Sample Surgical Disclosure Letter

Dear Mr./Mrs./Ms.___(Patient's Name)___________

As Dr. _(Physician's Name)________ is scheduled to perform a ___(Type of Surgery)__________ for you on ___(Date)_______, Medicare regulations require that we furnish you with information regarding the amount that Medicare will be paying for your surgery and the amount you will be responsible for paying. It is our understanding that you have, in addition to your Medicare coverage, a supplemental policy from ____(Name of Supplemental Carrier)_____. This policy may cover all or a portion of the bill that Medicare does not. The coverage will assist you in covering your out-of-pocket expenses according to your benefit package with them. So, after Medicare has paid their portion of this bill you will want to submit the remaining balance to (Name of Insurer)__________ for consideration of payment. Once your secondary insurance has paid their portion, if the remaining fee is more than you feel you can financially afford, please contact our office.

Type of Surgery: ____

Estimated Charge: ______________________________________

Surgeon: ____

Assistant Surgeon: ________________________________

Estimated Medicare Payment

Surgeon: ____

Assistant Surgeon: ________________________________

Physician's fees after Medicare payment: _____________________

It is necessary that you sign this notice prior to your surgery and return it to our office in the enclosed envelope. We have enclosed two copies, one for your records. Because this notice must accompany your patient file to surgery, a delay in returning this notice could result in postponement of your surgery. If you have any questions, please feel free to call our office.

____	______________________________
Patient Signature	Date
____	______________________________
Physician Signature	Date