CATHOLIC HEALTH INITIATIVES

Franciscan Medical Group

A Part of Franciscan Health System

"Welcome to Medicare" Initial Preventive Physical Examination (IPPE) Patient Acknowledgement

I understand that the Medicare Initial Preventative Physical Examination (IPPE) is strictly for those patients who are new to Medicare Advantage Part B within the last 12 months. I certify that I have enrolled in Medicare Advantage Part B, for the first time, within the last 12 months.

Please check the following:

❑ Yes ❑ No ❑ I don't know

By signing below, I also understand the following:

- This is an once-in-a-lifetime health assessment that is only available to patients enrolled in Medicare Advantage Part B within the first 12 months of joining the program.
- I am not entitled to coverage for this visit if it is not scheduled within the first 12 months of my enrollment in the program.
- This is not a comprehensive physical exam.
- Medicare does not provide reimbursement for routine physical exams.
- This exam does not include coverage for medication refills.
- This exam does not include coverage for routine physical checkups.
- This exam does not include treatment of new or existing health problems.
- I understand that if any additional services are provided during this visit, they will be billed separately and may not be covered by Medicare.

Patient Signature _____

Date _____

Medicare Annual Wellness Visit (AWV)
Patient Acknowledgement

I understand I understand that Medicare Part B coverage entitles me to receive an Annual Wellness Visit (AWV) once a year. I certify that it has been 12 months or longer since my last Annual Wellness visit.

Please check the following:

❑ Yes ❑ No ❑ I don't know

By signing below, I also understand the following:

- This is not a comprehensive physical exam.
- Medicare does not provide reimbursement for routine physical exams.
- This exam does not include coverage for medication refills.
- This exam does not include coverage for routine physical checkups.
- This exam does not include treatment of new or existing health problems.
- I understand that if any additional services are provided during this visit, they will be billed separately and may not be covered by Medicare.

Patient Signature _____

Date _____