CHIRO REHAB CENTER
220 Hamburg Turnpike Suite 14A • Wayne, NJ 07470 | T:(862) 336-1600 • F:(862) 336-1601

Certification of Medicare Eligibility

Claim #: _____

State of: _____ **County of:** _____

1. First Name: _____

2. Middle Initial: _____

3. Last Name: _____

4. My Date Of Birth is: _____

5. My Gender is: _____

6. Do you have a Social Security Number (SSN)? ◯ Yes ◯ No

If yes, please provide your SSN: _____

7. List your maiden name or other name(s) under which you have used the above SSN: _____

8. Are you a Medicare beneficiary? ◯ Yes ◯ No

9. Are you currently receiving Medicare benefits? ◯ Yes ◯ No

10. Are you eligible for Medicare benefits? ◯ Yes ◯ No

If you said yes to questions 8, 9, or 10 please provide your Medicare Health Insurance Identification Number: _____

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to certain action by Medicare including but not limited to possible penalties and fines and/or recovery of any funds improperly paid to me by Medicare in connection with the above-referenced claim.

_____ _____

Signature Date

_____

Print Name

Translated by: _____

(Employee Name)