

Elite Rehab and Sports Therapy

**MEDICARE QUESTIONNAIRE
REQUIRED**

Patient Name _____
Medical Record # _____

We are required by Medicare to ask you the following questions. We thank you in advance for the information.

1. If you have received Home Health care of any kind in the past 60 days, please provide the name and phone number of the Home Health agency:

Home Health Agency Name: _____

HH Agency Telephone #: _____

2. Are you entitled to benefits under the Black Lung Program Department of Veteran Affairs or other government program? Yes No
3. Was the injury / illness work related? Yes No
4. Was it the result of an automobile accident? Yes No
5. Was it an accident that occurred on property? Yes No
6. Do you feel that you have the right to be compensated by a party who may have caused the injury or illness? Yes No
....do you intend to file a liability claim or lawsuit? Yes No
7. Have you received a kidney transplant or started kidney dialysis for End Stage Renal Disease in the past 18 months? Yes No
8. Do you have group health insurance (other than Medicare) through your or a family member's employer? Yes No

*** If yes to any question above, we may be required to obtain further information to verify that Medicare is the primary payer for this injury/illness. If it is determined that Medicare is not the payer for this injury/illness further insurance information will be required.

Patient's Signature: _____ Date: _____