



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 return it to the pharmacy.

Last Name: _____ First: _____

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

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

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

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

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 Medi Gap Plan)? Yes No

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

Primary Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

White – Medi-Mart Pharmacy Yellow – Resident

FOX HILLS: (248) 858-2225
SOMERSET: (248) 237-4455



Statement to Permit Assignment of Medicare/Medigap Benefits

I understand that I am giving **Fox Hills Medi-Mart, Ltd** permission to ask for Medicare/Medigap payments for my medical care, including supplies and equipment.

I understand that Medicare/Medigap Insurer needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare/Medigap Insurer and the companies that handle Medicare/Medigap payment requests.

I understand that the Centers for Medicare & Medicaid Services (CMS) are the government's Medicare agencies. I understand that a photocopy of this release is as valid as the original document. Furthermore, I understand that I am responsible for paying any deductible or co-insurance amounts.

Therefore, I ask that payment of authorized Medicare/Medigap benefits be made to either me or on my behalf to **Fox Hills Medi-Mart, Ltd** for any services or items furnished to me by **Fox Hills Medi-Mart**. I authorize any holder of medical or other information about me to release such information to the Centers for Medicare & Medicaid Services (CMS)/Medigap Insurer and its agents as needed to determine these benefits or benefits for related services.

Patient Name: _____

Medicare #: _____

Medigap Policy Name: _____

Policy Number: _____

Representative Name: _____

Address: _____

Phone: _____ Relationship: _____

Signature: _____

(Beneficiary's/Representative's)

Date: _____

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