

**REQUEST FOR EMPLOYMENT INFORMATION****SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)**

|                       |  |                                       |          |
|-----------------------|--|---------------------------------------|----------|
| 1. Employer's Name    |  | 2. Date                               |          |
|                       |  | / /                                   |          |
| 3. Employer's Address |  |                                       |          |
|                       |  |                                       |          |
| City                  |  | State                                 | Zip Code |
|                       |  |                                       |          |
| 4. Applicant's Name   |  | 5. Applicant's Social Security Number |          |
|                       |  | - -                                   |          |
| 6. Employee's Name    |  | 7. Employee's Social Security Number  |          |
|                       |  | - -                                   |          |

**SECTION B: To be completed by Employers****For Employer Group Health Plans ONLY:**

|                                                                                                                                                             |               |                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------|
| 1. Is (or was) the applicant covered under an employer group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No                          |               |                           |
| 2. If yes, give the date the applicant's coverage began. (mm/yyyy)                                                                                          |               |                           |
| /                                                                                                                                                           |               |                           |
| 3. Has the coverage ended? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                         |               |                           |
| 4. If yes, give the date the coverage ended. (mm/yyyy)                                                                                                      |               |                           |
| /                                                                                                                                                           |               |                           |
| 5. When did the employee work for your company?                                                                                                             |               |                           |
| From: (mm/yyyy)                                                                                                                                             | To: (mm/yyyy) | Still Employed: (mm/yyyy) |
| /                                                                                                                                                           | /             | /                         |
| 6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer. |               |                           |
| From: (mm/yyyy)                                                                                                                                             | To: (mm/yyyy) |                           |
| /                                                                                                                                                           | /             |                           |

**For Hours Bank Arrangements ONLY:**

|                                                                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Is (or was) the applicant covered under an Hours Bank Arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 2. If yes, does the applicant have hours remaining in reserve? <input type="checkbox"/> Yes <input type="checkbox"/> No        |  |
| 3. Date reserve hours ended or will be used? (mm/yyyy)                                                                         |  |
| /                                                                                                                              |  |

**All Employers:**

|                               |  |              |
|-------------------------------|--|--------------|
| Signature of Company Official |  | Date Signed  |
|                               |  | / /          |
| Title of Company Official     |  | Phone Number |
|                               |  | ( ) -        |

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# Medicare Report Form 193

**RJ Shavelson**



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**Government Reports Announcements & Index**, 1994      *The Massachusetts register*, 2006      Computer Applications for the Medical Office Barbara A. Gyls, 1991 A comb bound text with disks for interactive learning of various aspects of computerized management of a medical office The simulations are self paced and cover concepts and techniques of billing and collections insurance processing building databases entering patient records and generating financial and productivity reports The software is a simplified version of Medical Care Basic Management and is configured for PCs Annotation copyrighted by Book News Inc Portland OR      *BNA's Health Care Policy Report*, 2003      **AMA Policy**

**Compendium** American Medical Association,1990      *Ohio Monthly Record* ,1989 Rules of state administrative agencies In full text with tables and index including chart of proposed rules with time and location of public hearings      *Understanding Social Welfare* Ralph Dolgoff,Donald Feldstein,1984 *Understanding Social Welfare* introduces readers to the issues historical influences trends methods of operation and unresolved conflicts of American social welfare This well organized comprehensive and scholarly book is accessible to social workers and helps them acquire the basic tools for understanding analyzing and evaluating social welfare policies and programs The book focuses on the impact of social structure on people s lives emphasizing the current concerns of a diverse client population and incorporating the latest social welfare legislation For those involved with social welfare and policy      *Insurance Advocate* ,1970      **Nursing Documentation** Patricia W. Iyer,Nancy Hand Camp,1995 Clearly and concisely provides guidelines for appropriate and careful documentation of care Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources In addition it plays a large role in how third party payors make payment or denial decisions This new edition includes the latest changes and trends in nursing documentation as related to the newly restructured healthcare environment Special attention focuses on the latest documentation issues specific to specialty settings such as acute care home care and long term care and a variety of clinical specialties such as obstetrics pediatrics and critical care Amazon com      **Digest of Official Actions: 1969-1978** American Medical Association,1959

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