PT NORTHWEST

Medicare Insurance Information Form

For your Medicare claim to be properly processed, Medicare requires you to answer some questions regarding your Medicare insurance. Please take a moment and thoroughly fill out this form. If you have any questions about this form, please don't hesitate to ask the front desk.

Patient Name: _____ **Medicare Number:** _____

PART ONE

Are you age 65 or older and entitled to Medicare based on Age? ☐ Yes ☐ No

Have you been diagnosed as having End Stage Renal Disease ☐ Yes ☐ No

If YES, date you began dialysis _____

(YOU MUST ALSO complete PART TWO of this form)

Are you under age 65 and entitled to Medicare based on Disability ☐ Yes ☐ No

(YOU MUST ALSO complete PART TWO of this form)

Are you under age 65 and entitled to Medicare based on having End Stage Renal Disease ☐ Yes ☐ No

If YES, date you began dialysis _____

Have you had a kidney transplant? ☐ Yes ☐ No Date of Transplant _____

(YOU MUST also complete PART TWO of this form)

Are you receiving benefits under the Federal Black Lung Program? ☐ Yes ☐ No

If YES, date benefits began _____

Has the Dept. of Veterans Affairs (DVA) authorized and agreed to pay for your services at this facility? ☐ Yes ☐ No

Is your illness/injury due to a WORK-RELATED accident or condition? ☐ Yes ☐ No

If YES, date of injury/illness _____

Name & Address of Workers Comp. Insurer

_____

_____

_____

Name & Address of Employer

_____

_____

_____

Policy or Claim Number: _____

PART TWO

Are you currently employed? ☐ Yes ☐ No

☐ Full Time ☐ Part Time

Number of Employees: _____

If YES, Name & Address of your employer:

_____

_____

(Continued on back)

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If NO, Date of Retirement: _____

PART TWO (Continued)

Is your spouse currently employed? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

If YES, Name & Address of your employer: _____

Number of Employees: _____

If NO, Date of Retirement: _____

Do you have Employer Group Health Plan (EGHP) coverage based on your own or your spouse's current employment? ☐ Yes ☐ No

YOUR OWN? ☐ Yes ☐ No

IF YES, Name & Address of EGHP Insurer: _____

Policy Number: _____

Group Number: _____

Name of Policyholder: _____

Relationship to Patient: _____

Effective Coverage Date: _____

YOUR SPOUSE'S? ☐ Yes ☐ No

Policy Number: _____

Group Number: _____

Name of Policyholder: _____

Relationship to Patient: _____

Effective Coverage Date: _____

PART THREE

Is your illness/injury due to a NON work-related accident? ☐ Yes ☐ No

If YES, Date of Accident: _____

What kind of accident caused your illness/injury? ☐ Auto ☐ Non-Auto ☐ Other

Was another party responsible for your accident/injury? ☐ Yes ☐ No

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name & Address of No Fault or Liability Insurer: _____

Claim/Policy Number: _____

Name of Insured: _____

Name & Address of Automobile Insurer: _____

Claim/Policy Number: _____

Name of Insured: _____

Have you hired an attorney to represent your interests in this case? ☐ Yes ☐ No

If YES, Name & Address of Attorney: _____

Phone: _____

Fax: _____

OMB Approval #098-0214