QUESTIONS & ANSWERS

Q: How do I meet the $100 deductible for Medicare?

A: Beginning on January 1 of each year, you may use the first $100 of all your "allowable" medical charges to meet your yearly Medicare deductible. (You may include charges from other doctors to meet your deductible) You must meet this deductible *before* Medicare will reimburse you for any charges.

Q: I have a supplemental insurance policy, what do I do?

A: Each Medicare supplemental insurance policy pays different percentages of you doctor's bills. In order to bill your supplemental insurance company, simply submit a copy of the "Explanation of Medicare Benefits (EOMB)" form which accompanies your Medicare payment to your supplemental insurance company.

Q: What is the difference between Medicare Part A and Part B?

A: The Medicare program is divided into two parts: Part A (Basic) coverage is for hospital services and related care. Part B (Supplemental medical Insurance) covers medical services by physicians, Chiropractors, outpatient hospital services, out-patient physical therapy services, ambulance services, durable medical equipment and independent laboratory services. You MUST have Part B coverage if you seek reimbursement for Chiropractic services.

Q: How do I submit my bills to Medicare for reimbursement?

A: As of September 1, 1990, you no longer have to handle the necessary paper-work for Medicare reimbursement. The physician that treated you MUST submit his/her charges directly to Medicare for you on an approved claim form in order for you or you physician to receive reimbursement for covered services.

If you have additional questions about Medicare, please feel free to office

Compliments of:

IMPORTANT INFORMATION FOR OUR MEDICARE PATIENTS

EXPLANATION OF NON-COVERED CHIROPRACTIC SERVICES

DEDUCTIBLE

Medicare requires that you pay a yearly deductible of $100 towards your Part B medical expenses before they will begin paying for covered services. If you have already been treated by other doctors this year, you may apply those bills towards your deductible.

MEDICARE COVERAGE

After, you have met your deductible, Medicare will reimburse 80% of the "allowable" treatment charges. The only "allowable" treatment charge by a Chiropractor is *Manual manipulation of the spine.*

According to Medicare guidelines. Medicare will only allow Chiropractic treatment that is reasonable and necessary to restore or arrest the patient's covered condition. Once Medicare determines that further manipulation treatment is not "reasonable or necessary", you will then be responsible to pay for all of your treatment charges.

X-RAYS

Medicare does not require x-rays in order to be reimbursed for chiropractic treatment. Your doctor may determine x-rays are necessary to assess your condition. If x-rays are taken or ordered by your Chiropractor, they are not covered by Medicare and therefore you are fully liable for the charges for x-rays.

EXAMINATIONS

In order to determine the extent of your condition, as well as the type of treatment you will need the doctor will examine you prior to the initiation of treatment, and periodically thereafter. Medicare will not reimburse for examination charges; and therefore, payment must be made by you.

PHYSICAL THERAPY, SUPPLEMENTS and SUPPORTS

During the course of your treatment in this office, the doctor may determine that certain physical therapy modalities or procedures, vitamin supplements or orthopedic supports may be necessary to assist in the treatment of your condition. Medicare will not reimburse for any of these services, and therefore, payment must be made by you.

I understand that. although the Chiropractic services listed above may be required for treatment of my condition, these charges are not covered by Medicare and I will be personally responsible for payment of these charges.

Patient's Signature _____ **Date** _____

Patient's Name _____ **Medicare Claim Number** _____

ADVANCE NOTICE OF NON-COVERED SERVICES

(Required Language)

PHYSICIAN NOTICE

In accordance with the Medicare Act, Section 1842(i), this letter is to advise you that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(i) of the Medicare Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment for :

Procedure description: Examinations, x-rays, physical therapy, supplements and supports.

Treatment plan (or dates of services):

Medicare pays for your spinal manipulation only.

the reason(s) for this denial is: If Medicare deems treatment is not medically necessary, then the patient is responsible for the treatment they have received.

BENEFICIARY AGREEMENT

I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Beneficiary's Signature _____ **Date** _____

Witness Signature _____ **Date** _____