

Medicare requires us to check for all other potential sources of payment whenever a patient is seen. Please assist us by answering these questions. (Some terms are confusing. If you don't understand any of these questions, please ask the receptionist or other health care worker).

Patient Name _____ Medicare # _____

1. Is your illness or injury due to:
 - Work related accident or condition? Yes No
 - Condition covered under federal Black Lung Program? Yes No
 - Automobile accident? Yes No
 - Non-Automobile Accident? Yes No
 - The fault of another party (person, business)? Yes No
 - ESRD/ Permanent Kidney Failure Yes No

2. Are you eligible for coverage under:
 - The Veteran's Administration (VA)? Yes No
 - United Mine Workers of America (UMWA)? Yes No
 - Government program such as Research Grants Yes No

3. Are you employed? Yes No
 IF YES:
 Are you covered under your employer's Group Health Plan (EGHP)? Yes No

4. Is your spouse employed? Yes No
 IF YES:
 Do you have coverage under your spouses EGHP? Yes No

5. Are you covered under any Family Member's EGHP? Yes No

6. Are you covered under your parent's / guardian's EGHP? Yes No

Patient Signature: _____ Today's Date _____

Please return this questionnaire to the receptionist or other healthcare worker. If you have marked any answer "YES", we may have to ask you for some more information including Date: *MM/DD/CCYY* _____

Repeat visits: Please review the questions above, and your answers. If all answers are still "NO", initial and date below. If there has been any change please see the receptionist or other health care worker for further information.

Date _____	Initials _____	Date _____	Initials _____
Date _____	Initials _____	Date _____	Initials _____
Date _____	Initials _____	Date _____	Initials _____