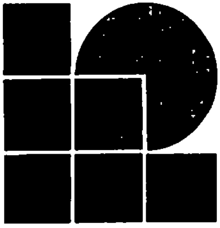

FOUNDATION FOR MEDICAL CARE
OF TULARE & KINGS COUNTIES, INC.

3335 South Fairway
Visalia, CA 93277
(559) 734-1321
(800) 662-5502
Fax: (559) 734-3828

Date ______________________

______________________ Patient

______________________ DOB

______________________ ID#

Group #

Dear Member:

We have received a claim for services, which may be reimbursable by the Federal Medicare Program. Please certify below whether or not you are covered by Medicare benefits and return this form to us in the enclosed envelope.

MEDICARE CERTIFICATION

Are you presently working full time? NO _____ YES _____

If YES, how many hours per week do you work? ____________

If eligible, please indicate your Medicare Number: ______________________

	YES	NO	
Medicare Part A	(____)	(____)	Effective Date: ___/___/___
Medicare Part B	(____)	(____)	Effective Date: ___/___/___

Please indicate below with an "X" the reason you are eligible for Medicare Benefits:

AGED, 65 YEARS OR OLDER ________ DISABLED, UNDER 65 YEARS OLD ________

END STAGE RENAL DISEASE (ESRD) ________ DISABLED AND ESRD ________

If patient has Medicare due to END STAGE RENAL DISEASE, Please indicate first date of Renal Treatment:

____/____/____.

Please enclose copy of Medicare ID Card.

I certify to the best of my knowledge the above Medicare information is complete and accurate.

Member's Signature: ______________________ Date: ______________

Your claims cannot be processed without the requested information. An envelope has been enclosed for your convenience. If you have any questions, please call Customer Service at 1-800-662-5502.

Thank you for your assistance in this matter.