

Patient Name:

Medicare Number:

Please check the types of coverage you have:

1. Medicare Hospital Part A? Y N 2. Medicare Physician Part B? Y N
 3. Black Lung Coverage? Y N 4. Veteran's Administration? Y N

Date Black Lung Coverage Began:
N

Was Service authorized by the VA? Y

5. Is the patient a member of a Medicare HMO (Health Maintenance Organization)? Y N

HMO Name & Address:

6. Is this illness/injury covered by Worker's Comp? Y N Claim #:

Employer Name & Address:

7. Is this illness/injury due to a type of accident? Y N Date of Accident:

Location of Accident:

How did accident occur:

Liability Insurance Name & Address:

8. Does the patient feel another party is responsible for illness/injury? Y N

Name of responsible party:

Attorney name & address:

9. Is patient age 65 or older? Y N

10. Is patient covered by Employer Group Health Plan? Y N Retire Date:

Employer Name:

Insurance company name & address:

11. Is patient entitled to Medicare based on: Age Disability End Stage Renal Disease

12. Has patient been confined to a hospital or skilled nursing facility within the past 60 days? Y N

Previous admission date:

Previous Discharge Date:

Signature of person supplying information: _____

Relation to patient:

Date:

Updated:		Initials:		Updated:		Initials:	
Updated:		Initials:		Updated:		Initials:	