*FOX HILLS MEDI-MART, LTD* *www.medimartrx.com*
*1539 S. Opdyke Road*
*Bloomfield Hills, Michigan 48304*

# 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: ______________________ 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 <u>MEDICAID</u> 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: _______________________________

<u>White</u> – Medi-Mart Pharmacy <u>Yellow</u> – Resident

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# Authorization Form

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: ______________________________________________

White – Medi-Mart Pharmacy Yellow – Resident

**TELEPHONE: (248) 858-2225 • FACSIMILE: (248) 858-2527**