

wellGroup

HealthPartners

Website: wellgroup.org

MEDICARE PATIENTS

333 Dixie Highway
Chicago Heights
Illinois 60411-1790

10043 Lincoln Highway
Frankfort,
Illinois 60423-1272

20939 S. Cicero
Matteson
Illinois 60443-1620

3800 W. 203rd. Street
Olympia Fields
Illinois 60461-1093

3700 W. 203rd. Street
Olympia Fields
Illinois 60461-1019

RECORD NO.	ACCOUNT NO.	EMPLOYEE INIT.	TODAY'S DATE	PATIENT D.O.B.	SOCIAL SECURITY NO. - -
PATIENT NAME			MEDICARE NO.	MEDICARE EFFECTIVE DATE	
RETIREMENT DATE	Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, do you have Health Insurance with this company? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Insurance Company _____ Effective Date: _____				
NAME OF SPOUSE				BIRTHDATE OF SPOUSE	
Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, do they have Health Insurance with this company? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Insurance Company _____ Effective Date: _____					
Are you covered by: Federal Black Lung Program ? <input type="checkbox"/> Yes <input type="checkbox"/> No United Mineworkers ? <input type="checkbox"/> Yes <input type="checkbox"/> No V.A. Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have supplement Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Company: _____ Effective date: _____					
Signature X _____				Date: _____	

WellGroup HealthPartners / Medicare Authorization

Date: _____

I request that payment under the medical insurance program be made to my physician at WellGroup HealthPartners on any bills for services furnished me by that physician during the period from January 1, _____ to December 31, _____.

Signature X _____