



Mayo Clinic, Medicare and You

General information

The following material has been developed to help you understand and reconcile Mayo Clinic billing and Medicare reimbursement.

Medicare Part B helps pay for:

- doctors' services (excluding routine physicals)
- outpatient medical and surgical services and supplies
- diagnostic tests
- ambulatory surgery center facility fees for approved procedures
- durable medical equipment (such as wheelchairs and oxygen)
- second surgical opinions
- outpatient physical and occupational therapy.

Like others around the country, Mayo Clinic in Jacksonville, Fla., has chosen to be a nonparticipating provider and thus does not accept assignment for services covered by Medicare Part B. Nonparticipating means that Mayo Clinic does not accept the Medicare-approved amount as payment in full. Accordingly, Mayo bills you for the full amount of the charges (which are set by the federal government) and expects full reimbursement from you. You will not be asked to make a payment "up front" unless a service is considered noncovered by Medicare.

Here's how Mayo's Medicare billing practice affects you:

Example

Mayo Clinic charge to Medicare patients	\$109.25
Medicare-approved amount	\$100
Medicare allowed when not accepting assignment	\$95
Medicare pays you 80% of allowed amount	\$76
Supplemental insurance (if you have coverage) pays you 20% of allowed amount	\$19
Total paid by Medicare & supplemental	\$95
Patient responsibility	\$14.25
(Patient responsibility if no supplemental	\$33.25)

Are there services for which Mayo Clinic must accept assignment from Medicare?

Yes. Those services are:

- Clinical laboratory tests covered by Medicare
- Services provided by nonphysician practitioners (such as physician assistants, nurse anesthetists, etc.)
- Ambulatory surgery center facility fees
- Covered drugs and biologicals

Details are available on the Medicare Web site at medicare.gov.

Mayo also must accept assignment if Medicaid is your secondary insurance.

Medicare Advantage Plans (MAPs)

Mayo Clinic's campus in Florida does not participate in any Medicare Advantage Plans offered by private insurance companies. We only see patients enrolled in the traditional or original Medicare program.

What to expect from Mayo Clinic billing

1. Mayo Clinic in Jacksonville, Fla., automatically bills Medicare for services you have received.
 2. After the bill is sent to Medicare, Mayo sends you a red and white Health Insurance Claim Form (see Example 1 on Page 5). You should use this form for submitting claims to any supplemental insurance you have.
 3. After each episode of care, Mayo Clinic will send you an itemized statement (see Example 2 on Pages 6-7) detailing your charges. This is not a bill. It provides detailed visit information that will not appear on your Monthly Statement. Please keep this for your records.
 4. Medicare sends you a payment and a Medicare Summary Notice form (see Example 3 on Pages 8-9) for services. We recommend you deposit the checks into your bank account.
 5. Mayo send you a Monthly Statement (Example 4 on Page 10) to advise you of your balance due and any activity on the account. Payment is expected when you receive the Monthly Statement.
 6. Payments may be made by personal check, credit card or money order and should be mailed to Mayo Clinic, P.O. Box 790124, St. Louis, MO 63179-0124. To pay by phone with a credit card or to sign up for online bill paying, call (904) 953-7058.
 7. Medigap policies are supplemental insurance that cover the difference between doctors' actual charges and Medicare's approved amount. Medicare labels Medigap policies F, G, I and J. They are available to Medicare patients for a fee.
 8. If you have supplemental insurance, you should match the red and white claim form with the Medicare Summary Notice and send both to any supplemental insurance you have. *
 9. Mayo will send statements to you once a month until the bill is paid in full.
- * If your supplemental coverage is a Medigap plan, the Medicare carrier may forward your claim to your supplemental health plan. In that case, there is no need to send the Medicare Summary Notice and the red and white form to your supplemental insurance. If you have an automatic crossover plan, the claim will be forwarded to the supplemental insurer.

Keeping track of your Mayo Clinic bill

Please refer to the Medicare Worksheet (Example 7 on Page 13) while reading these instructions.

- From your Mayo Clinic itemized statement, enter the date of service in column A and the charges in column B.
- When you receive the Medicare Summary Notice for those services from Medicare, enter the Medicare-approved amount under column C and the Medicare payment under column D.
- If you have supplemental insurance and you have sent in your claim, you will receive an Explanation of Benefits (EOB) (Example 5 on Page 11) from the insurer. From this EOB, enter the payment for each charge under column E.
- If a portion of the charge is adjusted by Mayo Clinic for any reason, enter the amount under column F.
- Now, subtract columns D, E and F (if applicable) from column B to compute your out-of-pocket responsibility. Enter the amount in column G.
- Add columns D, E and G and enter the total in column H. The amount under H is due to Mayo Clinic.
- Every charge on your Mayo Clinic statement should match the charges on your worksheet. If a payment is missing from your worksheet, please call Medicare at (800) 633-4227 to determine if the claim has been processed.
- If a charge is denied by Medicare or your supplemental insurer, or if the Medicare Summary Notice states that you are not responsible for the charge, please call Mayo Clinic at (904) 953-7058 for adjustment or claim resubmission. You also can write to us at Mayo Clinic, Patient Financial Services, 4500 San Pablo Road, Jacksonville, FL 32224. Please include a copy of the Medicare Summary Notice referring to the denied charge.
- To appeal a denied charge when Medicare states that you are responsible for the charge, follow the instructions under “Appeals Information” on the last page of your Medicare Summary Notice. You also can call Medicare at (800) 633-4227.

About noncovered services

Medicare considers some services to be routine or noncovered. A few examples are: eye refraction, foot care, hearing aids, cosmetic surgery, routine screenings and annual checkup visits. You will be financially responsible for these services.

In addition, there are other services for which Medicare will determine payment based upon your diagnosis. During your clinic visit, you may have been asked to sign an Advanced Beneficiary Notice or ABN (Example 6 on Page 12) notifying you that one or more scheduled services may not be covered. Any questions regarding a specific service should be directed to Medicare at (800) 633-4227.

For more information

Mayo Clinic in Jacksonville, Fla.

Patient Financial Services: (904) 953-7058

mcjmedicarehelp@mayo.edu

Medicare

Federal Government

- 800-MEDICARE [(800) 633-4227]
- Website: medicare.gov
- Medicare and You 2006 (CMS Publication # 10050)

Florida

- Medicare Part B Customer Service: (800) 633-4227
- Hearing Impaired: (800) 486-2048
- Web site: medicarefla.com
- Railroad Retirement Board: (800) 808-0772

Social Security Administration

- (800) 772-1213
- Hearing Impaired: (800) 325-0778

Example 1 (Red & White Form)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
CITY	STATE	CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH SEX	
b. OTHER INSURED'S DATE OF BIRTH SEX		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPCS Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1		NPI	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED _____ DATE _____		a. NPI b. NPI	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Example 2



MAYO CLINIC

Itemized Statement of Charges

Patient's Name	Mayo Clinic Number	Visit Number	Dates of Service
John K. Doe	5-572-792	8323	11/17/08-11/18/08

Please refer to patient's name, Mayo Clinic number and visit number on all correspondence.

Billing Account Number:

Statement Date: November 24, 2008

Addressee

Mr. John K. Doe
123 Anywhere
Your City, FL 11111

Services Provided By

MAYO CLINIC
4500 SAN PABLO ROAD
JACKSONVILLE, FL 32224

THIS IS NOT A BILL - PLEASE RETAIN FOR YOUR RECORDS

Important Information to Assist You

1. This Itemized Statement of Charges is for your information only. You will be receiving a Monthly Statement of Account (your bill) reflecting your financial responsibility. The visit number above will help you identify this specific visit on your Monthly Statement of Account.
2. Please review this statement carefully. If you have questions regarding this statement, Please contact Patient Financial Services:

Patient Financial Services
Mayo Clinic
4500 San Pablo Road
Jacksonville, FL 32224

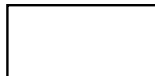
Telephone 904-953-7058
8 a.m. to 4 p.m. (ET) Mon-Thu
8 a.m. to 3 p.m. (ET) Friday

3. We have generated a claim for the following insurance company(ies):
Cigna Hmo MCJ Employees

****Verify the insurance is correct and notify us of any changes****

4. Please retain this Itemized Statement of Charges for your records.

SAMPLE



Example 2



MAYO CLINIC

*Itemized Statement
of Charges*



Patient's Name	Mayo Clinic Number	Visit Number	Dates of Service
John K. Doe	5-572-792	8323	11/17/08-11/18/08

Please refer to patient's name, Mayo Clinic number and visit number on all correspondence.

THIS IS NOT A BILL - PLEASE RETAIN FOR YOUR RECORDS

Date of Service	Service Code	Service Description	Amount
PHYSICIAN SERVICES - HOSPITAL INPATIENT			
11/18/08	76770-26	U/S RETROPERITONEAL B SCAN PROF	226.00
11/18/08	52332-LT	CYSTO W/INSERT URETERAL STENT	1,620.00
11/18/08	00910-QK	ADMIN ANESTHESIA MD (NOM)	331.20
		43 UNITS	
11/18/08	00910-QX	ADMIN ANESTHESIA CRNA (NOM)	220.80
		43 UNITS	
11/18/08	99254-25	CONSULT, HOSPITAL - LV 4	436.00
PHYSICIAN SERVICES - HOSPITAL OUTPATIENT			
11/17/08	76770-26	U/S RETROPERITONEAL B SCAN PROF	226.00
11/17/08	76856-26	U/S PELVIC PROF	168.00
11/17/08	76830-26	U/S TRANSVAGINAL LTD PROF	195.00
		TOTAL CHARGES	3,423.00

DIAGNOSIS CODE(S) FOR INSURANCE COMPANY USE: 592.1 591 649.63

PAYMENTS RECEIVED WILL BE REFLECTED ON YOUR MONTHLY STATEMENT OF ACCOUNT

SAMPLE

Example 3

John K. Doe
123 Anywhere
Your City, FL 11111

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A

If you have questions, write or call:

Medicare (#12345)
555 Medicare Blvd., Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Call: 1-800-MEDICARE (1-800-633-4227)

Ask for Doctor Services

TTY for Hearing Impaired: 1-877-486-2048

BE INFORMED: Beware of telemarketers offering free or discounted medicare items or services.

This is a summary of claims processed from 11/16/2008 through 11/30/2008

PART B MEDICAL INSURANCE - UNASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid You	You May Be Billed	See Notes Section
Claim number 01-0001-011-022 FL Mayo Clinic Jacksonville, 4500 San Pablo Road Jacksonville, FL 32224 A Doctor M.D.						
11/14/08	Sample (99999)	\$109.25	\$95.00	\$76.00	\$109.25	

SAMPLE

THIS IS NOT A BILL - Keep this notice for your records.

Example 3 (back)

Page 2 of 2

Your Medicare Number: 111-11-1111A

Notes Section:

- a This information is being sent to your private insurer. They will review it to see if additional benefits can be paid. Send any questions regarding your supplemental benefits to them.
- b This service is paid at 100% of the Medicare approved amount.
- c Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than \$39.02. If you have already paid more than this amount, you are entitled to a refund from the provider.

Deductible Information:

You have met the Part B deductible for 2008.

General Information:

You have the right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement.

Compare the services you receive with those that appear on your Medicare Summary Notice. If you have questions, call your doctor or provider. If you feel further investigation is needed due to possible fraud and abuse, call the phone number in the Customer Service Information Box.

SAMPLE

Appeals Information – Part B

If you disagree with any claims decisions on this notice, your appeal must be received by **November 1, 2008**. Follow the instructions below:

- 1) Circle the item(s) you disagree with and explain why you disagree.
- 2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1. (You may also send any additional information you may have about your appeal.)
- 3) Sign here _____ Phone number _____

Example 4



MAYO CLINIC

Monthly Statement of Account

SAMPLE

Mr. John K. Doe
123 Anywhere
Your City, FL 11111

Billing Account Number: 5-572-792
Statement Date: Nov. 20, 2008
Customer Service: 904-953-7058

Messages:	Account Summary:																		
<p>Thank you for choosing Mayo Clinic. PLEASE NOTE: Charges totaling \$0.00 are pending with your insurance. You will be responsible for the portion not covered. Contact your insurance representative with questions about insurance claims or payments.</p> <p>To view and pay your bill online, enroll at www.mayoclinic.org/portal/letter-rst.html</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Previous Account Balance as of 09/30/2008</td> <td style="width: 5%; text-align: center;">\$</td> <td style="width: 25%; text-align: right;">0.00</td> </tr> <tr> <td>New Charges</td> <td style="text-align: center;">\$</td> <td style="text-align: right;">109.25</td> </tr> <tr> <td>Payments/Adjustments</td> <td style="text-align: center;">\$</td> <td style="text-align: right;">0.00</td> </tr> <tr> <td>Current Account Balance</td> <td style="text-align: center;">\$</td> <td style="text-align: right;">109.25</td> </tr> <tr> <td>Insurance Claims Pending</td> <td style="text-align: center;">\$</td> <td style="text-align: right;">0.00</td> </tr> <tr> <td>CURRENT AMOUNT DUE</td> <td style="text-align: center;">\$</td> <td style="text-align: right;">109.25</td> </tr> </table> <p>If you dispute this debt: Any communication concerning disputed debts, including any payments tendered as full payment of your disputed account, must be mailed to: Mayo Clinic Florida, 4500 San Pablo Road, Jacksonville, FL 32224 Attn: MCF PASC COLLECTIONS/Sandcastle Office</p>	Previous Account Balance as of 09/30/2008	\$	0.00	New Charges	\$	109.25	Payments/Adjustments	\$	0.00	Current Account Balance	\$	109.25	Insurance Claims Pending	\$	0.00	CURRENT AMOUNT DUE	\$	109.25
Previous Account Balance as of 09/30/2008	\$	0.00																	
New Charges	\$	109.25																	
Payments/Adjustments	\$	0.00																	
Current Account Balance	\$	109.25																	
Insurance Claims Pending	\$	0.00																	
CURRENT AMOUNT DUE	\$	109.25																	

To help us process your payment, **please return the lower portion of this statement** with your payment. Do not send currency.

Billing Addressee	Billing Account Number	Date Due	Amount Due	Amount Enclosed
Doe, John	5-572-792	Upon Receipt	\$ 109.25	

To pay by credit/debit card:

Please indicate credit/debit card preference. Provide the account information and sign below, or call 904-953-7058.

<input type="checkbox"/> Credit	Type:	<input type="checkbox"/> American Express	<input type="checkbox"/> Discover
<input type="checkbox"/> Debit		<input type="checkbox"/> Mastercard	<input type="checkbox"/> Visa
Card Account Number		Amount	
Name on Card			Expiration Date
Authorized Signature			

Check here if your address has changed. Please indicate changes on back.

To pay by check or money order:

Make check payable to MAYO CLINIC. Write your **billing account number** on the front of your check or money order and mail in the enclosed envelope to:

MAYO CLINIC
P.O. BOX 790124
ST LOUIS, MO 63179-0124



Example 5



636 Grand Avenue
 Des Moines, Iowa 50309-2565

Explanation of Health Care Benefits Medicare Supplement

Identification Number: 123456789

Page 1

Claim Number: 110111001111

Provider Number: 99988

JOHN K DOE
 123 ANYWHERE
 YOUR CITY, USA 11111

Provider Name: Mayo Clinic Jacksonville

This is not a bill. It is a statement showing how we applied your Wellmark Blue Cross and Blue Shield of Iowa coverage to claims submitted to us. If you have a question, please detach the top of this form and send it to us with a letter or call: 800/524-9242 TOLL FREE. Customer Service is available to answer calls Mon. - Fri. 8:00 a.m.-4:00 p.m.

From		Through	SER- VICE CODE	Charge		Medicare Approved		Medicare Benefit Amount		Wellmark Benefit Amount	Notes	Claim Summary	
11/15	11/30/08		36	109	25	95	00	76	00	19	00		Total Charges Submitted
												109.25	
												Medicare Approved	
												95.00	
												Medicare Benefit Amount	
												76.00	
												Noncovered Services	
												33.25	
												Amount You Owe*	
												33.25	
												Wellmark Benefit Amount For This Claim	
												19.00	

This is not a bill and you should not send us money. However, if you have not paid for the service shown here, you may owe the provider. You may want to keep this statement for your records.

Notes

SAMPLE

*This is the amount you owe the provider indicated above. If you already paid this provider, please disregard this amount.

Identification Number 123456789	Group Number 00001001-111	Claim Number 110111001111	Account Number 22222
Claim Received 12/15/08	Claim Processed 1/15/09	Provider Name MAYO CLINIC	Patient Name JOHN K DOE

If you have a question regarding this Explanation of Health Care Benefits, call: 800/524-9242 TOLL FREE

Example 6: Advanced Beneficiary Notice



200 First Street SW
Rochester, Minnesota 55905
507-289-9195

Mayo Clinic Number	Date (Month DD, YYYY)
Patient Name (First, Middle, Last)	

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Note: If Medicare doesn't pay for _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the _____ below.

	Reason Medicare May Not Pay	Estimated Cost
Description of Service:		\$ _____

What you need to do now:

Read this notice, so you can make an informed decision about your care.

- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed
- OPTION 3.** I don't want the _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature	Date (Month DD, YYYY)
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08)

Form Approved OMB No. 0938-0566

Patient at Clinic Print two copies. One copy to be kept by the patient. Signed (second) copy to be retained by desk staff. Desk staff to forward this copy to: Data Entry – Mayo Mezz 70E, Patient Financial Services.

MC2934-62rev0808

Mayo Clinic, Medicare and You



4500 San Pablo Road
Jacksonville, Florida 32224
www.mayoclinic.org

MCJ6280/R0109

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