Medicare Release

Medicare requires that the physical therapists at Lymphedema Rehab keep in close contact with your doctor throughout your treatment. We will send your initial evaluation and plan of care, as well as any progress notes to your doctor to get his/her certification as needed. Medicare requires that you have seen your doctor (Primary Care or Specialist) within the last 30 days for your physical therapy visits to be covered. Please inform your therapist if you have not seen a doctor within the past 30 days, as your visit will not be covered and you will be responsible for payment.

Medicare Cap for 2018
As of January 2018, Medicare has determined the financial cap for both Physical Therapy (PT) and Speech and Language Pathology (SLP) combined to be $2,010.00 per calendar year. If you have received Physical Therapy (PT) or Speech and Language Pathology (SLP) services elsewhere within this calendar year, it is important that you inform Lymphedema Rehab, as the benefit used on either of these services prior to this appointment, will lessen the amount of benefit that you have left. We will do our best in keeping you informed on where your benefit amount is during your treatment with us.

Medicare Deductible for 2018
As of January 2018, Medicare has established a deductible of $183.00 per year. After your deductible has been met, you will typically be responsible for 20% of the Medicare-approved amount for the service provided. If you have a secondary insurance, please provide this to Lymphedema Rehab upon your initial visit, as this may cover your Medicare coinsurance.

I authorize payment of my insurance benefits be made directly to Lymphedema Rehab for ay services that are reimbursable by Medicare or any other insurance company that I provide.

I understand that I am responsible for any payment not made by my insurance, such as deductibles and coinsurance. I understand that these are payable at the time of services OR by statement receipt. I understand that I am responsible to pay the amount owed by the billing statement due date.

I certify that the information that I provided to Lymphedema Rehab for payment under the Social Security Act (Medicare) is truthful and accurate to the best of my knowledge.

Name ____

Sign ____ Date________________________