STAR PHYSICAL THERAPY
Sports Therapy & Advanced Rehabilitation

PATIENT NAME: ______________________________________

REQUIRED MEDICARE QUESTIONNAIRE

Please read/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; 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.
   DVA IS PRIMARY FOR THESE SERVICES IF YES.

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

   ______ Yes; Date of injury/illness: _____/_____/________ ______ No. **GO TO PART II.**

   IF YES, Name and address of workers' compensation plan (WC) plan:

   ____

   WC# identification number: ____

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

PART II

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

   ______ Yes; Date of accident: _____/_____/________ ______ 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, Name and address of no-fault insurer(s) and no-fault insurance policy owner:
____
Insurance claim number(s):________________________________

3. Is liability insurance available?

______ Yes. ______ No.

If Yes, provide 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 ? GO TO PART VI.**

PART IV- AGE

1. Are you currently employed?

______ Yes. Name and address of your employer:
____

_____ No. If applicable, date of retirement: _____/_____/______ ______ No. Never employed.

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

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

______ No. If applicable, date of retirement: _____/_____/_______

______ No. Never employed.

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

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

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

______ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS YOU HAVE ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

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. **GHP IS PRIMARY.** ______ **No.**

If YES, Name and address of GHP:____

____

Policy identification number: _________________ Membership Number:
____

Name and relation of Policy Holder(*name insured):* ______________________________________

PART V-DISABILITY

1. Are you or your spouse currently employed?

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

______ No. If applicable, date of retirement: _____/_____/________

______ No. Never employed.

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 PRIMARY UNLESS YOU HAVE ANSWERED '"YES" TO QUESTIONS IN PART I OR II.

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. **GHP IS PRIMARY.**

Name and address of GHP:

Policy identification number: ______________________

Group identification number: ______________________

Name of Policy holder/named insured: ________________________________

Relationship to the patient: ___________________________

______ No.

IF YOU HAVE ANSWERED "NO" TO QUESTION 4 MEDICARE IS PRIMARY UNLESS YOU HAVE ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART VI- ESRD

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

______ Yes.

IF APPLICABLE, PLEASE PROVIDE GHP INFORMATION:

Name and address of GHP:

Policy identification number: _______________________

Group identification number: ______________________

Relationship to the patient: ________________________

______ No. **STOP MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

______ 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 PRIMARY.**

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

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

______ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

The questions in this Medicare Questionnaire have been answered with the most accurate information possible.

Patient's Signature ___________________________________ **Date** ______________

STAR PT representative ___________________________________ **Date** ______________