PT PROS
Physical Therapy & Sports Centers

Medicare Annual Limit Questionnaire

To: Medicare Beneficiaries

Medicare places limits on the amount they pay for outpatient physical therapy, occupational therapy and speech therapy services. For 2024, there are two levels of limitations, or caps.

The first level of therapy cap is:

$2,330 for physical therapy and speech therapy combined.
$2,330 for occupational therapy.

After meeting your deductible, Medicare will pay up to 80% of the allowed limit, which will be $1,864. You may qualify for an exception to this therapy cap limit so that Medicare will continue to pay its share for your therapy services up to the second level cap of $3,000.

A Medicare contractor will review your medical records to check for medical necessity if you reach the second level of limitation, which is:

Any therapy services exceeding $3,000 will require review from a Medicare contractor to determine medical necessity.

PT PROS, Inc. will not compromise your care in any manner; we will assist you in tracking your visits and limits. If you reach your limit, we will work with you on a self-pay basis to continue your care so that your functional outcome will be maximized. Upon reaching your allowable limit, you will also have the option of receiving covered services in a hospital outpatient therapy setting.

To assist us in tracking your available benefits, please answer the following questions:

1. Have you received any physical therapy in the following settings of Hospital, Home Health, Outpatient Clinic, Rehab Facility, or Doctor's Office since 1/1/24? Yes ☐ No ☐

2. Have you received any speech therapy in the following settings of Hospital, Home Health, Outpatient Clinic, Rehab Facility, or Doctor's Office since 1/1/24? Yes ☐ No ☐

3. Are you enrolled or have been enrolled over the past year in Home Health for ANY medical conditions? Yes ☐ No ☐

If you are unsure about the above questions, please ask a staff member for assistance.

I have read and understand the above information.

_____ _____
Patient Signature Date

_____
Witness Signature

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Medicare Secondary Payer Questionnaire (September 2002)

Medicare Patient Information:

Patient Name: _____

Person Who Supplied Information: _____

Relationship to Patient: _____

1. Workers Compensation (WC):

Per the patient, should the illness/injury be covered by a WC claim? _____ Yes _____ No

If yes, this should be an MSP or conditional claim, Medicare primary. Please Note: WC is primary only for claims related to a WC injury.

Original Date of Illness/Injury:: _____ Claim Number: _____

Name of WC Plan: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

2. Federal Black Lung (BL):

Is the patient covered by the BL program? _____ Yes _____ No

Date Benefits Began: _____ (BL is primary only for claims related to BL.)

3. Department of Veterans Affairs (DVA):

Is the patient entitled to benefits through DVA? _____ Yes _____ No

If Yes, has the DVA authorized and agreed to pay for care at this facility? _____ Yes _____ No

4. Public Health Services (PHS):

Are the services to be paid by a government program such as a reserch grant? _____ Yes _____ No

If Yes, the government program will pay primary benefits for these services.

What is the name of the PHS? _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

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5. Accident:

Are these services the result of a non-work related accident? _____ Yes _____ No

If yes, what type of accident was this or give a description of the accident (for example: auto, slip and fall, malpractice, product liability, homeowners)? _____

Date of Accident: _____ Location of Accident (home, restaurant, etc.): _____

A. Non-Liability Insurance:

Is non-liability insurance available (e.g., premises medical, auto medical coverage, no-fault, homeowner's premises)? _____ Yes _____ No

If yes, name of the insurance company: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Who is listed as the insured? _____ Claim Number: _____

B. Liability Insurance:

Does the patient feel someone else is responsible for the accident/injury? _____ Yes _____ No

If yes, name of the responsible party's insurance company: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of Resposible Insured Party? _____ Claim Number: _____

6. Working Aged:

Is the patient 65 years or older? _____ Yes _____ No **(If No Move to Question #7)**

Is the patient currently employed by an employer of 20 or more employees? _____ Yes _____ No

If yes, name of the employer: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

If the patient is no longer employed, please give a retirement date: _____ (MM/DD/CCYY)

Is the spouse currently employed by an employer of 20 or more employees? _____ Yes _____ No

If yes, name of the employer: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

If the spouse is no longer employed, please give a retirement date: _____ (MM/DD/CCYY)

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Medicare Secondary Payer Questionnaire

6. Working Aged (Continued):

If the patient or spouse is employed by an employer of 20 or more employees, is the patient covered by that Group Health Plan (GHP)? _____ Yes _____ No

If yes, name of the GHP: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____ Group Identification #: _____

Name of Policy Holder: _____ Relationship to Patient: _____

7. Disablility:

Is the patient under the age of 65? _____ Yes _____ No **(If No Move to Question #8)**

If yes, is the patient entitled to Medicare due to a disability other than end stage renal disease? _____ Yes _____ No **(If No Move to Question #8)**

Is the patient employed by an employer of 100 or more employees? _____ Yes _____ No

If yes, name of employer: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

If the patient is no longer employed, please give a retirement date: _____ (MM/DD/CCYY)

Is a family member currently employed by an employer of 100 or more employees? _____ Yes _____ No

If yes, name of employer: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Is the patient covered by that Group Health Plan (GHP)? _____ Yes _____ No

If yes, name of the GHP: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____ Group Identification #: _____

Name of Policy Holder: _____ Relationship to Patient: _____

(Continue with Question #8)

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Medicare Secondary Payer Questionnaire

8. End-Stage Renal Disease:

Is the patient entitled to Medicare due to end-stage renal disease (ERSD)? _____ Yes _____ No

Is the patient covered by a GHP through a current or former employer of any size? _____ Yes _____ No

If yes, name of the GHP: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____ Group Identification #: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Name of Employer Sponsoring GHP: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Is the patient within the 30-month coordination period? _____ Yes _____ No

Month/year of first regular dialysis: _____ (MM/CCYY)

If the patient participated in a self-dialysis training program, provide the date training started: _____ (MM/DD/CCYY)

Has the patient had a kidney transplant? _____ Yes _____ No

If yes, the date of transplant: _____ (MM/DD/CCYY)

Note: If the patient is within the 30-month coordination period, the GHP should be primary.)

(Continue with Question #9)

9. Dual Entitlement:

Is the patient entitled to Medicare on the basis of both ESRD and Working Aged or ESRD and Disability? _____ Yes _____ No

Was the patient's initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? _____ Yes _____ No

Do either the Working Aged or Disability MSP provisions apply? _____ Yes _____ No

Note: If yes to the last question, the GHP remains primary for the 30-month coordination period.

Signature: _____ **Date:** _____