BENSON AREA MEDICAL CENTER, INC.
3333 NC HWY 242 N
P. O. BOX 309
BENSON, NC 27504
919-894-2011

Medicare Consent Form

Patient Name: _____ **Date of Birth:**_____
Medicare ID #: _____

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made payable on my behalf to Benson Area Medical Center, Inc., for any services furnished to me by Benson Area Medical Center, Inc. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits of related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until evoked by me in writing.

_____ _____ _____

Signature of Beneficiary | Medicare ID Number | Date

Medi-Gap Insurance Lifetime Assignment of Benefits

I, the undersigned, have Medi-gap Insurance coverage and assign directly to Benson Area Medical Center, Inc. all medical benefit payments on my behalf. I hereby authorize release of medical information necessary to secure benefit payments. I authorize the use of the signature on all insurance submissions whether manual or electronic. This assignment is in effect until evoked by me in writing.

_____ _____ _____

Signature of Beneficiary | Medicare ID Number | Date

Medicare Secondary Payer (MSP) Form

Benson Area Medical Center, Inc.
P.O. Box 399
Benson, NC 27504

Patient Name: _____

Medicare #: _____

Provider #: _____

Date: _____

1. Do you receive Veteran's benefits? Yes No

2. Are you receiving benefits under the Black Lung Program? Yes No

If yes, date benefits began _____

If yes, are the services you will be receiving related to a non-black lung condition? Yes ( ) No( )

3. Was this injury/illness due to a work related accident/condition? Yes ( ) No( )

If yes, date of injury/illness _____

4. Was this injury/illness related to an automobile accident? Yes ( ) No( )

If yes, date of accident _____

5. Was this injury/illness related to an accident in which you intend to file a liability suit or litigation is pending? Yes ( ) No( )

If yes, please provide: Attorney's name: _____

Address: _____

Phone number: _____

6. Are you entitled to Medicare based on:

Age 65 & over? If yes, go to question 7 Yes ( ) No( )

Disability: If yes, go to question 7 Yes ( ) No( )

End Stage Renal Disease? Yes ( ) No( )

Do you have group health plan (GHP) coverage? Yes ( ) No( )

Are you within the 30-month coordination period? Yes ( ) No( )

7. Are you currently employed? Yes ( ) No( )

Date of retirement _____

Is your spouse currently employed? Yes ( ) No( )

Date of retirement _____

8. Do you have a group health plan (GHP) as primary coverage

based on your own or a spouse's current(or former) employment? Yes No

Does the employer that sponsors your GHP employ 20 or more employees? Yes No

9. If you answered Yes to questions #3, #4 or #7 above, please complete the following information:

Insurance Co: _____

Address: _____

Policy/Cert #: _____

Group name & #: _____

Patient's name _____ Date ____/____/_____

Responsible party_____

Relationship _____