INHEALTH™
TECHNOLOGIES

Blom-Singer®
voice restoration systems

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Medicare Information/Address Change Form

Patient (Beneficiary) Medicare Information

☐ **Address Change Only (Complete form on reverse)**

Please complete all areas and sign on reverse. Please print clearly.

Please submit a copy of your Medicare Health Insurance Card, along with the completed information below. This form need only be submitted one time, unless information has changed. For secondary insurance, please complete form on reverse.

Patient's Name: _____
FIRST MIDDLE LAST

Street Address: _____
PERMANENT ADDRESS (WHERE YOU RESIDE 6 MONTHS A YEAR)

City: _____ State/Zip: _____

Telephone: **(area code)** — E-mail: _____

Patient's date of birth: ☐☐ ☐☐ ☐☐ (MONTH DAY YEAR) Gender: ☐ Male ☐ Female

Beneficiary's Medicare Claim Number: _____
(9 NUMBERS WITH ALPHA CODE, FROM YOUR MEDICARE HEALTH INSURANCE CARD)

Effective Dates from Medicare Health Insurance Card:

Hospital (Part A): ☐☐ ☐☐ ☐☐ (MONTH DAY YEAR) Medical (PartB): ☐☐ ☐☐ ☐☐ (MONTH DAY YEAR)

Is Medicare your primary insurer for Medical (Part B) claims? ☐ Yes ☐ No

Note: *If Medicare is your* ***secondary*** *insurer for Medical (Part B) claims, you must file the claim with the appropriate primary insurer (i.e., employer group plan, worker's compensation, etc.).*

REQUIRED PHYSICIAN INFORMATION

Please complete the information below for your ordering or referring physician. Medicare will not accept a speech pathologist's name. This must be your physician's name. Your physician does not need to sign this form.

Physician's Name: _____
FIRST MIDDLE LAST

Street Address: _____

City: _____ State/Zip: _____

Telephone: **(area code)** — Fax: **(area code)** —

E-Mail: _____ _____
PHYSICIAN'S 6 DIGIT MEDICARE UPIN NUMBER

SECONDARY PAYER INFORMATION

The secondary payer information must be completely filled out for us to include this information along with your Medicare claims. Any incomplete forms will delay processing. Please include a copy of your insurance card, front and back.

Policy Holder's Name: _____
FIRST MIDDLE LAST

Street Address: _____
PERMANENT ADDRESS (WHERE YOU RESIDE 6 MONTHS A YEAR)

City: _____ State/Zip: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company's Name: _____

Group number: _____ Policy number: _____

ADDRESS CHANGE

If your address has changed, please provide current address:

Patient's Name: _____
FIRST MIDDLE LAST

Street Address: _____
PERMANENT ADDRESS (WHERE YOU RESIDE 6 MONTHS A YEAR)

City: _____ State/Zip: _____

Telephone: **(**area code**)** **—** E-mail: _____

REQUIRED PATIENT'S SIGNATURE

Signature of Patient or Authorized Person is required for both Medicare Information and Address Change:

I request that payment of authorized Medicare benefits be made directly to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medical Services and its agents any information needed to determine these benefits for related services.

I understand that benefits quoted to me by InHealth Technologies, Medicare, or my insurance company is not a guarantee of reimbursement. Reimbursement is made on an individual claim-by-claim basis. Previous reimbursement on items or services is not a guarantee of future reimbursement. I understand that once a claim has been filed the products are not returnable to InHealth Technologies for a refund.

I agree that all costs of Blom-Singer Voice Prostheses, ATSV II and Humidifilter System and accessories, Blom-Singer Laryngectomy Tubes, Servox products and accessories, Barton-Mayo Button, and all InHealth Technologies accessory supplies are my responsibility and prepaid before claims are processed.

X _____ _____
PATIENT'S SIGNATURE TODAY'S DATE