FLORIDA PEDIATRIC ASSOCIATES

MEDICARE BENEFICIARY QUESTIONNAIRE

Instructions

The following questionnaire must be completed by Medicare beneficiaries at the initial visit and then annually to comply with federal statute that requires the practice to identify health insurance coverage that may be primary to Medicare. Please complete this form and answer questions with either a "Y" for yes or "N" for No. Dates should be entered in the month/day/year (mm/dd/year) format.

Patient/Medicare Beneficiary Name: _____

Medicare ID #: _____ Account #: _____

Spouse Name: _____ Is patient enrolled in Medicare Hospice? ___ Yes ___ No

PART I - GOVERNMENT PROGRAM COVERAGE

1. Is the patient receiving Black Lung Benefits? _____

Date benefits began: _____/_____/_____

2. Are services covered by a government program (research)? _____

3. Has Dept of Veteran Affairs agreed to pay for care? _____ If Yes, do you have an authorization? _____

4. Was illness due to work related accident/condition? _____

If yes, name and address of workers compensation plan:

_____

_____

_____

(**Please note: If you answered "yes" to any questions, then that plan is primary to Medicare.**

If you answered "no" to all, then go to the next section).

PART II - ACCIDENT RELATED INJURIES

1. Was illness/injury due to non-work related accident? _____

If "No", then go to the next section

If "yes, date:_____/_____/_____

2. Was accident caused by automobile_____, non-automobile _____

or another party? _____

If yes, provide name, address, phone, claim # of no-fault or liability insurer:

_____

_____

_____

PART III - REASONS FOR MEDICARE BENEFITS

1. Is beneficiary entitled to Medicare benefits based on

Age:_____

Disability: _____; **if yes, go to Part V**

End Stage Renal Disease: _____, if **yes, go to Part VI**

2. Is beneficiary part of a Medicare HMO? _____

If yes, then the HMO replaces Medicare.

PART IV - EMPLOYMENT STATUS

1. Does patient have current employment status? _____

if no, what was the Date of retirement?_____/_____/_____

(If yes, provide the name and address of employer on registration form or screens).

If no, record the date of retirement on the occurrence code).

2. Does patient's spouse have current employment status? _____

if no, what was the spouse's Date of retirement ?_____/_____/_____

If yes, provide the name and address of spouse's employer on registration form or

Screens). If no, record the spouse's date of retirement on the occurrence code).

If no to both questions, then Medicare is primary. If health insurance exists through employment and there are 20 or more employees, health insurance is primary.

If unable to obtain retirement date, state the reason why?

_____

_____

PART V - DISABILITY

Is patient RETIRED disability? _____

If yes, date of disability retirement _____/_____/_____

(Medicare is primary unless spouse employed with benefits)

If disability, does patient or spouse have current employment status? _____

(If yes, provide the name and address of employer on registration form or screens. If no to employment questions, Medicare is primary. If health insurance exists, plan is primary).

PART VI - END STAGE RENAL DISEASE

Does patient have current insurance coverage? _____

(If yes, record information on registration form or insurance screens, that plan becomes primary).

Has patient received a kidney transplant? _____

If yes, date of transplant: _____/_____/_____

Has patient received dialysis? _____

If yes, date dialysis began: _____/_____/_____

If self- dialysis, date of training: _____/_____/_____

Is patient within the 30 month coordination period? _____

If yes, insurance is primary until 30 months is up.

Was patient's initial entitlement to Medicare based on ago or disability? _____

(**If yes, Medicare primary**. In no, insurance coverage primary until 30 months is up).

_____ _____

Questionnaire completed by Relationship to patient

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Patient's Representative (If Patient is unable to sign) Date