HOSPITAL FOR **SPECIAL SURGERY**

PATIENT REGISTRATION FORM
HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)		PREFERRED NAME		DATE OF BIRTH	SOC. SEC. NUMBER
SEX ASSIGNED AT BIRTH ❑ FEMALE ❑ MALE ❑ INTERSEX	SEX LISTED WITH HEALTH INSURANCE ❑ FEMALE ❑ MALE	WHAT IS YOUR GENDER IDENTITY? ❑ SAME AS SEX LISTED WITH INSURANCE ❑ OTHER:_____		PREFERRED PRONOUNS ❑She/Her ❑ Ze/Hir ❑He/His/Him	
PERMANENT STREET ADDRESS			CITY	STATE	ZIP CODE
COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS ❑MYCHART ❑ DISCHARGE INSTRUCTIONS ❑ DECLINE		
TEMPORARY ADDRESS (IF APPLICABLE)			CITY	STATE	ZIP CODE

GENERAL INFORMATION

HISPANIC ETHNICITY? ❑ YES ❑ NO ❑UNKNOWN ❑ DECLINE		RACE	ADDITIONAL RACE	ETHNICITY
FURTHER DESCRIPTION OF ETHNICITY # 1	FURTHER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH ❑ VERY WELL ❑ WELL ❑ NOT WELL ❑ NOT AT ALL ❑ DECLINED ❑ UNAVAILABLE		
WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?		IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?		
WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? ❑ YES ❑NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ❑ YES ❑ NO		
MARITAL STATUS	VISUALLY IMPAIRED? ❑ YES ❑NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS		

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? ❑ YES ❑ NO	NOTIFY PCP OF RESULTS? ❑ ALL ❑ ABNORMAL ❑ NONE	
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE			
PATIENT'S EMPLOYER	PATIENT OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., stret, city, state, zip code)			EMPLOYER PHONE	

EMERGENCY CONTACT

FULL NAME CONTACT #1		ADDRESS (no., street, apt#, city, state, zip code)			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO
FULL NAME CONTACT #2		ADDRESS			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

HSS **Department of Medicine**
HOSPITAL FOR SPECIAL SURGERY

STOP-BANG Sleep Apnea Questionnaire

Name: _____

Height:_____ Weight:_____ Age: _____ Sex: ☐ Male ☐ Female

PATIENT RESPONSES

STOP	YES	NO
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed door)?		
Do you often feel **TIRED**, fatigued, or sleepy in the daytime?		
Has anyone **OBSERVED** you stop breathing during your sleep?		
Do you have-or are you being treated for high blood **PRESSURE**?		
TOTAL		

DOCTOR'S OFFICE USE ONLY

BANG	YES	NO
BMI higher than 35kg/m2?		
AGE over 50 years old?		
NECK circumference greater than 16 inches (40cm)?		
GENDER: MALE?		
TOTAL		

Risk of OSA:
☐ **High Risk:** 5 - 8 "Yes" ☐ **Intermediate:** 3 - 4 "Yes" ☐ **Low Risk:** 0 - 2 "Yes"

Rev 03.2017

HSS

Lawrence V. Gulotta, MD

(646) 797-8735

Cancellation Policy for Surgery

In an effort to serve our patients better we have instituted a cancellation policy for scheduled surgery dates.

Scheduling surgery is a time consuming and complicated process, and the office understands that it is very disruptive to patient's normal lives. Likewise, when surgery is indicated, the office invests a considerable amount of time and effort beforehand, to ensure that the day of surgery goes as smoothly as possible. Ahead of your surgery, the office commits many hours of work to ensure that all aspects of your care are prepared for- including, but not limited to: pre-certification and follow up with your insurance plan, coordination of your care with related caregivers (including other physicians when indicated, allied health professionals, and anesthesiologists), and post-operative care in the form of rehabilitation preparation.

From time to time, extenuating circumstances cause a surgery to be canceled. However, in situations when the patient electively cancels a procedure within 10 days of the scheduled surgery, **a non-refundable cancellation fee of $500 will be charged to the patient.**

If your surgery is cancelled for a medical reason this charge does not apply. Please keep this in mind when scheduling your surgery date.

I ,_____ have received and reviewed the surgery cancellation policy of Dr. Lawrence V. Gulotta. I hereby accept and agree to adhere to the above policy.

_____

Patient Signature or Parent/Guardian (if patient is a minor)

_____

Date

HSS Lawrence Gulotta, MD

Financial Interest Disclosure Form
Medical Staff, Allied Health Professional Staff,
Residents, and Fellows

As your treating physician and as a member of the Medical Staff of Hospital for Special Surgery (HSS), I would like you to know that I have a financial relationship with the following orthopedic/biomedical device company whose products I may use, or prescribe, for you in your care at HSS. The following will provide you with information about my financial relationship with this company:

I am a consultant for, and a Speaker's Bureau participant with, Biomet, Inc. and Exactech for which I receive compensation for my time.

I DO NOT RECEIVE ANY PAYMENTS FROM THIS COMPANY FOR USE OF ITS PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with me, you may contact Scott Rodeo, MD, Co-Chief of Service, (212-606-1513), the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship I have disclosed to you, you choose to refuse a particular treatment, or would like to revoke any informed consent you have previously given for a particular operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that I have discussed the financial interest or relationship described above. You also confirm that you have read and fully understand this document, and that you have been given the opportunity to ask questions about my financial interest or relationship and your questions have been answered to your satisfaction.

Signature_____
Patient/Parent/Guardian/Health Care Agent **Date**

Print Name_____
Patient/Parent/Guardian/Health Care Agent

_____
Relationship to Patient

PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD

HOSPITAL FOR SPECIAL SURGERY

Patient-Provider Agreement for Short-Term Opioid Therapy

1. I _____ understand that after my upcoming surgery, and possibly during the period leading up to such surgery, I am likely to experience some pain and discomfort, and this may be treated with a short course of prescription opioid pain medication (**"Opioids"**). I understand that as I recover from surgery, my opioid use should decrease.
2. I agree that Dr. _____ and/or his/her designee (**"my Physician"**) alone will prescribe opioids to me. That is, during the time leading up to my surgery and during a short-term period of recovery after my surgery, I will only obtain my prescriptions for opioids from my Physician. If an emergency situation necessitates an exception to the aforementioned agreements, I will inform my Physician immediately.
3. I will take my opioids only at the dose and frequency prescribed by my Physician. I agree not to increase the dose of opioids beyond what is recommended without first discussing it with my Physician.
4. I understand that my Physician does not typically refill opioids earlier than expected, even if lost, destroyed or stolen.
5. I will disclose to my Physician all of my opioid prescriptions and other prescription medications.
6. I agree to be responsible for the secure storage and disposal of my opioids.
7. I understand that sharing my opioids is illegal and I agree not to give or sell my prescribed opioids to any other person.
8. I understand that common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy and when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.
9. Using an opioid to treat pain may result in the development of a physical dependence on opioids and increased pain. As such, I understand that my Physician may require that I see an addiction medicine specialist should a concern arise about addiction.
10. I understand that I should avoid sudden decreases or discontinuation of opioids, as this may lead to symptoms of withdrawal.
11. The use of a mood-modifying substance, such as tranquilizers, sleeping pills, benzodiazepines (Xanax, Valium, etc.), can cause adverse effects and/or interfere with opioid therapy. Therefore, I agree not to use any of these substances without prior approval from my Physician, and will consult with my Physician or pharmacist before taking other medications, including over-the-counter and herbal products. Further, I understand that I should not mix opioids with alcohol and/or illicit drugs (e.g. cannabis, cocaine, heroin or hallucinogens).
12. I understand that in order to ensure my safety, my Physician may require urine, blood, saliva, or hair testing to monitor for both prescribed and non-prescribed substances.
13. I will attend all appointments, treatments and consultations as requested by my Physician. I agree to consider other pain management strategies as may be recommended by my Physician.
14. I consent to open communication between my Physician and any other health care professionals involved in my care, including pharmacists, other specialists, emergency medical personnel, etc.
15. By signing this Patient-Provider Agreement, I agree to comply with it. **I understand my Physician also agrees with the statements listed above and understand that if I break this Agreement, my Physician may (and reserves the right to) stop prescribing opioids for me and may ultimately terminate our Physician-patient relationship.**
16. **I understand that if I do not sign this Agreement, my insurance company may not authorize any opioids prescriptions.**

_____	_____	_____
Patient Name	**Signature of Patient/Patient/Guardian**	**Date**

HOSPITAL FOR SPECIAL SURGERY
AMBULATORY SURGERY CENTER OF MANHATTAN

Patient Acknowledgement

Disclosure of Physician Ownership in HSS ASC of Manhattan

Due to concerns that there may be a conflict of interest, New York State passed a law that prohibits physicians (with certain exceptions) from referring patients for clinical laboratory services, pharmacy services, x-ray or imaging services to a facility in which the physician or any of the physician's immediate family members have a financial interest. If any of the exceptions in the law apply, or if the physician is referring the patient for services other than clinical laboratory, pharmacy, x-ray or imaging services, the physician can make the referral as long as the physician discloses this financial interest and tells the patient about alternative facilities where he/she may obtain these services. This disclosure of financial interest is also required under federal law.

Thus, the following disclosure is hereby made to you, as a patient of HSS ASC of Manhattan:

> The physicians listed below are owners of, and therefore have a financial interest in, *Hospital for Special Surgery Ambulatory Surgery Center of Manhattan, LLC d/b/a HSS ASC of Manhattan*, located at 1233 Second Ave., New York, New York. This disclosure is intended to help you make a fully informed decision about your health care. For more information about alternative facilities, please ask your physician or his or her staff. They will provide you with names and addresses of providers best suited to your individual needs that are nearest to your home or place of work.

Physician Owners of HSS ASC of Manhattan

Frank Cordasco, M.D.	Lawrence Gulotta, M.D.	Anil Ranawat, M.D.
Aaron Daluiski, M.D.	Lana Kang, M.D.	Matthew Roberts, M.D.
Mark Drakos, M.D.	Steve Lee, M.D.	Beth Shubin Stein, M.D.
Andrew Elliott, M.D.	David Levine, M.D.	Sabrina Strickland, M.D.
Scott Ellis, M.D.	Robert Marx, M.D.	Scott Wolfe, M.D.
Stephen Fealy, M.D.	Andrew Pearle, M.D.	

*** All of the above Physicians are also affiliated with the Hospital for Special Surgery**

HOSPITAL FOR SPECIAL SURGERY
AMBULATORY SURGERY CENTER OF MANHATTAN

PATIENT ACKNOWLEDGEMENT

Disclosure of Physician Ownership in HSS ASC of Manhattan

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law that prohibits physicians, with certain exceptions, from referring patients for clinical laboratory services, pharmacy services or x-ray or imaging services to a facility in which the physician or any of the physician's immediate family members have a financial interest. If any of the exceptions in the law apply, or if the physician is referring the patient for services other than clinical laboratory, pharmacy, or x-ray or imaging services, the physician can make the referral as long as he or she discloses this financial interest and tells the patient about alternative facilities where they may seek to obtain these services. This disclosure of financial interest is also required under federal law.

Thus, the following disclosure is hereby made to you:

> I, _____, M.D., am an owner of, and therefore have a financial interest in, *Hospital for Special Surgery Ambulatory Surgery Center of Manhattan, LLC d/b/a HSS ASC of Manhattan*, located at 1233 Second Ave., New York, New York. This disclosure is intended to help you make a fully informed decision about your health care. For more information about alternative facilities, please ask my staff or me. We can provide you with names and addresses of providers best suited to your individual needs that are nearest to your home or place of work.

By signing below, you (or your legal representative) acknowledge that you have read and understand the foregoing Disclosure of Physician Ownership, that the disclosure was made to you prior to the performance of any medical procedures and, after the disclosure was made, you have decided to have a medical procedure performed at HSS ASC of Manhattan.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

If signed by a legal representative of the patient:

NAME OF REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

If you would like someone to be able to communicate with the office on your behalf please complete:

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: _____

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: _____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____

Name of Witness 1
(print) _____

Name of Witness 2
(print) _____

Signature _____ Signature _____

Address _____ Address _____

_____ _____

HSS

LAWRENCE V. GULOTTA, MD
Chief, Shoulder and Elbow Surgery
Sports Medicine Institute
Head Team Orthpaedic Surgeon, New York Mets
www.shouldersurgerynewyork.com

Notice to Medicare Beneficiaries

Dear Medicare Beneficiary:

As of January 1, 2021, my status with the Medicare Program is "Opt-out." I made this decision voluntarily. As an "Opt-out" Provider, I will not accept assignment of Medicare claims, or receive any payment for service furnished to a Medicare beneficiary under a Medicare Managed Care Plan. This does not mean I am excluded from Medicare. I cannot, however, provide services to any patient that will submit a claim to Medicare or to another health plan or organization that accepts money from Medicare or a Medicare Managed Care Plan. If you would like to submit claims for treatment to Medicare or to a Medicare Managed Care Plan, I will gladly refer you to another physician who participates in the Medicare Program. However, if you would like to receive services from me, you must understand the following:

1. You must agree not to submit a claim to Medicare or a Medicare Managed Care Plan ("Medicare") or ask me, Dr. Gulotta, to submit a claim to Medicare even if services are covered by the Medicare Program ("Medicare Covered Services");

2. You or your legal representative must agree to be responsible for payment for the Medicare Covered Services furnished by me and acknowledge that no reimbursement will be provided by Medicare for these services;

3. You should understand that no limitation on charges set by Medicare apply to the Medicare Covered Services furnished by me;

4. You should understand that Medicare payment will not be made for any items or Medicare Covered Services furnished by me that otherwise would be covered by Medicare;

5. You should understand that Medigap Plans do not, and other supplemental insurance may not, provide reimbursement for such Medicare Covered Services; and

6. You have the right to obtain Medicare Covered Services from physicians and practitioners who have not opted-out of Medicare, and you should not feel compelled to enter into a private contract for these services.

If you would like to see me as your physician, please read and sign the attached form. If you have any questions, we will be happy to discuss this with you further.

Very truly yours,

Lawrence V. Gulotta, M.D.

hss.edu

OFFICE LOCATIONS
The Pavilion
541 East 71st Street 1st Floor
New York, NY 10021

HSS | Westchester
1133 Westchester Avenue
White Plains, NY 10604

MAILING ADDRESS
HSS | Hospital for Special Surgery
535 East 70th Street
New York, NY 10021

TEL 646.7978735
FAX 646.7978726

national government SERVICES

MEDICARE

Medicare Private Contract

This agreement is entered into this ___ day of _____, by and between Dr.LawrenceGulotta (hereinafter called "physician"), whose principal medical office is located at 535 East 70th St. NY, NY 10021 and _____ (a patient enrolled in Medicare Part B, hereinafter called "patient"), who resides at _____.

Background

A provision in the Social Security Act permits Medicare beneficiaries and physicians to contract privately outside of the Medicare program. Under the law as it existed prior to January 1, 1998, a physician was not permitted to charge a patient more than a certain percentage in excess of the Medicare fee schedule amount. A new provision, which became effective on January 1, 1998, permits physicians and patients to enter into private arrangements through a written contract under which the patient may agree to pay the physician more than that which would be paid under the Medicare program.

A "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for two years for all covered items and services he/she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician/practitioner and to pay the physician/practitioner without regard to any limits that would otherwise apply to what the physician/practitioner could charge.

The purpose of this contract is to permit the patient (who is otherwise a Medicare beneficiary) and the physician to take advantage of this new provision in the Medicare law and sets forth the rights and obligations of each. This agreement is limited to the financial arrangement between physician and patient and is not intended to obligate either party to a specific course or duration of treatment.

Patients and physicians who take advantage of this provision are not permitted to submit claims or to expect payment for those services from Medicare.

Exception:

In an emergency or urgent care situation, a physician/practitioner who opts out may treat a Medicare beneficiary with whom he/she does not have a private contract and bill for such treatment. In such a situation, the physician/practitioner may not charge the beneficiary more than what a nonparticipating physician/practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with that physician/practitioner.

A. Obligations of Physician

1. Physician agrees to provide such treatment as may be mutually agreed upon by the parties and at mutually agreed upon fees.

2. Physician agrees not to submit any claims under the Medicare program for any items or services even if such items or services are otherwise covered by Medicare.

3. Physician acknowledges that (s)he will not execute this contract at a time when the patient is facing an emergency or urgent health care situation.

B. Obligations of Patient

1. Patient or his/her legal authorized representative agrees not to submit a claim (or to request that the physician submit a claim) under the Medicare program for such items or services as physician may provide, even if such items or services are otherwise covered under the Medicare program.

2. Patient or his/her legal authorized representative agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under the Medicare program for such items or services.

3. Patient or his/her legal authorized representative acknowledges that that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner.

4. Patient acknowledges that Medigap plans do **not**, and other supplemental insurance plans may elect not to, make payments for items and services not paid for by Medicare.

5. Patient acknowledges that (s)he has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the (s)he is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.

6. Patient acknowledges that (s)he or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

C. Physician's Status

Patient further acknowledges his/her understanding that physician (has/ has not) been excluded from participation under the Medicare program under Section 1128.

D. Term and Termination

This agreement shall commence on the above date and shall continue in effect until _____ (physician should insert date which is two [2] years after [s]he signs the affidavit). Despite the term of the agreement, either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both physician and patient agree that the obligation not to pursue Medicare reimbursement, for items and services provided under this contract, shall survive this contract.

I have read and understand the provisions regarding private contracting.

By signing this contract, I accept full responsibility for payment of the physician's or practitioner's charges for all services furnished to me from the date written above.

Dr.Lawrence Gulotta
Name of Physician (printed)

Signature of Physician

Date

Name of Patient (printed)

Signature of Patient

Medicare Estimation

Due to CMS guidelines, even if a Member has commercial insurance they consider as primary, when Member is eligible for Medicare, commercial insurance may process the claim as if Medicare is primary. This is often referred to as "Medicare Estimation" and is especially applicable if the Member has Part A, and no Part B.

Medicare Estimation reduces the payment by the amount the primary Medicare Part B would have paid if the eligible member was enrolled. This amount is not covered by the plan.

As such, your commercial insurance carrier may leave you with a significant amount of Patient Financial Responsibility.

We encourage you to contact your plan to inquire whether Medicare Estimation may apply.

When doing so, please note the Date, Time, Name of Representative and obtain a Reference Number.

More information can be found here:
https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/working-past-65

Patient Signature

Date

hss.edu

OFFICE LOCATIONS
The Pavilion
541 East 71st Street, 1st Floor
New York, NY 10021

HSS | Westchester
1133 Westchester Avenue
White Plains, NY 10604

MAILING ADDRESS
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535 East 70th Street
New York, NY 10021

TEL 646.797.8735
FAX 646.797.8726

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Medicare Entitlement

When a person becomes eligible for Medicare, the individual automatically receives Medicare Part A free of charge. The individual can choose to sign up for Medicare Part B. There is a premium the individual has to pay for Medicare part B benefits.

Many health plans and insurance policies include a Medicare eligibility clause. Such clauses provide that the plan or insurer will provide secondary coverage, for certain categories of Medicare eligible individuals as permitted by the Social Security Act including, but not limited to, retirees, age/ disability eligible employees enrolled in certain small group plans, and customers with end stage renal disease following 30 months of Medicare eligibility.

Where an individual in one of the above categories is eligible for Medicare Part B, but chooses not to elect the coverage, the payor will process the claim as if the individual had Medicare Part B. The payer estimates the amount that Medicare Part B would have paid had the individual enrolled. The individual would be responsible for the portion of the bill that Medicare would have paid had Medicare Part B coverage been elected.

Step 1

Working past 65

If you (or your spouse) are still working when you turn 65, Medicare works a little differently. Need a refresher on Medicare basics?

Do I need to sign up for Medicare when I turn 65?

Answer a few questions to find out when to sign up, or review some common situations here:

In this situation:	You need to know:
You (or your spouse) are: • Still working at a job that has **more than** 20 employees • Have health insurance from that job	• **You can wait until you (or your spouse) stop working** (or lose your health insurance, if that happens first) **to sign up for Part B (Medical Insurance),** and you won't pay a late enrollment penalty. • If you don't have to pay a premium for Part A (Hospital Insurance), you can choose to sign up when you turn 65 (or anytime later). Do I qualify? • Your job-based insurance pays first, and Medicare pays second.

In this situation:	You need to know:
You (or your spouse) are: • Still working at a job that has **fewer than** 20 employees • Have health insurance from that job	• **You can wait until you (or your spouse) stop working** (or lose your health insurance, if that happens first) **to sign up for Part B (Medical Insurance)**, and you won't pay a late enrollment penalty. • Ask the employer that provides your health insurance if you need to sign up for Part A and Part B when you turn 65. If you don't sign up for Part A and Part B, your job-based insurance might not cover the costs for services you get. • If you do get Medicare and keep your job-based insurance, Medicare pays for services first, and your job-based insurance pays second.
You (or your spouse) are still working and have health insurance, but it's not from a job (like Medicaid or Marketplace).	• **Answer a few questions** to find out when to sign up and other important information you need to know, based on the specific type of coverage you have. • The rules vary depending on what type of other health insurance you have. Contact your health insurance to get more information.
You're still working and are self-employed or have health insurance that's not available to everyone at the company.	• Ask your insurance provider if your coverage is employer group health plan coverage (as defined by the IRS.) If it's not, sign up for Medicare when you turn 65 to avoid a monthly Part B late enrollment penalty. • If you have retiree coverage from a previous job, it may not pay for your health services if you don't have both Part A and Part B. Ask your benefits administrator how your retiree coverage works with Medicare.

In this situation:	You need to know:
You have COBRA coverage and **haven't** signed up for Medicare yet.	• Sign up for Medicare when you turn 65 to avoid gaps in coverage and a monthly Part B late enrollment penalty. • If you have COBRA before signing up for Medicare, your COBRA will probably end once you sign up. **Don't wait until your COBRA coverage ends to sign up for Part B** — Getting COBRA doesn't extend your limited time to sign up for Medicare.
You got COBRA coverage **after** you signed up for Medicare.	COBRA pays after Medicare (unless you have End-Stage Renal Disease).
You're still working and you (or your spouse) get a stipend from your employer to buy your own health insurance.	• Ask your health insurance company if you need to sign up for Part A and Part B when you turn 65. • Some private insurance has rules that lower what they pay (or don't pay at all) for services you get if you're eligible for other coverage, like Medicare. • Generally, Medicare doesn't work with your insurance. • Once you sign up, Medicare pays first.
You're still working, but don't have any health insurance.	• Sign up for both Part A (Hospital Insurance) and Part B (Medical Insurance) when you're first eligible (usually when you turn 65). • Generally, there are risks to signing up later, like having to pay a penalty. • If you can't afford insurance there are ways to get help paying costs.

Feedback

How do I sign up for Medicare?

If you're already getting benefits from Social Security (or Railroad Retirement Board), you'll automatically get Medicare. If not, you'll need to sign up. Answer a few questions to find out how you get Medicare.

Retiring in the next year? Find out what you need to do before you retire.

If you have a Health Savings Account (HSA): To avoid a tax penalty, you and your employer should stop contributing to your HSA 6 months before you retire or apply for benefits from Social Security (or the Railroad Retirement Board).
Why should I stop contributions before I retire?

Do I need to get more coverage?

After you sign up for Part A (Hospital Insurance) and Part B (Medical Insurance), you can choos how you get your coverage.

Before you go further: It's important to learn more about your coverage options so you understand your choices.

Feedback

When can I get more coverage?

Type of coverage:	**When you can get it:**
Medicare Advantage Plan	You have 2 months after your job-based insurance ends to join a plan. If you want your plan's coverage to start when your job-based insurance ends, sign up for Medicare **and** join a plan **before** your job-based insurance ends.

Type of coverage:	When you can get it:
Medicare drug plan	You have 2 months after your job-based insurance ends to join a plan. If you want Medicare drug plan coverage to start when your job-based insurance ends, sign up for Medicare **and** join a plan **before** your job-based insurance ends.
Medicare Supplement Insurance (Medigap) policy	You have 6 months after you first get both Part A and Part B (if you're 65 or older) to buy a policy. Learn more about Medigap.

Feedback

Don't risk losing your retiree coverage. Check before joining a plan.
The employer may offer coverage when you have Medicare, like a supplemental plan, drug coverage, or Medicare Advantage Plan. If they do, **ask if you or your family will lose your retiree coverage** if you join a plan the employer doesn't offer.

What else do I need to know?

As long as you have other creditable drug coverage, you can wait to join a Medicare drug plan or a Medicare Advantage Plan with drug coverage.

- If you're not sure your current drug plan is considered creditable drug coverage, ask your plan – they have to tell you. Your plan will also send you this information every year.
- Keep this information — you may need it when you're ready to join a Medicare drug plan. (Don't send this information to Medicare.)

You won't pay the Part D late enrollment penalty as long as you don't go more than 63 days without creditable drug coverage. Learn how to avoid the late enrollment penalty.

Get more details on how Part D works with other insurance.