

Questionnaire for Medicare Beneficiaries Age 65 and Over

1. Are you currently working full or part time? **YES / NO**
2. Are you married? **YES / NO**
3. Is your spouse currently working full or part time? **YES / NO**
If yes, how many employees does your employer or Spouse's employer have? _____
4. Are you covered under an Employer Group Health Plan based on your current employment of your spouse? **YES / NO**
If yes, please provide the following information:
 - A) Name of insured, relationship to patient: self / spouse
 - B) Name and address of employer
 - C) Name and address of insurer, underwriter, third party, Administrator, HMO, etc.
 - D) Group and Identification number
5. Are you entitled to Black Lung Medical Benefits? **YES / NO**
6. Was this service for treatment of a work-related Injury or illness? **YES / NO**
If yes, please provide the names and addresses of the Worker' Compensation Agency, Worker's Compensation carrier and your employer.
7. Was this service for the treatment of an illness or injury which resulted from an automobile or other accident? **YES / NO**
If yes, please provide the name, address, and policy number of the automobile or non-automobile liability or no-fault insurer.
7. Are the services to be paid by a government program, such as a research grant? **YES / NO**

NAME: _____ **DATE:** _____

