# MEDICARE QUESTIONNAIRE

Patient Name:___________________________ Account Number:_______________

**Must be completed by Medicare patients per Medicare guidelines.**

1. If you have received home health care of any kind in the past 60 days, please provide the name and phone number of the home health agency.

HHA______________________________ Phone:______________________________

2. Are you entitled to benefits under the Black Lung Program, Department of Veteran Affairs or other government program? YES or NO

Program Name:_______________________________________________________
Address:_____________________________________________________________
Phone:_______________________________________________________________

**This Government Program will be primary insurance**

3. Is your injury related to any of the following? (Please Circle One)

Work Auto Accident Accident on someone else's property N/A

Injury date and details:_________________________________________________

**Medicare requires that we file with the liability insurance first**

4. Do you feel you should be compensated by another party who may have caused this injury? YES or NO

If yes, do you intend to file a claim or lawsuit for this injury? YES or NO
Attorney Name:________________________________________________
Address:______________________________________________________
Phone:________________________________________________________

5. Have you received a kidney transplant? YES or NO

Are you currently receiving dialysis for End Stage Renal Disease? YES or NO

If the date is less than 18 months ago, are you currently covered under another insurance?
YES or NO
If YES the other insurance will be primary if NO then Medicare will be primary

6. If the above does not apply to you, and your Medicare insurance is due to age or a disability, do you have coverage through another insurance? YES or NO
If YES the other insurance will be primary if NO then Medicare will be primary.

Patient Signature:_______________________________Date:______________