

## MEDICARE QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

(Circle One)

1. Is this illness/injury covered by Workers' Compensation? <i>If yes, note employer or insurer's name and address and claim number in #10.</i>	Yes	No
2. Is this illness/injury covered under the Black Lung Program?	Yes	No
3. Are you entitled to benefits through the Department of Veterans Affairs (DVM)? <i>If yes, do you want the DVA to be contacted for authorization of these services?</i>	Yes	No
4. Is this illness/injury the result of an auto accident? <i>If yes, enter the responsible auto insurance/insured in #10.</i>	Yes	No
5. Is another party's liability insurance responsible for this illness/injury? <i>If yes, enter the responsible party's insurance in #10.</i>	Yes	No
6. Are you covered by an Employer Group Health Plan (EGHP), including Federal Employee Health Benefits? <i>If yes, enter the EGHP data in #10.</i>	Yes	No
7. Are you or your spouse actively employed by an establishment of 20 or more employees? <i>If yes, enter the EGHP data in #10.</i>	Yes	No
8. Are you under age 65 and entitled to Medicare due to a disability? <i>If no, move to #9.</i> <i>If yes, are you or your spouse actively employed by an establishment of 100 or more employees (LGHP - Large Group health Plan.)?</i> <i>If yes, enter the LGHP data in #10.</i>	Yes	No
9. Are you entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)? <i>If yes, have you completed the ESRD coordination period?</i> <i>If no, enter the EGHP data in #10.</i>	Yes	No
<i>Complete the following information only if you answered "Yes" to one or more of questions 1-8, or "No" to question 9b.</i>		
10. Name of insurance company:		
Insured's name and policy number:		
Employer:		
Insurer's address:		
Claim Number:		