Baystate Medical Center

CARDIAC REHABILITATION PROGRAM
INSURANCE INFORMATION

Welcome to the Outpatient cardiac Rehabilitation Program at Baystate Medical Center.
To prevent unexpected bills due to your participation in our program we ask you to call your insurance company and complete this form **PRIOR** to your first appointment

Your cooperation with this matter is greatly appreciated.

Patient Name _____ **Date Insurance Company Called:**_____

Diagnosis: ____Heart Attack ____Stable Angina _____Angioplasty
____Angioplasty with Stent ____Heart Bypass Surgery ____Heart Valve Surgery
____Heart Failure ____Cardiomyopathy

1. **Please call your insurance company and ask the following questions.** Please write the responses in the space below and bring this completed form with you on your first visit. You will also need to give this form with your insurance card to the secretaries who will review the information below.

   a. Does my insurance plan cover outpatient hospital-based Cardiac Rehabilitation Program for the diagnosis above? YES _____ NO_____

   b. Is there a deductible? YES_____ NO_____ Amount: $_____

   c. Is there a co-pay? What is the amount I will owe per visit? $_____

   d. Do I need a referral from my doctor? YES_____ NO_____

   d. How many visits are covered by my plan? _____

   e. How long do I have to complete these visits? _____

   f. What is the Reference Number # _____

   g. What is the Authorization Number # _____

2. **If your insurance company informs you of a need for a referral, contact your Primary Care Physician BEFORE your first Cardiac Rehabilitation appointment (Fax: 413-794-7125).**
3. **I understand the above information and agree to participate in Cardiac Rehabilitation/Wellness**

_____ _____ _____
Participant Signature Baystate Medical Secretary Date Reviewed

4/17/2009 White copy- File Yellow copy-Patient

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