

Conditions of Admission: Attachment B Medicare

(Please Complete All Questions on This Form)

Patient Name _____ Patient Account # _____
Medicare # _____ Effective Date: _____

Please provide your Medicare card so that a copy can be made for your record.

1. Are you receiving Black Lung Benefits?

___ No

___ Yes Date Benefits began _____ (Mo/Day/Yr)

2. Are services to be paid by a Government Program such as a research grant?

___ No

___ Yes Agency _____

Contact Person _____

Phone # _____

3. Has the Department of Veterans Affairs authorized and agreed to pay for services?

___ No

___ Yes Contact Person _____

Phone # _____

4. Are you receiving services as a result of a work related accident?

___ No

___ Yes Employer at the time of injury _____

Work Comp Carrier _____

Date of Injury _____

Claim Number _____

5. Are you receiving services as a result of a non-work related accident?

No

Yes Type: Automobile Other: _____

(i.e. fell off roof, slipped on ice,
burn, tractor rollover)

Date of Accident _____

Location of Accident _____

Was another party involved? Yes No

Claim Number _____

6. Are you receiving Medicare based on:

Age (if yes, please skip to question 9)

Disability (if yes, please skip to question 9)

Renal Disease

7. Did you initially receive Medicare based on Kidney Disease (even if you were of age or disabled at the same time)?

No

Yes Have you received a kidney transplant? Yes No

If yes, date of transplant _____

Are you receiving dialysis treatments? Yes No

If yes, date dialysis treatments started _____

Type of dialysis: Hemodialysis C.A.P.D.

Are you within the 30-month coordination period? Yes No

Coordination Period	
For Transplant Patients	30 months after transplant date
For Hemodialysis Patients	33 months after first dialysis treatment
For C.A.P.D. Patients	30 months after first dialysis treatment

8. Are you receiving Medicare on the basis of either Kidney disease **and** Age
OR Kidney disease **and** Disability?

No Yes

9. Are you employed?

No Date of Retirement _____ (Mo/Day/Yr)

No Never Employed

Yes Full Time Part Time

Employer _____

Address _____

Phone _____

Are there more than 20 people employed at this company? Yes No

Are there more than 100 people employed at this company? Yes No

10. Is your spouse employed?

No Date of Retirement _____ (Mo/Day/Yr)

No Never Employed

Yes Full Time Part Time

Employer _____

Address _____

Phone _____

Are there more than 20 people employed at this company? Yes No

Are there more than 100 people employed at this company? Yes No

11. Do you have Group Health Insurance coverage based on your employment?

No

Yes Insurance Company _____

Policy Number _____

Group Number _____

Membership Number _____

Please present insurance card to Registrar

12. Do you have Group Health Insurance coverage based on your spouse' s employment?

No

Yes Insurance Company_____

Policy Number_____

Group Number_____

Membership Number_____

Please present insurance card to Registrar

13. Are you covered under Group Health Insurance of a family member other than your spouse?

No

Yes Family Member' s Name_____

Family Member' s Employer_____

Employer Address_____

Employer Phone #_____

Insurance Company_____

Policyholder' s Name_____

Relationship to Patient_____

Policy Number_____

Group Number_____

Membership Number_____

Please present insurance card to Registrar

14. Are you currently receiving any of the following services?

Name of Agency / Facility

Home Health Care Yes No _____

Hospice Care Yes No _____

Resident of Nursing Care Facility Yes No _____

Patient / Representative Signature

Date