

Chronic Care Management Patient Agreement

Medicare is offering a new benefit for beneficiaries with multiple chronic conditions, and by consenting to this agreement, you allow _____ (“Provider”) to provide chronic care management services to you.

CCM services are only available to patients with two or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last for at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Benefits of CCM Services include:

- 24/7 access to a care provider to help with your chronic healthcare needs
- A comprehensive plan of care for health needs, available on paper or electronically
- Coordination with both home and community-based service providers
- Transition management among health care providers, including referrals, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Medication oversight and management
- Use of a certified electronic health record (EHR) as mandated by Medicare

Should you desire to receive CCM services through your provider, he/she agrees to only bill Medicare for CCM services once per 30-day billing cycle. Furthermore, your provider agrees only to bill Medicare for CCM services if you have more than one chronic condition.

Beneficiary Acknowledgment and Agreement

By signing this agreement, you agree to the following terms:

- You consent to your provider providing CCM services to you.
- You certify that your provider has fully explained the scope of CCM services to you.
- You acknowledge that only one practitioner can furnish and be paid for CCM services during a calendar month.
- You authorize electronic communication of your medical information between treating providers as part of your care.
- You understand that CCM services are subject to Medicare Co-Insurance, and so you may be billed for a portion of the CCM services.
- You understand that you have the right to terminate CCM services at any time by revoking this agreement effective at the end of the then-current month. You may revoke this agreement verbally by notifying _____ by telephone at (____)____-_____, or by mailing your written revocation to _____. Your provider will then give you written confirmation, including the effective date of revocation.

Beneficiary/Responsible Party Signature: _____

Print Name: _____ Date: _____

This sample is for informational purposes only, and is not meant to constitute legal advice.