



MEDICARE PATIENTS 65 AND OVER

1. Are you currently working full or part-time? **Yes or No**

2. Are you married and is your spouse currently working full or part-time? **Yes or No**
If **Yes**, How many employees does your employer or your spouse's employer have? (Approximately) _____

3. Are you covered under an employer group health plan based on your current employment or your spouse's current employment? **Yes or No**
If **yes**, please provide the following:
 - Name of insured, relationship to patient (self, spouse)

 - Name and address of employer _____

 - Name and address of insurer, underwriter, third party administrator HMO, etc. _____

 - Group identification number and policy identification number

4. Are you entitled to Black Lung Benefits? **Yes or No**

5. Was this service for treatment of a work related injury or illness? **Yes or No**
If **yes**, the name and address of the worker's compensation agency, the worker's comp carrier and your employer. _____

6. Was this service for treatment of an illness or injury, which resulted from an automobile accident or other accident? **Yes or No**
If **yes**, provide the name, address and policy number of the automobile or non-automobile liability or no fault insurer. _____

7. Are the services to be paid by government program such as a research grant?
Yes or No

Patient Signature: _____ **Date:** _____
HIC Number: _____
