MEDICARE PATIENT INFORMATION

Patient Name:_____

Patient DOB:_____ Patient Age:_____ Patient Sex: Male☐ Female☐

Please read each of the following sections and answer as they apply to you.

Part I

1. Are you receiving Black Lung (BL) Benefits? YES NO
   Date Black Lung benefits began _____
   BL IS PRIMARY PAYOR ONLY FOR CLAIMS RELATED TO BL
2. Are the services to be paid by a government program such as a research grant? YES NO
   GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THIS SERVICE
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? YES NO
   DVA IS PRIMARY FOR THESE SERVICES
4. Was the illness/injury due to a work related accident/condition? YES NO
   Date of injury/illness_____
   Name and address of WC plan_____
   WC IS PRIMARY ONLY FOR CLAIMS WORK-RELATED INJURY OR ILLNESS, GO TO PART III

Part II

1. Was illness/injury due to a non-work related accident? YES NO
   Date of accident_____

Part III

1. Are you entitled to Medicare based on Age?_____ Disability?_____ ESRD(End Stage Renal Disease_____

Part IV –ESRD

1. Do you have Group Health Plan (GHP) coverage? YES NO
   IF NO, STOP. MEDICARE IS PRIMARY
   GHP Policy: Name_____
   Employer:_____
2. Have you received a kidney Transplant? YES NO
   Date of transplant:_____
3. Have you received maintenance dialysis treatments? YES NO
   Date Dialysis began:_____
   If you participate in a self-dialysis training program, provide the date training started:_____
4. Are you with the 30-month Coordination Period? YES NO
   IF NO, STOP. MEDICARE IS PRIMARY
5. Are you entitled to Medicare (including simultaneous or dual entitlement based on ESRD? YES NO
   IF YES, STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.
   IF NO, INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.

Please sign so we may have your Medicare authorization on file:
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carrier any information need for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits wither to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature:_____ Date:_____

Please sign so we may have your Supplemental authorization on file:
I request authorized MEDIGAP benefits be made on my behalf for services furnished to me. I authorize any holder of medical information to release to MEDIGAP insurance needed to determine these benefits payable for related services.

Signature:_____ Date:_____

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