

MEDICARE QUESTIONNAIRE  
REQUIRED

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

We are required by Medicare to ask you the following questions. We thank you in advance for the information.

1. If you have received Home Health Care of any kind in the past 60 days, please provide the name and phone number of the Home Health Agency:

Home Health Agency Name: \_\_\_\_\_

HH Agency Telephone #: \_\_\_\_\_

2. Are you currently covered by a group health plan under yourself or your spouse? Yes No
3. Are you under 65 and entitled to disability benefits? Yes No
4. Have you received End Stage Renal Disease (ESRD) intervention? Yes No
5. Are you entitled to benefits under the Federal Black Lung Program? Yes No
6. Was the injury/illness work related? Yes No
7. Are you entitled to benefits under the Veterans Administration? Yes No
8. Is this injury covered by Third Party Liability (ex auto, personal injury, No-Fault)? Yes No
9. Are you covered under any other Public Health or Federal Programs? Yes No

\*\*\* If yes to any question above, we are required to obtain further information to verify that Medicare is the primary or secondary payer for this injury/illness.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Revised: 11/17/11