Medicare Patient Information

Name _____
First M.I. Last

Date of Birth . _____/_____/_____ Age _____ Sex: ☐ Female ☐ Male

Home Address _____
Street

_____
City State Zip Code

Home Phone ( ) _____ Work Phone ( ) _____

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does NOT apply to you, please check NO.

YES	NO	
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you covered by a HMO/PPO which makes Medicare secondary?
☐	☐	Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
☐	☐	Are you eligible for any benefits under the Federal Black Lung Program?
☐	☐	Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?
☐	☐	Are you coming to this office due to Medicare disability coverage?
☐	☐	Are you covered by the Federal End Stage Renal Disease Program?
☐	☐	Are you presently receiving Workers' Compensation?
☐	☐	Is the illness or injury you are coming to this office for the result of work-related causes?
☐	☐	Do you have medical assistance through Welfare or state-aid?

If you answered YES to ANY of the above questions: _____
Name of Company

Policy Number _____ Group Number _____

Name of Spouse or Close Relative or Friend _____ Phone# ( ) _____
(In Case of Emergency)

Name as it appears on your Medicare card _____ (Please Print)

Medicare Health Insurance Claim Number as it appears on your card _____
(This is usually your social security number. Be sure to include the letter after the nine digit number. It is important that we have both number and letter.)

Please sign so we may have your Medicare authorization on file:
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

X Date _____ Signature _____

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance info.). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare. (Medigap Coverage)

Name of Insurance Company _____

Policy Number _____ Group Number _____

Please sign so we may have your Supplemental authorization on file:
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

X Date _____ Signature _____