RESPIRE PHYSICAL THERAPY LLC

MEDICARE QUESTIONNAIRE

Patient Name: _____ Date: _____

Social Security Number: _____

	(Circle One)	
1. Is this illness/injury covered by Workers' Compensation? If yes, note employer or insurer's name and address and claim number in #10.	Yes	No
2. Is this illness/injury covered under the Black Lung Program?	Yes	No
3. Are you entitled to benefits through the Department of Veterans Affairs (DVA)?	Yes	No
If yes, do you want the DVA to be contacted for authorization of these services?	Yes	No
4. Is this illness/injury the result of an auto accident? If yes, enter the responsible auto insurance/insured in #10.	Yes	No
5. Is another party's liability insurance responsible for this illness/injury? If yes, enter the responsible party's insurance in #10.	Yes	No
6. Are you covered by an Employer Group Health Plan (EGHP), including Federal Employee Health Benefits? If yes, enter the EGHP data in #10.	Yes	No
7. Are you or your spouse actively employed by an establishment of 20 or more employees? If yes, enter the EGHP data in #10.	Yes	No
8. Are you under age 65 and entitled to Medicare due to a disability? If no, move to #9.	Yes	No
If yes, are you or your spouse actively employed by an establishment of 100 or more employees (LGHP - Large Group Health Plan)? If yes, enter the LGHP data in #10	Yes	No
9. Are you entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)?	Yes	No
If yes, have you completed the ESRD coordination period? If no, enter the EGHP data in #10.	Yes	No
Complete the following information only if you answered "Yes" to one or more of questions 1-8, or "No" to answer 9b. 10. Name of Insurance Company:		
Insured's Name and Policy Number:		
Employer:		
Insurer's Address:		
Claim Number:		