

**HEMATOLOGY ONCOLOGY
ASSOCIATES, P.C.**

2828 E. Barnett Rd. • Medford, OR 97504
(541) 774-5853

Chart #: _____
Patient Name: _____

MEDICARE SECONDARY PAYOR

Type of Coverage

Medicare Part A & B..... Yes No Medicare Part B Only.... Yes No Medicaid Yes No

Medicare Supplemental Coverage: Yes No Effective Date: _____

HMO Coverage: Yes No HMO Enrollment Date: _____ HMO Name: _____

MEDICARE IS: PRIMARY SECONDARY

Employment

Are you employed? Yes No.....Where? _____

Do you have insurance? Yes No.....Name of insurance: _____

Is your Spouse employed? Yes No.....Where? _____

Does your Spouse have insurance for You? Yes No....Name of insurance: _____

Is your Spouse retired? Yes No If yes, enter date: _____ Spouse D.O.B. _____

Other Information

If patient is over 65 years, enter date of retirement: _____

ARE SERVICES TO BE PAID BY A PROGRAM,
SUCH AS A GOVERNMENT RESEARCH GRANT? Yes No

ARE YOU COVERED BY VETERANS ADMINISTRATION BENEFITS?..... Yes No

ARE YOU COVERED BY FEDERAL BLACK LUNG PROGRAM? Yes No

ARE YOU COVERED BY WORKER'S COMPENSATION?..... Yes No

If yes, enter date and type of accident: _____

If yes, enter insurance/billing information/claim number: _____

ARE YOU COVERED BY AUTO OR LIABILITY INSURANCE? (for medical services) Yes No

If yes, enter insurance billing information: _____

IS THIS ILLNESS DUE TO AN INJURY? Yes No

If yes, When: _____ Where? Work Auto Home Other

Describe how injury occurred: _____

Is legal action involved? Yes No If yes, enter attorney's name: _____

Questionnaire Completed By: _____ Date: _____

QUESTIONNAIRE FOR MEDICARE BENEFICIARIES UNDER AGE 65

Medicare beneficiaries under age 65 can be entitled because they either are disabled or because of end-stage renal disease. Therefore, you must determine the reasons for the beneficiary's entitlement by asking the following questions:

1. Did you become entitled to Medicare benefits solely on the basis of end-stage renal disease?..... Yes No
2. If yes, what was the start date of your dialysis treatments or date of transplant (whichever is applicable)?

3. If no, were you receiving any benefits on or after January 1, 1987 from the employer group health plan of an employer for whom you used to actively work? Yes No
4. Name of insurer (insurance company) and address: _____
Telephone Number: _____
5. Policy Number: _____
6. Name and address of employer: _____
Telephone Number: _____
7. Number of employees: Fewer than 99 More than 100 Not sure
8. Your retirement date (if applicable): _____
9. Were you receiving any benefits on or after January 1, 1987 from a group health plan of your spouse or any other family member who is an employee or is self-employed? Yes No
10. Name and address of employer: _____
Telephone Number: _____
11. Group Name (employer or other plan name): _____
12. Policy Number: _____
13. Name and address of employer: _____
Telephone Number: _____
14. Number of employees: Fewer than 99 More than 100 Not sure
15. Contract holder's name (subscriber): _____
16. Your relationship to contract holder: _____
17. Spouse's (or other family member's) retirement date (if applicable): _____
18. Telephone Number at Work: _____ Home: _____

Questionnaire Completed By: _____ Date: _____