Cardiac Rehabilitation and Wellness Center

Name: ____ DOB: _____________________________

In addition to demographic and insurance information that is collected prior to enrollment in CR, the following information specific to CR is also important to individualize patient care.

1. Primary Insurance Company: ____
2. Spoke with: _____________________________Date: _______ Reference #: _________
3. Diagnosis qualifying CR referral: ____
4. Confirmation of coverage for this diagnosis: **Yes** **No** ICD-10 Code: ______________
5. Primary insurance company payment amount for **CPT 93798**: ______________________
6. Co-payment: ________________ Deductible: ______________ Met: **Yes or No**
7. Out-of-pocket max __________________________ Met: **Yes or No**
8. Do you cover **CPT 93797**-AMA definition-“Cardiac rehab services, without ECG monitoring”?

   *This code is covered by Medicare for education/counseling components of CR or for non-ECG monitored exercise for patients who are electrographically stable, but continue to need secondary prevention interventions for their cardiovascular disease.

   If YES, payment amount: ________________________________
9. How many CR sessions are covered?

   *Medicare covers up to 36 sessions over 36 weeks, based on evidence of continued functional improvement for patients in a structured CR program.
10. Is there a time limit (weeks) on program completion? ____
11. Authorization (“pre-cert”) #: ____
12. Secondary insurance company: ____

If you need further assistance, please call UCSF’s Financial Counseling Department at (415) 353-1966.

Patient Acknowledgement

We are a provider for your insurance and benefit verification is a courtesy that we provide for our patients. These benefits are only a quote/description of your benefits and <u>not</u> a guarantee of payment. It is ultimately up to you the subscriber/patient to be aware of your insurance coverage as this is a contract between you and your insurance company.

I, the undersigned, as the patient, or the guardian, spouse, guarantor or agent of the patient, hereby certify I have read and fully and completely understand this Benefit Summary and have been given the opportunity to ask questions.

Patient/Legal Representative: ___________________________ Date:_______ Time: ___________