# HealthWorks Medicare Policy

We are pleased that you have made HealthWorks your Physical Therapy Center of Choice. As a service to you we have voluntarily decided to accept assignment for Medicare patients. This means the following:

1. We accept Medicare's reimbursement level for our services.
2. We file your claim for you, free of charge.
3. Medicare will reimburse us directly for 80% of your covered charges. You will be billed monthly for your 20% co-payment and any deductible.

Also, you need to be aware of some special requirements that Medicare applies to those receiving outpatient physical therapy.

## MEDICARE REGULATIONS

1. A dictated evaluation with a plan of care will be sent to your referring physician.
**2.** At least every 30 days we will forward a re-evaluation with an updated plan of care.
**3. Medicare does not pay for most rehabilitation supplies/equipment for home use.** You will be responsible for any such non-covered charges.
**4.** Medicare rules limit routine physical therapy services in all outpatient clinics. The limit is **$1900.00** for the year. *However, a patient may qualify for an exception when the patient's condition is justified by documentation indicating the patient requires continued skilled care beyond the cap. Medicare has been generous with extending care for beneficiaries in need of additional care. Your physical therapist will decide if you qualify for extended care.*

Signature: _____ Date: _____

## ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to HealthWorks for any services furnished me by that supplier. 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 payable for related services.

Signature: _____ Date: _____

## NAME OF BENEFICIARY,HICN,MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap benefits be made on my behalf to HealthWorks for any services furnished me by that supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits.

Signature: _____ Date: _____