

JAWORSKI PHYSICAL THERAPY, INC.

MEDICARE QUESTIONNAIRE

Patient Name _____ Acct# _____

SECTION I

Questions 1-7 must be answered for all Medicare patients regardless of age.

1. Should this illness/injury be covered by a past Workers Compensation claim or will the patient be filing a new claim with the Bureau of Workers' Compensations? **Y or N**

If yes, provide Claim # _____ Date of Injury _____

2. Is the patient covered under the Federal Black Lung Program? **Y or N**

3. Is the patient entitled to benefits through the Veteran's Administration? **Y or N**

If yes, does the patient want the VA to be contacted for authorization of these services? **Y or N**

4. Are these services the results of an accident? **Y or N**

If yes, a. Type (ie, Auto/Fall) _____

b. Location _____

c. Is non liability insurance available: (ie, auto medical payments, premises medical, no fault or homeowners) **Y or N**

If yes, provide the name of that insurance

Insurance Name _____

Address _____

5. Does the patient feel someone is responsible for this illness or injury? **Y or N**

If yes, provide the following:

Name of Responsible Party _____

Address _____

Liability Insurance Name _____

Address _____

Attorney Name _____

Address _____

6. Are these services covered by a Public Health Service (other than Medicare or Medicaid)? **Y or N**

If yes, provide name and address of PHS

Name _____

Address _____

7. Is the patient, regardless of age, entitled to Medicare due to End Stage Renal Disease? **Y or N**
If yes, is the patient covered by an Employee sponsored Group Health Plan? **Y or N**
If yes, is the patient within the 18 month coordination of Benefits periods? **Y or N**
If yes, provide the name and address of the EGHP that covers the patient.
Name of the Insurance _____
Address _____

SECTION 2

If a patient is "65" years of age or older, the following must be asked.

8. Is the patient and/or spouse actively employed by an employer of 20 or more employees? **Y or N**
If yes, is the patient covered by that Employee Group Health Plan (EGHP)
Name of EGHP _____
Address _____

SECTION 3

If patient is under the age of 65, the following must be asked.

9. Is the patient entitled to Medicare solely due to a disability other than End Stage Renal Disease? **Y or N**
If yes, is the patient or family member employed by an employer of 100 or more employees? **Y or N**
If yes, is the patient covered by that Large Group Health Plan? **Y or N**
Name of LGHP _____
Address _____

SECTION 4

I _____ (patient's name) REFUSE TO GIVE THE NECESSARY ACCIDENT INSURANCE INFORMATION FOR THE ACCIDENT WHICH HAPPENED ON _____ (date) I UNDERSTAND THAT ACCORDING TO THE MEDICARE LAW. MEDICARE CANNOT BE BILLED WITHOUT THE ACCIDENT INSURANCE INFORMATION AND THEREFORE, I WILL BE RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT MYSELF. (Refer to Section 411.51 of the Federal Register)

Signature

SECTION 5

Name of person who supplied the above information _____
Relationship to Patient _____
Clinic/Hospital Employee present _____
Date _____

Are you currently receiving any type of home health care services in your home? **Y or N**
If yes, please explain _____