HOMEPSYCH

MEDICARE LIFETIME SIGNATURE FORM

Patient Information

Name: _____

Date of Birth: _____

Medicare Beneficiary Number: _____

Address: _____

Phone Number:_____

Authorization

I, _____, hereby authorize North American Mental Health Services to disclose my Medicare lifetime mental health services usage information to the Centers for Medicare & Medicaid Services (CMS). This information will be used by CMS to administer the Medicare program and to ensure that I am not receiving more than the lifetime limit on Medicare-covered mental health services.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Instructions

Please sign and date this form and give it to a staff member at North American Mental Health Services. If you have any questions, please ask a staff member for assistance.

Additional Information

- This form is only necessary if you are a Medicare beneficiary who has received Medicare-covered mental health services from North American Mental Health Services.
- You can revoke this authorization at any time by writing to North American Mental Health Services at:

Attn: Billing Department
2165 Larkspur Lane,
Redding, Ca 96002

- If you have any questions about your Medicare lifetime limit on mental health services, please contact Medicare at 1-800-Medicare.

Privacy Notice

North American Mental Health Services will protect your privacy and will only use your Medicare lifetime mental health services usage information for the purposes authorized by this form. We will not disclose your information to any other party without your consent, except as required by law.