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