Dear Medicare Patient:

In order to properly file your charges with Medicare, we have been instructed to ask you the following questions. Please answer all of the questions in full. If your status changes at any time in the future, you must let us know at the time of your next date of service so that we can update your account.

(Please check the appropriate answer, or fill in the blank[s])

Name: _____ **Medicare Number:** _____

Age: _____ **Date of Birth:** _____ **Sex:** ❑ Male ❑ Female

Basis for Medicare eligibility: ❑ Age ❑ Disability ❑ End Stage Renal Disease

- Are you or your spouse currently working full or Part-time? ❑Yes ❑ No
  - If NO, please provide the following:
    Retirement Date of Patient _____
    Retirement Date of Spouse _____
- If you and/or your spouse work(s), how many employees does your employer or your spouse's employer have? ❑ Less than 20 ❑ More than 20
- Are you covered under an employer Group Health Plan based on the current employment of you or your spouse? ❑Yes ❑ No
  - If YES, please provide the following:
    - Name of insured and relationship to patient (self, spouse)
      _____;
    - Name and Address of employer
      _____
      _____
      _____;
    - Name and Address of Insurance Company
      _____
      _____
      _____;
    - Group Identification Number
      _____;
    - Policy Identification Number
      _____.

- Are you entitled to Black Lung Medical Benefits? ❑Yes ❑ No

- Was this service for treatment of a work-related injury or illness? ❑Yes ❑ No

  - If YES, provide the name and address of the Workers' Compensation Agency, the Worker's Compensation Carrier and your employer.

    _____
    _____
    _____
    _____

- Was this service for the treatment of an illness or injury which resulted from an automobile or other accident? ❑Yes ❑ No

  - If YES, provide the name, address, and policy number of the automobile or non-automobile liability or no-fault insurer:

    _____
    _____
    _____

    Policy Number: _____

- Do you have a veterans Administration fee service card? ❑Yes ❑ No

- Are the services to be paid by a government program such as a research grant? ❑Yes ❑ No

Patient's Signature _____

Date _____

ONETIME MEDICARE FILING AUTHORIZATION

I authorize any holder of medical information concerning me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature _____ Date_____

(if unable to sign) _____
Signature of person signing for patient and relationship

_____
Reason for inability of patient to sign