

# MEDICARE QUESTIONNAIRE

Patient Label Here

1. Are you CURRENTLY enrolled in a Hospice Program? *Yes/No*  
Is Hospice responsible for today's visit? *Yes/No*  
IF YES, HOSPICE will pay PRIMARY benefits for these services.  
IF NO, USE CONDITION CODE 07.

2. Have you EVER been enrolled in a Hospice Program? *Yes/No*  
IF YES, please provide date Hospice was revoked: \_\_\_\_\_  
Name of Hospice: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

3. Has patient had an outpatient hospital visit in past 3 days? *Yes/No*  
IF YES, Name of facility \_\_\_\_\_
4. Has patient been an inpatient in the past 60 days? *Yes/No*  
IF YES, Name of facility \_\_\_\_\_  
Admit date: \_\_\_\_\_ Discharge date \_\_\_\_\_

## Part 1

1. Are you receiving Black Lung (BL) Benefits? *Yes/No*  
Date benefits began: \_\_\_\_\_
2. Are the services to be paid by a government research program? *Yes/No*  
IF YES, Government Program will pay PRIMARY benefits for these services.
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? *Yes/No*  
IF YES, DVA is PRIMARY for these services.
4. Was illness/injury due to work related accident/condition? *Yes/No*  
Name and address of WC plan: \_\_\_\_\_  
Name/address of your employer: \_\_\_\_\_  
WC IS PRIMARY PAYER ONLY for claims for work-related injuries or illness.

## Part 2

1. Was illness/injury due to a non-work related accident? *Yes/No*  
IF YES, date of accident: \_\_\_\_\_
2. Is no-fault insurance available? *Yes/No*  
Name and address of no-fault insurer(s): \_\_\_\_\_  
Name and address of no-fault insurance policy owner: \_\_\_\_\_  
Insurance claim number(s): \_\_\_\_\_

## Part 3

1. Are you entitled to Medicare based on :  
AGE? *Yes/No* IF YES GO TO PART 4.  
DISABILITY? *Yes/NO* IF YES GO TO PART 5.  
END-STAGE RENAL DISEASE (ESRD)? *Yes/No* IF YES GO TO PART 6.

## Part 4: AGE

1. Is patient currently employed? *Yes/No* If no, Date of Retirement \_\_\_\_\_  
If yes, Name and address of employer \_\_\_\_\_
2. Is patient's spouse currently employed? *Yes/No* Date of Retirement \_\_\_\_\_
3. Is patient's spouse deceased? *Yes/No*

If ANSWER IS NO to questions 1 AND 2 PROCEED TO PAGE 2 AND SIGN.

3. Does patient have group health plan (GHP) coverage based his/her own or a spouse's current employment status? *Yes/No*

**IF NO, PROCEED TO PAGE 2 AND SIGN.**

4. Does the employer that sponsors your GHP over 19 employees? *Yes/No*

**IF NO, PROCEED TO PAGE 2 AND SIGN.**

**IF YES, GROUP HEALTH PLAN IS PRIMARY, please provide the following.**

Name of Policy Holder: \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Policy Identification Number \_\_\_\_\_

Group Identification Number \_\_\_\_\_

**Part 5: DISABILITY**

1. Are you currently employed? *Yes/No*

Name and Address of employer: \_\_\_\_\_

Date of retirement? \_\_\_\_\_

2. Do you have a spouse that is currently employed? *Yes/No*

**IF YES, Name and address of your spouse's employer** \_\_\_\_\_

**IF NO, Date of spouse's retirement** \_\_\_\_\_

**IF ANSWER IS NO to questions 1 AND 2 PROCEED TO PAGE 2 AND SIGN.**

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment? *Yes/No*

**Part 6: ESRD**

1. Do you have group health plan (GHP) coverage? *Yes/No*

**IF NO, PROCEED TO PAGE 2 AND SIGN.**

**IF YES, please provide the following.**

Name of Policy Holder: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Policy identification number: \_\_\_\_\_

Group identification number: \_\_\_\_\_

2. Have you received a kidney transplant? *Yes/No*

**If yes, date of transplant** \_\_\_\_\_

Have you received maintenance dialysis treatments? *Yes/No*

**If yes, date dialysis began:** \_\_\_\_\_

If you participated in a self-dialysis training program, provide date training started: \_\_\_\_\_

Are you within the 30-month coordination period? *Yes/No*

**IF NO, MEDICARE IS PRIMARY, PROCEED TO PAGE 2 AND SIGN.**

Are you entitled to Medicare on the basis of either **ESRD and AGE** or **ESRD and Disability**? *Yes/No*

**IF NO, GHP IS PRIMARY during the 30-month coordination period.**

Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? *Yes/No*

**IF YES, GHP pays primary during the 30-month coordination period.**

**IF NO, Initial entitlement based on Age or Disability?**

Does the working age or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)? *Yes/No*

\_\_\_\_\_  
Signature of patient/person filling out questionnaire

\_\_\_\_\_  
Date