WEST HILLS DERMATOLOGY GROUP
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Medicare Patient Information

Patient Name: ____

Social Security Number: ________________________________

Date of Birth: _____/_____/_____ Gender: ❒ Female ❒ Male

Race: ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian or Other Pacific Islander
❑ Black or African American ❑Hispanic or Latino ❑ White

Address: ____

____
City State Zip Code

( ) _______________________ ( ) _______________________
Home Phone Work Phone

____
Please print your name as it appears on your Medicare card

____
Medicare Health Insurance Claim Number as it appears on your card. *This is usually your Social Security number. Be sure to include the letter after the nine-digit number. It is important that we have both the numbers and letter)*

Referring Physician

Name:______________________________ Phone# ( ) _______________

Emergency Contact

Name of Spouse or Close Relative or Friend: ______________________________
(In Case of Emergency)

Phone# ( ) ___________________________

Please Sign So We May Have Your Medicare Authorization On File

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

____ ___/___/____
Signature of Patient Date

Payment Policy

***Medicare**:* **We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $183.00 deductible and paying for the 20% coinsurance. We do file with secondary or supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.**

WE DO NOT Accept Medicare HMO or any MEDI-CAL Plans

Supplemental Insurance or Medicare Advantage Plans

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare.

Name of Insurance Company: ____

Policy Number: _________________________ Group Number: ___________________

Name Policy Holder (Insured):____________________________________

❒ Male ❒ Female Date of Birth: ___/___/___

Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above carrier any information needed to determine these benefits or the benefits payable for related services.

____ ___/___/____

Signature of Patient Date