

**University of Utah Hospital and Clinics**

2009 Medicare Billing Form: Fax to (801)587-6318 Attn: Kelly Jaramillo or Dorothy Matiyasic

**Patient Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: Male/Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Medicare # (include letter): \_\_\_\_\_

Insulin Dependent: \_\_\_\_\_ Non Insulin Dependent: \_\_\_\_\_ (please ask at each fill)

Secondary Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Date of last fill: \_\_\_\_\_ Form completed by: \_\_\_\_\_

**Rules and Restrictions**

Medicare's deductible for 2009 is \$135.00. After this deductible has been met, Pharmacy Administration will invoice the patient and/or secondary insurance for the remaining 20%.

Patient received DMEPOS Supplier Standards.  Yes  No \_\_\_\_\_

**Patient Signature** **Date**

**20% COSTS ARE:**

Test Strips 50ct = \$7.76

Test Strips 100 ct = \$15.52

Lancets 100 ct = \$2.53

Lancet Device = One every 6 months \$3.73

Control Solutions = One box every 6 months = \$2.04

**IF YOU ARE NON-INSULIN DEPENDENT, YOU MUST PAY FOR ANY QUANTITY OVER MEDICARE'S ALLOWABLE OF 100 STRIPS PER 90 DAYS.**

**IF YOU ARE INSULIN DEPENDENT, YOU MUST PAY FOR ANY QUANTITY OVER MEDICARE'S ALLOWABLE OF 100 STRIPS PER 30 DAYS.**

By signing this form you agree to be responsible for all fees not covered by Medicare and/or your insurance company.

Patient Signature required \_\_\_\_\_

▼Attach Prescription Labels Here▼