

Date: _____ Qualifier: _____ Account #: _____

Office Use Medicare Filing Form

What is your primary insurance? _____ Is it an HMO? **Yes** **No**

Are you covered under your Wife's insurance? **Yes** ***No** (if Yes, get Wife's info)

Wife's Name: _____ Wife's DOB: _____

Are you still employed? **Yes** **No** Have you ever discussed ED with your Dr.? **Yes** **No**

Has Medicare ever bought you VED? ***Yes** **No** *If Yes when? _____

Patient's full name _____
(as on Medicare Card)

Permanent Address _____

City, State, Zip Code _____

Patient's phone number _____ Alternate phone number _____

Patient's date of birth _____ Email address _____

Medicare number _____ Medicare Part B? **Yes** **No**

Supplemental insurance name _____

Address _____

City, State, Zip Code _____

Phone number _____ CMS # _____

Supplement policy ID number _____ Group number _____

Physician's Name _____

Address _____

City, State, Zip Code _____

Phone Number _____ Fax _____

NPI _____ UPIN _____

BOS _____ MVP _____ DVD _____ VHS _____
Verify Dr. Licensure _____