

## MEDICARE QUESTIONNAIRE

Patient Name:	Date:
Social Security Number: _	

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