Notice to Medicare Beneficiaries about Coverage for Foot Care and Services

Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. When you receive foot care services and items that are not covered Medicare benefits, you must pay for them personally or through any other insurance that you may have.

The purpose of this advance notice is to help you make an informed choice about whether or not you want to receive these foot care services or items, knowing that you will have to pay for them yourself. We do not send claims to Medicare for foot care services or items that are excluded from Medicare coverage.

Before you make a decision, you should read this entire notice carefully.

- The Medicare program does not cover most routine foot care and flat foot care. The Medicare law clearly excludes coverage for services in connection with "the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care." The Medicare law clearly excludes coverage for services in connection with "treatment of flat foot conditions and the prescription of supportive devices thereof" or with "the treatment of subluxations of the foot." Providers may not be required to submit Medicare claims for such services.
  NOTE: A narrow exception permits coverage of some foot care services when certain conditions result in severe circulatory problems or areas of diminished sensation.
- The Medicare program does not cover most orthopedic shoes or other foot support (orthotics). The Medicare law clearly excludes coverage for services in connection with "orthopedic shoes or other supportive devices for the feet."
  NOTE: A narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.

This means that Medicare will not pay for most routine foot care, flat foot care, orthopedic shoes, or orthotics, because they are not Medicare covered benefits. Payment for these excluded foot care services and items is your responsibility.

If you have any additional questions concerning Medicare coverage for foot care services or items, you can contact Medicare at 1-800-MEDICARE (1-800-633-4227).

This notice is published by: American Podiatric Medical Association (APMA), P.O. Box 9312 Georgetown Road, Bethesda, MD 20814-1621. The Centers for Medicare & Medicaid Services has reviewed this APMA notice about foot care coverage and confirmed the accuracy of its content. This notice is only a general summary of foot care exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

Medicare Beneficiary Signature: _____ Date: _____

Medicare/Medicaid Authorization - Assignment Agreement for Payments

Please place your initials beside each line indicating that you understand and will abide by the following:

____ I authorize Hoosier Foot & Ankle to furnish Medicare Part B or Medicaid with all the necessary information concerning diagnosis and treatment for my dependent or myself.

____ I assign to Hoosier Foot & Ankle the medical and/or surgical benefits to which my dependent or I are entitled under Medicare Part B or Medicaid.

____ After all efforts have been made to collect payment from Medicare Part B and any secondary insurance carriers, I agree to pay the balance of my bill within 30 days; I understand that if my balance is outstanding beyond 60 days, a 20% collection fee will be added to my balance. If that balance goes beyond 150 days, legal action may be taken. All legal fees will be applied to my unpaid balance. (This does not apply to patients covered by Public Assistance.)

____ I understand that payment plans are accepted only in certain circumstances, which must be discussed in advance with the office manager or doctor. If I cannot pay the co-insurance amount due, I will have to complete a financial hardship form which will be added to my medical record.

____ I may request a financial estimate prior to any treatment.

____ I understand that some services require a prepaid deposit. I agree to pay deposits when necessary.

_____ _____

Patient Name Date

_____ _____

Signature of Patient/Responsible Party Date