HOSPITAL
FOR
SPECIAL SURGERY

Medicare Questionnaire

Patient name: ________________________________Date __________MRI #__________

1. Are you entitled to Medicare based on?

a. ☐ Age b. ☐ Disability c. ☐ End Stage Renal Disease

Only If you check **c. ESRD** fill out below
Have you received a kidney transplant? If Yes, date of transplant:____________
Have you received maintenance dialysis treatment? If Yes, date dialysis began: _____________
Are you within the 30-month coordination period? ☐ Yes ☐ No

2. Are you currently employed (including self-employment and part-time employment)?

Yes ☐ How many people work for your employer? ☐ Less than 20 ☐ 20 or more ☐ 100 or more
Name & Address of your employer ____

No ☐ If you are not employed, are you retired? If Yes, when did you retire? ___________
No ☐ Never worked

3. Is your spouse currently working (including self-employment and part-time employment)?

Yes ☐ How many people work for their employer? ☐ Less than 20 ☐ 20 or more ☐ 100 or more
Name & Address of Employer ____

No ☐ *(___Check if Deceased or No spouse.)* If alive, when did your spouse retire? ___________
No ☐ Never worked

4. Do you have Group Health Plan coverage based on your own, spouse's or family member's current employment?

Yes ☐ *(Fill in information)* Name & address of GHP: ________________________________

No ☐ Policy / Group ID#: ___________Subscriber Name ____________-__

Relationship _____________________

5. Is there any other benefit program (including government programs) that could pay for this service?

Yes ☐ *(Check all that apply below)*

No ☐

☐ Black Lung ☐ VA/Tricare ☐ Research Grant

Date benefits began: _____/_____/_____

If VA, has the Veterans' Affairs authorized and agreed to pay for care at this facility? ☐ Yes ☐ No

If yes, VA authorization #_________________________

(Black Lung is primary only for claims related to Black Lung. VA is primary only with VA letter of authorization)

6. Is this service related to an illness or injury that occurred while on your job or in an auto accident? *(Or a result of another type of accident for which a person or business has been maybe held responsible?)*

Yes ☐ *(Fill out details)* Date of accident or injury ____/____/_____

No ☐ *(No open case)* Insurance company address ________________________

City: ____________________ State: _____Zip: __________

Active Policy ***or*** Workers' Comp Case # ____________________

Type of accident: __________________

(No Fault is primary only for those claims related to this accident. Worker's Compensation is primary only for claims resulting from work-related injuries/illness.)

Signature ____ Date __________________