



SURGICAL ASSOCIATES OF SUSSEX COUNTY, PA
135 Newton Sparta Road
Newton NJ 07860
Ph (973) 383-6244 Fax (973) 383-0573

Financial Policy for Medicare Recipients

It is our desire to provide you with the best possible medical care. This involves mutual understanding between the patients, doctors and staff. We encourage you, our patients to discuss any questions you may have regarding our professional fees, this financial policy, and your responsibility.

Deductible and Co-pays:

You will be financially responsible for your annual deductible and for co-payments representing 20% of the allowable Medicare fee for service. **We will not waive the annual deductible and co-payments. This is federal law, with which we must comply.**

Excluded Services:

The Medicare program specifically excludes payment for certain items, services and procedures recommended by the doctor that are not covered by Medicare. You will be asked to sign an Advanced Beneficiary Notice (ABN) prior to the delivery of non-covered services. Your claim will be submitted to Medicare. When we receive the Medicare denial, you will be billed.

Secondary Insurance:

If you have secondary coverage, the Medicare program can set up a crossover to many insurance companies. Please call **Medicare Secondary Payer Inquiries (MSP) phone 1-800-999-1118. You will need your Medicare number and your secondary insurance information. You will also have to call your secondary insurance company to notify them of the Medicare Crossover.**

Coordination of Benefits:

If you neglect to respond to Medicare regarding your "Coordination of Benefits", you will automatically be responsible for all unpaid medical charges filed on your behalf with Medicare. **Medicare Coordination of Benefits phone number is 1-800-999-1118.**

SIGNATURE ON FILE PROVISION REQUIRED BY MEDICARE

Patient Name _____
Last First MI

Medicare ID # _____

I request that payment of authorized Medicare benefits be made on my behalf to Surgical Associates of Sussex County, PA for any services furnished to me by physician or supplier. I authorize the release of my medical information or other information necessary to process this claim to the Centers for Medicare and Medicaid Services (CMS) and its agents.

Signature of Patient Date

If you have any questions, please do not hesitate to speak to our Practice Administrator.