

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

If YES, Name & Address of your employer:

Number of Employees: _____

(Continued on back)

