NOTCH
Northern Tier Center for Health
Federally Qualified Health Center

Medicare Questionnaire

Name: _____ DOB: _____ Age: _____ Medicare # _____

Medicare Regulations require that each patient have a completed development form on file with the provider of medical services. This form contains answers to specific questions that help Medicare determine the primary insurance. The following questions must be completed before a claim is submitted to Medicare.

Working Aged

Are you still working? ☐ Yes ☐ No

If ***YES***, Do you have insurance with your employer ☐ Yes ☐ No

Name of Employer: _____

# of Employees: _____

Are you Retired? ☐ Yes ☐ No Date Retired: _____

Disability

Are you receiving Medicare Benefits due to disability? ☐ Yes ☐ No

Is your Spouse working? ☐ Yes ☐ No ☐ N/A

If ***YES***, what is your spouse's age? _____

Are you covered under your spouse's insurance? ☐ Yes ☐ No

If ***YES***, Name of Spouse's Employer: _____

Telephone Number: _____

If ***NO,*** when did your spouse retire? _____

Auto/Liability/Trauma

Was this illness/injury the result of any kind of accident? ☐ Yes ☐ No

If ***YES***, Date of Accident: _____

Type of Accident? (Auto, Motorcycle, ATV, etc.): _____

How did the accident occur? _____

Have you filed or do you intend to file a liability claim or lawsuit against any part that caused the injury? ☐ Yes ☐ No

If ***YES***, Please provide the name, address, and phone number of the insurance company and person you feel is responsible _____

_____

Workman's Comp or Black Lung Program

Were you injured on the job? ☐ Yes ☐ No

Are you covered by the Black Lung Program? ☐ Yes ☐ No

If ***YES*** to either question above, please complete the following:

What was the date of the accident? _____

Where did the accident occur? _____

How did the accident occur? _____

Provide the name of the Workman's Comp or Black Lung Program _____

Who was your employer at the time of injury? _____

What is your insurance claim #? _____

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Medicare Questionnaire and Claim Authorization

PUBLIC HEALTH (FEDERAL GRANT)

Have you ever received treatment that has been covered under a Federal grant? ☐ Yes ☐ No

RENAL

Have you ever had renal disease or been on kidney dialysis? ☐ Yes ☐ No

Are you currently receiving dialysis treatment? ☐ Yes ☐ No

If ***YES***, List date you started dialysis treatment: _____

List date of kidney transplant: _____ ☐ N/A

Is your dialysis being given in a hospital or at home? ☐ Hospital ☐ Home ☐ N/A

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Richford Health Center, Inc. D.B.A NOTCH for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the CMS/HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Co-insurance and deductible are based on the charge determination of the Medicare Carrier.

_____ _____

Patient Signature Date Completed

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of patient
- ☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependent healthcare coverage)