIATE ACCESS?
(DOES NOT INCLUDE QUALIFIED RETIREMENT) _____

8) WHAT IS YOUR MONTHLY NET INCOME FROM: YOUR EMPLOYMENT: _____
SOCIAL SECURITY: _____
RETIREMENT: _____
INVESTMENTS: _____
OTHER: _____

9) WHAT ARE YOUR MONTHLY EXPENSES: RENT OR HOUSE PAYMENT: _____
UTILITIES: _____
CAR PAYMENT: _____
OTHER TRANSPORTATION: _____
FOOD: _____
MEDICAL BILLS: _____
OTHER: _____
TOTAL MONTHLY EXPENSES: \$ _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND I REQUEST THAT THE
MEDICARE CO-INSURANCE BE WAIVED.

BENEFICIARY SIGNATURE

_____/_____/_____
DATE

SIGNATURE IF BENEFICIARY UNABLE TO SIGN

RELATIONSHIP TO BENEFICIARY

REASON BENEFICIARY UNABLE TO SIGN

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FOR OFFICE USE ONLY

DATE: ____/____/____

WAIVER APPROVED

WAIVER DENIED

APPROVAL SIGNATURE: _____

TITLE: _____

DATE: ____/____/____