LONG ISLAND Physical Therapy

# MEDICARE QUESTIONNAIRE

Patient Name: _____ Date: _____

Social Security Number: _____

| | (Circle One) | |
|---|---|---|
| **1.** Is this illness/injury covered by Workers' Compensation?<br>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?<br>If yes, enter the responsible auto insurance/insured in #10. | Yes | No |
| **5.** Is another party's liability insurance responsible for this illness/injury?<br>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?<br>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?<br>If yes, enter the EGHP data in #10. | Yes | No |
| **8.** Are you under age 65 and entitled to Medicare due to a disability?<br>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)?<br>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)?<br>If yes, have you completed the ESRD coordination period?<br>If no, enter the EGHP data in #10. | Yes<br>Yes | No<br>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: | | |