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Company Letterhead
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Application for Medicare Co-Insurance Waiver

MEDICARE LAW REQUIRES A HEALTH CARE PROVIDER (SUCH AS A PHARMACY OR MEDICAL EQUIPMENT COMPANY) THAT ACCEPTS AN ASSIGNMENT FOR SERVICES BILLED TO THE MEDICARE PROGRAM, TO BILL THE BENEFICIARY FOR A PORTION OF THE COST OF THESE SERVICES. THIS IS CALLED MEDICARE CO-INSURANCE. THE HEALTH CARE PROVIDER MAY, HOWEVER, ELECT TO WAIVE ALL OR A PORTION OF THE MEDICARE CO-INSURANCE IF THE HEALTH CARE PROVIDER DETERMINES THAT THE BENEFICIARY DOES NOT HAVE THE ABILITY TO PAY THE MEDICARE CO-INSURANCE. IN ORDER TO ASSIST US IN DETERMINING IF YOU HAVE THE ABILITY TO PAY THE MEDICARE CO-INSURANCE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

NAME: ______________________________ PHONE NUMBER: ____________________

ADDRESS: ______________________________ DATE OF BIRTH: ___/___/_____ SEX: _____

______________________________ MEDICARE # ____________________

1) ARE YOU RECEIVING ANY TYPE OF ASSISTANCE FROM LOCAL, COUNTY, STATE, OR FEDERAL GOVERNMENT AGENCIES? IF SO, DESCRIBE THIS ASSISTANCE: ______________________________

____

2) IF NOT, DO YOU QUALIFY FOR ASSISTANCE FROM LOCAL, COUNTY, STATE, OR FEDERAL GOVERNMENT AGENCIES? IF SO, WHAT TYPE OF ASSISTANCE ARE YOU QUALIFIED TO RECEIVE?

____

____

3) DO YOU HAVE OTHER HEALTH INSURANCE THAT COVERS HEALTH RELATED PRODUCTS OR SERVICES?
YES ☐ NO ☐ IF "YES", LIST THE COMPANIES AND POLICY NUMBERS:

____

____

4) IS A GUARDIAN OR ANYONE ELSE LEGALLY RESPONSIBLE FOR YOUR MEDICAL BILLS?
YES ☐ NO ☐ IF "YES", GIVE THE NAME, ADDRESS AND PHONE NUMBER OF THIS PERSON:

____

____

5) ARE YOU EMPLOYED? YES ☐ NO ☐
IF "YES", WHAT IS YOUR PAY PERIOD (E.G., WEEKLY, EVERY OTHER WEEK, 1ST & 15TH)? __________
HOW MUCH DO YOU GROSS PER PAY PERIOD? _____________
HOW MUCH DO YOU NET PER PAY PERIOD? _____________

6) DO YOU OWN YOUR OWN HOME? YES ☐ NO ☐
IF "YES", IS IT PAID FOR OR ARE YOU STILL MAKING PAYMENTS ON IT? YES ☐ NO ☐
HOW MUCH IS EACH MONTHLY PAYMENT? _________________

7) How much do you have in savings to which you have immediate access?
(does not include qualified retirement) ______________________________

8) What is your monthly net income from:

Your Employment:________________
Social Security: __________________
Retirement: ______________________
Investments: _____________________
Other: ___________________________

9) What are your monthly expenses:

Rent or House Payment:________________
Utilities:_____________________________
Car Payment: __________________________
Other Transportation: _________________
Food:_________________________________
Medical Bills:__________________________
Other:________________________________
Total Monthly Expenses: $_____________________________

I certify that the above information is true and correct and I request that the Medicare co-insurance be waived.

____ ______/______/______
Beneficiary Signature Date

____ ____________________
Signature if Beneficiary Unable to Sign Relationship to Beneficiary

____
Reason Beneficiary Unable to Sign

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FOR OFFICE USE ONLY

Date:_____/_____/_____

Waiver Approved ☐

Waiver Denied ☐

Approval Signature: ____

Title: ____ Date:_____/_____/_____