Patient Information & Insurance Intake Form

MED-EL

PATIENT INFORMATION

First name:	Last name:	
Middle name:	Nickname:	
Mailing address:		
City:	State:	Zip code:

MED-EL is unable to send replacement parts to a P.O. Box. If the mailing address listed above is a P.O. Box, please provide a physical mailing address for shipment of replacement parts in the shipping address section below.

** Your protected health information cannot be protected using unencrypted email addresses through email services such as Gmail, Yahoo, etc. If you send or are receiving protected health information via email, please be aware that there is risk to your protected health information.*

Shipping address:			
City:		State:	Zip code:
Home phone:	Cell phone:	Work phone:	
Email address*:			
Preferred contact method: ☐ Home phone	☐ Cell phone	☐ Work phone	☐ Email
Date of birth (mm/dd/yyyy):			
Social security number:			
Gender: ☐ Male ☐ Female			
Surgeon:			
Clinic:			
Implanted side: ☐ Left ☐ Right ☐ Bilateral			

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

We request that you sign and date this form in the box below to acknowledge your receipt of the following forms included herein:

- Privacy Practices
- Client Bill of Rights
- Customer Service Billing Policy
- Service Contract Options
- DMEPOS Standards
- Product User Manuals that came with your initial kit

*Please note that we are required by **federal law** to ask for written confirmation of your receipt of the Notice of Privacy Practices and Bill of Rights.* Please return this form to MED-EL using the self-addressed stamped envelope enclosed for this purpose. If you have any questions feel free to contact MED-EL at (888) 633-3524.

Patient's name:	
Signature:	

MED-EL requires documentation if patient is over 18 years old, but assigned a legal guardian (i.e. Power of Attorney).

Legal guardian name (If patient is under 18 years old or if patient is unable to care for self):	
Legal guardian signature:	Relationship to patient:
Date (mm/dd/yyyy):	

If you did not receive any of the forms listed above please write them in the space below.
We will send them to you as soon as possible.

AUTHORIZED DESIGNEES (Persons that may act on your behalf)

MED-EL Corporation is authorized to release my Protected Health Information to the individuals listed below.
Each authorized designee must have a unique email address on file for conducting transactions.
Authorized designees will have access to the following information: Demographic information, appointments/surgery information, insurance and billing information, payment & equipment history

Legal Guardian - Authorized Designee

Last name:	First name:
Preferred Phone number:	Email address:
Relationship:	
Is this person an Authorized Designee for another MED-EL patient/user? ☐ Yes ☐ No	

Authorized Designee Last name:	First name:
Relationship:	Preferred phone number:
Email address:	
Is this person an Authorized Designee for another MED-EL patient/user? ☐ Yes ☐ No	

Authorized Designee Last name:	First name:
Relationship:	Preferred phone number:
Email address:	
Is this person an Authorized Designee for another MED-EL patient/user? ☐ Yes ☐ No	

Authorized Designee Last name:	First name:
Relationship:	Preferred phone number:
Email address:	
Is this person an Authorized Designee for another MED-EL patient/user? ☐ Yes ☐ No	

Authorized Designee Last name:	First name:
Relationship:	Preferred phone number:
Email address:	
Is this person an Authorized Designee for another MED-EL patient/user? ☐ Yes ☐ No	

ASSIGNMENT OF BENEFITS, MEDICAL RELEASE, AND FINANCIAL RESPONSIBILITY

MEDICAL INFORMATION RELEASE AUTHORIZATION

I authorize MED-EL Corporation to release my personal health information to insurance companies and health care professionals for the purposes of treatment, payment and other healthcare related options.

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY CONSENT

I request that any payment of authorized insurance benefits be made directly to MED-EL for any equipment purchases provided by MED-EL Corporation.

I further agree to assume financial responsibility for all claims due to MED-EL for equipment not paid by my insurance. If my primary, secondary and/ or tertiary insurance coverage changes or if payment/ coverage is denied, I understand that I am financially responsible for any amount not covered.

Patient's name:	Date (mm/dd/yyyy):
Signature:	Relationship to patient:

If you are requesting that MED-EL Corporation submit claims on your behalf to your insurance company, please complete pages 3 and 4 attached.

Please note that MED-EL Corporation is not contracted with all insurance companies and may not submit claims in all circumstances. Please contact our Reimbursement Department with questions related to your insurance coverage.

PRIMARY INSURANCE INFORMATION

Insurance company name:
Policy holder's name:
Policy holder's social security number:
ID number (if different from social security number):
Group number:
Type of insurance plan: ☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid ☐ Other:

SECONDARY INSURANCE INFORMATION

Insurance company name:
Policy holder's name:
Policy holder's social security number:
ID number (if different from social security number):
Group number:
Type of insurance plan: ☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid ☐ Other:

TERTIARY INSURANCE INFORMATION

Insurance company name:
Policy holder's name:
Policy holder's social security number:
ID number (if different from social security number):
Group number:
Type of insurance plan: ☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid ☐ Other:

PLEASE INCLUDE A COPY (FRONT AND BACK) OF ALL INSURANCE CARDS ALONG WITH THIS FORM

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Are you currently employed? ☐ Yes ☐ No

If you answered yes, are you covered under a group health plan from your employer? ☐ Yes ☐ No

If you are currently employed, does your employer employ more than 20 employees?

☐ Yes. Your group health plan is primary to Medicare.

Name of group health plan:

Policy number:

☐ No

If you are not currently employed, are you retired? ☐ Yes ☐ No

Date of retirement (mm/dd/yyyy):

Is your spouse currently employed? ☐ Yes ☐ No

If yes, are you covered under your spouse's group health plan from their employer? ☐ Yes ☐ No

Does your spouse's employer employ more than 20 employees?

☐ Yes. Your spouse's group health plan is primary to Medicare.

Name of group health plan:

Policy number:

☐ No

If your spouse is not currently employed, is your spouse retired? ☐ Yes ☐ No

Date of retirement (mm/dd/yyyy):

ADDITIONAL MEDICARE INFORMATION

Are you enrolled in a Medicare HMO/PPO? ☐ Yes ☐ No Date (mm/dd/yyyy):

Are you enrolled in: ☐ Medicare Part A *or* ☐ Medicare Part B (select all that apply)

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