PROVIDENCE Health & Services

MEDICARE SURVEY

Today's Date: ________________

Medicare requires that we make every effort to verify that they are the carrier responsible for payment of your healthcare services. Please complete the information below:

Patient's Name: ____ Date of Birth: _____/_____/_____

Part I

1. Are you receiving black lung benefits? ☐ Yes ☐ No If YES, dates benefits began _____/_____/_____
2. Are the services to be paid by government research Programs? ☐ Yes ☐ No
3. Are you entitled to benefits through department of Veterans Affairs (DVA)? ☐ Yes ☐ No
4. Is the illness/injury due to a work related accident/condition? ☐ Yes ☐ No

Part II

1. Is the illness/injury due to a non work related accident? ☐ Yes ☐ No

Part III

1. Are you entitled to Medicare based on Age? ☐ Yes ☐ No
2. Are you entitled to Medicare based on Disability? ☐ Yes ☐ No
3. Are you entitled to Medicare based on End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

Part IV (Answer only if YES to the above Part III (ESRD) Question)

1. Have you received a Kidney Transplant? ☐ Yes ☐ No If YES, date of transplant _____/_____/_____
2. Have you received maintenance dialysis treatment? ☐ Yes ☐ No
   If YES, date treatment began _____/_____/_____
3. If you participated in a self dialysis training program, provide the date the training started _____/_____/_____
   Are you within the 30 month coordination period? ☐ Yes ☐ No

Part V

1. Are you currently employed? ☐ Yes ☐ No
   If YES, do you have group Health plan coverage based on your current employment? ☐ Yes ☐ No
2. Do you have a spouse currently employed? ☐ Yes ☐ No
   If YES, do you have group Health plan coverage based on your spouse's current employment? ☐ Yes ☐ No
3. Are you covered under a group Health plan on the current employment of the family member other than your spouse? ☐ Yes ☐ No