

Name: _____ Medicare No.: _____ Medicare Effective Date: _____

ATTENTION MEDICARE RECIPIENTS

Medicare has put forth guidelines for Health Care Providers to follow in determining whether services rendered are to be billed as primary or secondary to Medicare. To ensure compliance with these guidelines from Medicare, we have included a brief questionnaire as part of your registration information packet. We ask that you complete the brief questionnaire below and return this form to the front desk staff. This questionnaire will be kept on file in your chart and reviewed for any changes.

Thank you for your cooperation.

MEDIGAP BENEFIT AUTHORIZATION

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Sentara Medical Group for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.

(name of secondary policy)

MEDICARE BILLING QUESTIONNAIRE

1) Do you have any Medical Insurance other than Medicare? YES NO
 If yes, what Insurance are you covered by?

Insurance Name: _____ Group/Plan No.: _____

Name of Policyholder: _____ Relationship to Policyholder: _____

2) Are you/your spouse working/employed **and** receiving employee health insurance benefits? YES NO

If yes, please give the name of the employer: _____

How many employees work for the company providing your health insurance benefits?

20 Employees or Less 21 to 100 Employees More than 100 Employees

3a) Is the illness or injury you are being treated for due to a work-related accident or condition that is covered by: YES NO
 Workers Compensation
 Public Health Service or other Federal Agency
 Black Lung Benefits (If yes, please give effective date: _____)
 Veteran Affairs

If you answered **yes** to any of the above, please provide the following:

Insurance Name: _____	Claim/Policy No.: _____
Employer Name & Address _____	

3b) If you answered **no to all of the above**, was the illness or injury due to a non-work related injury? YES NO
 If yes, please specify the date and nature of the accident which caused the injury/illness:

Is there any liability coverage? YES NO
 If yes, please specify:
 No Fault Insurance (Including Auto Insurance)
 Other Liability Insurance

Insurance Name: _____ Claim/Policy No.: _____

4) Is your Medicare eligibility based solely on a disability? YES NO
 If yes, please specify the date of the disability began: _____

5) Is your Medicare eligibility based solely on End Stage Renal Disease? YES NO
 If yes, please specify the date dialysis or disability began: _____

PATIENT'S SIGNATURE

DATE

FOLLOW-UP REVIEW (OFFICE USE ONLY)

INITIAL	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL	DATE
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