STAR PHYSICAL THERAPY
Sports Therapy & Advanced Rehabilitation

Patient's Name: ___________________________

REQUIRED MEDICARE QUESTIONNAIRE

Please read and respond only to the questions below that apply to your current situation.

PART I

1. Have you received treatment from a Home Health Agency in the past 30 days?

________Yes. ________ No.

If Yes, HHA Name:____ Phone: __________________

2. Are you receiving Black Lung (BL) benefits?

______ Yes. (If Yes, date benefits began: _____/_____/_______) ______ No.

3. Are these services to be paid by a government research program?

______ Yes. ______ No.

IF YES, THIS GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THIS SERVICE.

4. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

______ Yes. ______ No.

IF YES, DVA WILL BE THE PRIMARY PAYER FOR THESE SERVICES.

5. Was this illness / injury due to a work-related accident / condition?

______ Yes. (If Yes, date of injury / illness: _____/_____/________) ______ No. **IF NO, GO TO PART II.**

IF Yes, please provide the name and address of workers' compensation plan (WC) plan:

____

WC# identification number: ____

WC IS THE PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS.
CONTINUE TO PART III.

PART II

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

______ Yes. (If Yes, Date of accident: _____/_____/________) ______ No. **IF NO, GO TO PART III**

2. Is no-fault insurance available?: *(No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property, regardless of who is at fault.)*

______ Yes. ______ No.

If Yes, please provide the name and address of no-fault insurer(s), no-fault insurance policy owner, and insurance claim #:

____

3. Is liability insurance available?

______ Yes. ______ No.

If Yes, please provide the name and address of liability insurer(s) and responsible party:

____

PART III

1. Are you entitled to Medicare based on:

____ Age? **GO TO PART IV.** ___ Disability? **GO TO PART V.** ___ End-Stage Renal Disease (ESRD)? **GO TO PART VI.**

PART IV- For those entitled to Medicare based on age:

1. Are you currently employed?

______ Yes. Name and address of your employer: ______________________________

______ No. If formerly working, date of retirement: _____/_____/________ If NEVER employed, check here. ______

2. Do you have a spouse who is currently employed?

______ Yes. Name and address of your spouse's employer:______________________________

______ No. If spouse formerly worked, date of retirement: _____/_____/_______
If spouse was NEVER employed, check here. ______

IF YOU HAVE ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE WILL BE THE PRIMARY PAYER. DO NOT PROCEED ANY FURTHER UNLESS YOU HAVE ANSWERED "YES" TO QUESTIONS IN PART I OR II. **!!PLEASE SKIP TO THE LAST PAGE AND SIGN!!!**

3. Do you have group health plan (GHP) coverage based on your own or your spouse's current employment?

______ Yes, both. ______ Yes, self. ______ Yes, spouse.

______ No. **STOP. MEDICARE WILL BE THE PRIMARY PAYER UNLESS YOU HAVE ANSWERED YES TO QUESTIONS IN PART I OR II. SKIP TO THE LAST PAGE AND SIGN.**

4. If you have GHP coverage based on your own, or your spouse's current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?

______ Yes. **IF YES, GHP WILL BE THE PRIMARY PAYER.** ______ No.

If Yes, provide the name, address, and policy identification number of GHP: ______________________________
____

Membership Number and Name and relation of Policy Holder(*name insured)*:______________________________
____

PART V- For those entitled to Medicare based on disability:

1. Are you or your spouse currently employed?

______ Yes. Name and address of your/spouse's employer: ______________________________

______ No. If formerly working, date of retirement: _____/_____/_______ If NEVER employed, check here. ______

2. Do you have group health plan (GHP) coverage based on your own or spouse's current employment?

______ Yes, both. ______ Yes, self. ______ Yes, spouse. ______ No.

3. Are you covered under the GHP of a family member's employer? ______ Yes. ______ No

Name and address of your family member's employer: :______________________________

IF YOU HAVE ANSWERED "NO" TO QUESTIONS 1, 2, AND 3, STOP. MEDICARE IS THE PRIMARY PAYER UNLESS YOU HAVE ANSWERED "YES" TO QUESTIONS IN PART I OR II. SKIP TO THE LAST PAGE AND SIGN.

4. If you have GHP coverage based on your own, spouse's, or family member's current employment, does your employer that sponsors or contributes to the GHP employ 100 or more employees?

______ Yes. **If Yes, GHP IS THE PRIMARY PAYER.** Please provide the name and address of GHP:

____

Policy and Group identification numbers: ____
Name of Policy holder/named insured:____________________________ Relationship to the patient:________________

IF YOU HAVE ANSWERED "NO" TO QUESTION 4, STOP. MEDICARE IS THE PRIMARY PAYER UNLESS YOU HAVE ANSWERED "YES" TO QUESTIONS IN PART I OR II. SKIP TO THE LAST PAGE AND SIGN.

PART VI- For those entitled to Medicare based on ESRD:

1. Do you, your spouse, or a family member have (GHP) coverage?

______ Yes. If applicable please provide GHP name and address: ______________________________________

Policy, and identification numbers: _____________________ Insured's relationship to the patient: ______________

______ No. **STOP. MEDICARE IS THE PRIMARY PAYER. SKIP TO THE LAST PAGE AND SIGN.**

2. Have you received a kidney transplant? ____Yes. (If Yes, date of transplant: _____/_____/________) ______ No.

3. Have you received maintenance dialysis treatments?

______ Yes. Date dialysis began: _____/_____/________ ______ No.

If you participated in a self-dialysis training program, provide date training started: _____/_____/______

4. Are you within the 30-month coordination period?

______ Yes. ______ No. **STOP. MEDICARE IS THE PRIMARY PAYER. SKIP TO THE LAST PAGE AND SIGN.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?______ Yes. ______ No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

______ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

______ No. (INITIAL ENTITLEMENT BASED ON AGE OR DISAILTY.)

7. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?

______ Yes. **GHP CONTINUES TO BE THE PRIMARY PAYER DURING THE 30-MONTH COORDINATION PERIOD.**

______ No. **MEDICARE WILL BE THE PRIMARY PAYER.**

Signature:

By signing below, patient certifies that the questions in this Medicare Questionnaire have been answered with the most accurate information possible.

Patient's Signature ____________________________________ **Date** ______________

STAR PT representative ____________________________________ **Date** ______________