BROADVIEW
CHRISTIAN SCIENCE CARE
COMFORT • PROGRESS • HEALING

4570 Griffin Ave.
Los Angeles, CA 90031
Ph: (323) 221-9174
www.csbroadview.org

MEDICARE RELEASE OF INFORMATION

TO THOSE APPLYING FOR BENEFITS UNDER
THE SOCIAL SECURITY HEALTH INSURANCE PROGRAM (MEDICARE)

According to the provisions of this program, the following costs are covered while staying at an accredited Christian Science nursing facility:

- Christian Science nursing care where the services of a *Journal*-listed Christian Science nurse are required; these services include qualities, judgments, and skills that are intrinsic to Christian Science nursing care.
- Standard room and board.
- Supplies and equipment.

To be eligible, it must be determined by the Admissions and Utilization Review Committee that you are in need of this level of care each day you are at Broadview.

With the most recent changes in the Medicare law, the following policies are in effect as of January 1, 2026:

- Length of stay under Medicare is limited to 90 days, the first 60 days of which are paid entirely by Medicare;*
- After the first 60 days are up, you may stay an additional 30 days at a daily coinsurance premium to you of $434.00 per day.
- After this subsequent 30 day period is used up, you may draw on an additional 60 “lifetime reserve days” at a coinsurance cost to you of $868.00 per day.
- You will pay a deductible of $1,736.00 upon your admission for care to any Medicare-rated facility. Before any new benefit period can begin, 60 days must elapse where no covered care is needed.

I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare claim.

_____	_____	_____
Signature	*Date*	*Medicare Number*

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MEDICARE INITIAL QUALIFYING MEMO

_____ _____
Patient's Name *Medicare Admission Date*

In accordance with established directives and Broadview's Utilization Review Plan, the Ad Hoc Committee has determined that the type of care you require at this time qualifies for Medicare. This is subject to concurrence by Broadview's Utilization Review Committee (URC) and acceptance by Palmetto GBA, the insurance provider for the Federal government, and in accordance with all pertinent criteria.

_____
Wm. F. "Bill" Cunningham (Signature)

I acknowledge that I received this notice of coverage of services under Medicare:

_____ _____
Signature *Date*

~ ~ ~ ~ ~ ~ ~ **OR** ~ ~ ~ ~ ~ ~ ~

Telephone contact with beneficiary's representative _____
Name of person contacted

on _____ by _____. ☐ Attempted ☐ Completed
Date *Broadview Staff Member*

Patient Declination Of Medicare Coverage

I understand that my current needs qualify me to receive Medicare benefits as provided by the Social Security Administration.

I acknowledge that I have been informed of my rights to use Medicare benefits and have been given every opportunity to use said benefits while a patient at Broadview.

Although I may qualify for these benefits while a patient at Broadview, I voluntarily refuse Medicare coverage at this time. I understand that should I change my mind, I may elect to use my Medicare benefits at Broadview at the time of my choosing, provided my care needs still qualify me for this coverage.

_____ _____
Patient Signature *Date*

_____ _____
Broadview Staff Member Signature *Date*

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MSP SCREENING QUESTIONNAIRE

Patient Name _____ Medicare No. _____

Ask all four questions of each Medicare patient. If the patient responds "Yes" to any question, continue to page two asking all applicable questions. The patient or representative should sign the form whenever possible.

NOTE: It is important to ask all questions and document all answers regarding MSP. A provider may be held liable if an overpayment occurs & Medicare finds that the provider furnished erroneous information or failed to disclose facts it knew were relevant to payment.

1. Is the patient covered by the Veterans Administration, the Black Lung Program or Workers Compensation?
   - ☐ No — Proceed to question No. 2
   - ☐ Yes — Bill the other insurer prior to Medicare

2. Is the illness or injury due to any type of accident?
   - ☐ No — Proceed to question No. 3
   - ☐ Yes — Continue with question No. 3 and complete next page

3. Is the patient 65 or over and employed, or is the spouse employed at time of service?
   - ☐ No — Proceed with question No. 4
   - ☐ Yes — Complete next page - Medicare may not be primary

4. Is the patient under 65 and covered under any Employer Group Health Plan (EGPH) or Large Group Health Plan (LGHP)?
   - ☐ No — See Note
   - ☐ Yes — Complete next page

NOTE: If the answer to all questions is "No", bill Medicare as primary. If any response is "Yes", continue to Next Page: *Medicare may not be primary*.

Patient/Representative Signature _____

Date _____

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Patient Name: _____ Medicare No: _____

Check the appropriate box and answer the questions

1. ILLNESS/INJURY CAUSED BY ACCIDENT
   A. ☐ Motor Vehicle: Name of Patient's Automobile Insurer _____
   B. ☐ Another party was responsible for accident.
   Name and address of Liability Insurer _____

   Name and address of Attorney _____

   C. ☐ Work Related: Name of Workman's Comp. Insurer _____

   D. ☐ Other accident (slip and fall etc.); explain where accident occurred _____

   If fall other than patient's home, has the patient filed or intend to file a liability suit?
   ☐ **Yes** - Name and address of: ☐ **No** - Bill Medicare and send copies of all pertinent documentation

   Liability Insurer _____
   Attorney _____
   Bill other insurer prior to Medicare; submit documentation to Medicare if conditional payment requested.

2. EMPLOYER GROUP COVERAGE FOR THOSE 65 AND OVER
   A. ☐ Patient employed at time of this service. Give name of patient's company/employer _____
   _____
   Does Employer employ 20 or more employees? ☐ **Yes** ☐ **No**
   Does the patient have an Employer Group Health Plan (EGHP) by reason of his/her current employment?
   ☐ **Yes** ☐ **No** If "**Yes**" give the name of the EGPH _____
   Bill EGPH prior to Medicare
   B. ☐ Patient's spouse employed at the time of this service? Give name of spouse's company/employer
   Does the spouse's employer employ 20 or more employees. ☐ **Yes** ☐ **No**
   Does the spouse have an EGHP by reason of current employment which covers the patient? ☐ **Yes** ☐ **No**
   If "**Yes**" give name of EGHP _____
   Bill EGHP prior to Medicare

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3. EMPLOYER GROUP COVERAGE FOR THOSE YOUNGER THAN 65

A. ☐ Patient is entitled to Medicare solely due to End Stage Renal Disease and in first 12 months of Medicare entitlement. Date of first Dialysis treatment or date of Kidney transplant MM/YY _____.

Does patient have coverage through his/her, his/her spouse's, a parent's or a guardian's Employer Group Health Plan? ☐ **No** - Medicare Primary ☐ **Yes** - Give Name of the Employer_____

Give Name of EGHP _____

Bill EGHP prior to Medicare

B. ☐ The patient is entitled to Medicare solely because of disability (does not have/has not had ESRD)

Does the patient have coverage through his/her spouse's, a parent's or a guardian's Employer Group Health Plan? ☐ **No** Medicare Primary ☐ **Yes** Continue

Does employer(s) employ 100 or more employees ☐ **No** Bill Medicare ☐ **Yes**

If Yes: Give name of each insured whose policy covers the patient

a._____

b._____

Give name of corresponding employer

a._____

b._____

Give name of corresponding EGHP

a._____

b._____

Bill EGHP(s) prior to Medicare

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Patient Name: _____ Medicare No: _____

1. Is the patient covered by the Veterans Administration, Black Lung or Workers Compensation?
   Worker Compensation? **Yes** ☐ Bill other insurer **No** ☐ Go to No. 2

2. Was illness due to any accident? **Yes** ☐ Continue **No** ☐ Go to No. 3

   A. What type of accident caused the illness/injury?
      ☐ Automobile: Stop bill other insurer
      ☐ Other:
      Explain_____

   B. The patient has filed or intends to file a liability suit.
      Yes ☐ Bill Liability Insurer/Medicare Conditionally
      No ☐ Go to No. 3

      Give name and address of attorney _____

      Give name and address of Liability Insurer _____

3. Is the patient 65 or over; employed and covered by an Employer Group Health Plan (EGHP)?
   Yes ☐ Continue/Bill EGHP **No** ☐ Continue

   A. Is the patient's spouse currently employed?
      Yes ☐ Continue **No** ☐ Go to No. 4

   B. Is the patient covered under the spouse's group plan?
      Yes ☐ Bill the EGHP **No** ☐ Continue

      Give name, address and group member of the plan _____

4. Is the patient under 65 and entitled to benefits solely on the basis of End Stage Renal Disease?
   Yes ☐ Continue **No** ☐ Go to No. 5

   A. Is the patient covered by an EGHP?
      Yes ☐ Continue **No** ☐ Go to No. 5

   B. Is the patient in his/her first 12 months of Medicare entitlement?
      Yes ☐ Bill the EGHP **No** ☐ Medicare is Primary

(Effective for services on or after 01/01/87)

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5. Is the patient under 65 and entitled to benefits solely on the basis of disability (does not have/has not had ESRD)?

   Yes ☐ Continue **No** ☐ Medicare Primary

   A. Is the patient covered through his/her, his/her spouse's, a parent's or a guardian's Employer Group Health Plan?

      Yes ☐ Continue **No** ☐ Medicare Primary

   B. Does the employer(s) employ 100 or more employees?

      Yes ☐ EGPH is Primary **No** ☐ Medicare Primary

Patient/Representative Signature _____ Date _____