



MEDICARE PATIENTS UNDER 65

1. Have you received a kidney transplant? **Yes or No** If yes, Date.

2. Have you received maintenance dialysis treatments? **Yes or No**
If yes, Date. _____

If you answered **Yes** to questions **1 or 2**, please respond to questions under **Section A**. If you answered **No** to questions **1 or 2**, please skip down to **Section B**.

Section A

1. Are you covered under an employer group health plan through your current or former employment or through the current or former employment of your spouse or other family member? **Yes or No**
If **yes**, please provide the following:
 - Name of insured, relationship of patient (self, spouse or other family member) _____
 - Name and address of employer

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

 - Group and policy identification number _____
2. Are you entitled to Black Lung Medical Benefits? **Yes or No**
3. Was this service for the treatment of a work related injury or illness?
Yes or No
If **Yes**, provide the date of accident, name and address of the worker compensation plan or policy and the employer.

