Insurance and Medical Assistance Coverage Form

Patient's Name:_____ Date of Birth: _____

Form Completed by: _____ Relationship to Patient: _____

Date Completed: _____

Please answer the following questions:

- Patient currently receives SSDI benefits from the state of _____ and has been receiving these benefits since _____.

- Patient is the beneficiary of **Medicare/MDCR** (not Medicaid) as the primary healthcare insurance. ____YES ____NO

- Patient is the beneficiary of **Medicare/MDCR** (not Medicaid) as the secondary healthcare insurance. _____YES _____NO

- Patient is the beneficiary of PRIMARY healthcare coverage under
  ____BlueCrossBlueShield ____ United Healthcare
  ____ Maryland Medical Assistance ____ Medicare/MDCR
  ____ Other: _____

- Patient is the beneficiary of SECONDARY healthcare coverage under
  ____BlueCrossBlueShield ____ United Healthcare
  ____ Maryland Medical Assistance ____ Medicare/MDCR
  ____ Other: _____

I, _____, understand that The Pediatric Development Center is NOT a preferred provider with Medicare/MDCR and under the penalty of law cannot legally provide services to any patients who are beneficiaries of Medicare either as a primary nor a secondary insurance coverage plan. PDC is required to refer patients who are beneficiaries of Medicare elsewhere for therapy services.

I, _____, understand that The Pediatric Development Center requires any changes in patient healthcare coverage which occur during the course of treatment at PDC must be reported immediately to the billing department or the administrative staff.

Signature: _____ Date: _____

Print Name: _____