MEDICARE QUESTIONNAIRE
REQUIRED

Patient Name: ____________________________

Date of Birth: ____________

Our office requires that we ask you the following questions to insure that Medicare is your Primary Payor for this illness or injury.

1.	Have you received Home Health Care of any kind in the past 60 days?	Yes	No
2.	If Yes, please provide the name and phone number of the Home Health Agency: a. Home Health Agency Name: ____________________ b. Home Health Agency Telephone Number: ____________________		
3.	Are you currently covered by a group health plan under yourself or your spouse?	Yes	No
4.	Are you under 65 and entitled to disability benefits?	Yes	No
5.	Have you received End Stage Renal Disease (ESRD) intervention?	Yes	No
6.	Are you entitled to benefits under the Federal Black Lung Program?	Yes	No
7.	Was the injury/illness work related?	Yes	No
8.	Are you entitled to benefits under the Veterans Administration?	Yes	No
9.	Is the injury covered by Third Party Liability (Ex. Auto, personal injury, No-Fault)?	Yes	No
10.	Are you covered under any other Public Health or Federal Program?	Yes	No
11.	Are you covered under a Medicare Replacement Plan?	Yes	No

***If yes to any question.above, we may be required to obtain further information to verify that Medicare is the primary payer for this injury/illness.

Patient's Signature: ______________________________ Date: ____________

Revised: 05/03/2013