FOR OFFICE USE ONLY:
☐ **Check if the information below is different than CWF On-line3 Medicare Screen.**

MEDICARE ELIGIBILITY QUESTIONNAIRE

Reset Form

Name (Last, First) _____ **DOB:** **MR #:**

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance. Please answer the following questions regarding your Medicare eligibility.

PART I: Are you entitled to Medicare benefits because of:

1. Your age? ○ Yes ○ No
2. A Disability? ○ Yes ○ No
3. End Stage Renal Disease (ESRD)? If Yes, Please complete Part V. ○ Yes ○ No

Date of Medicare Eligibility:

PART II: Are the services you are seeking related to:

1. Black Lung? ○ Yes ○ No
   Note: Black Lung is primary only for claims related to Black Lung
2. Veteran's Administration Program? ○ Yes ○ No
   Note: Department of Veteran's Administration is primary for these services.
3. Government Program or Research Grant? ○ Yes ○ No
   Note: Government Program is primary for these services.
4. Accidental Injury? Date: ○ Yes ○ No
   Cause of Injury: ○ Automobile ○ Liability ○ Worker's Comp
   If Yes, please complete insurance information in Part VI below.

PART III: Employment - Self

- Are you employed? ○ Yes ○ No If No, indicate Retirement Date:
- If Yes, are you covered under your employer's Group Health Plan (GHP)? ○ Yes ○ No
  If yes, does your employer have at least 20 employees? ○ Yes ○ No
  If yes, does your employer have at least 100 employees? ○ Yes ○ No

If yes to any of the above questions, please complete insurance information in Part VI below.

PART IV: Employment – Spouse or Other Family Member ○ Not Applicable

- Is your spouse employed? ○ Yes ○ No If No, indicate Retirement Date:
- If Yes, are you covered under your spouse's employer Group Health Plan (GHP)? ○ Yes ○ No
  If yes, does the employer have at least 20 employees? ○ Yes ○ No
  If yes, does the employer have at least 100 employees? ○ Yes ○ No
- Are you covered under a family member's GHP (other than spouse)? ○ Yes ○ No
  If yes, does the employer have at least 20 employees? ○ Yes ○ No
  If yes, does the employer have at least 100 employees? ○ Yes ○ No

If yes to any of the above questions, please complete insurance information in Part VI on next page.

MEDICARE ELIGIBILITY QUESTIONNAIRE

PART V: For End Stage Renal Disease (ESRD) Only

- Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and Disability? ○ Yes ○ No
  If No, Group Health Plan is primary during the 30 month coordination period.
- Are you within the 30 month coordination period? ○ Yes ○ No
- Have you received a kidney transplant? ○ Yes ○ No
  If Yes, Date of Transplant:
- Have you received maintenance dialysis treatments? ○ Yes ○ No
  If Yes, Date Dialysis began:
- Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? ○ Yes ○ No
  If No, initial entitlement based on age or Disability applies.

PART VI: Group Health Plan or Other Insurance Information

- Name & Address of Insurance Company:
- Insurance Company Phone Number / Name of Contact:
- Name of Policy Holder:
- Relationship to Policy Holder: Policy Number / Group Number:
- Policy Holder's Employer's Name & Address:
- Other Insurance Information:

Signature: Sign in office upon arrival Date:_____