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Medicare Questionnaire

Patient's Name: _____ Medicare #:_____

Legislation makes Medicare the secondary payor under certain circumstances. The following questions are designed to recognize those circumstances. This form will be retained in your folder for Medicare auditing purposes.

Do you have traditional Medicare ( ) or Medicare HMO ( )?

Questions	**YES**	**NO**
Was your illness/injury due to a WORK RELATED ACCIDENT/CONDITION and is it being covered by a WORKERS COMPENSATION plan or the FEDERAL BLACK LUNG PROGRAM?		
Was your illness/injury due to an AUTO or LIABILITY ACCIDENT?		
Is the patient EMPLOYED AND COVERED BY THE EMPLOYER'S HEALTH PLAN?		
Is the patient's SPOUSE EMPLOYED AND THE PATIENT IS COVERED BY THE SPOUSE'S EMPLOYER'S HEALTH PLAN?		
Is the patient ENTITLED TO BENEFITS SOLELY ON THE BASIS OF END STAGE RENAL DISEASE?		
Have you had Physical Therapy or Speech Therapy services already this year?		
Are you receiving currently home care for ANY services (home health aide, dressing changes, blood work, injections, medications, suture removal)?		

Patient's Certification: I certify that the information given by me in applying for payment under TITLE XVIII of the SOCIAL SECURITY ACT is correct.

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Patient Signature Date Witness Signature