DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE FOR DISABLED BENEFICIARIES

NAME	DATE OF BIRTH	MEDICARE NUMBER
MARY SMITH	5/10/54	123456789A

INSTRUCTIONS: This form will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. **USE BLACK OR BLUE INK.**

EXAMPLE | | A | B | C | | | 1 | 2 | 3 | | |

SECTION A - INFORMATION ABOUT YOU

1) Are you getting any group health coverage from an employer for whom you **now** work (full or part-time)?
YES [X] **NO** [ ] (If **NO, STOP**, complete **Sections B**)

2) How many employees, including yourself, work for the employer from whom you get group health benefits?
Don't Know [ ] 100 or more [X] Less than 100 [ ] (If less than 100, **STOP**, go to **Section B**)

3) What type of coverage do you have under your employer's group health plan?
Worker only coverage [ ] Family coverage (husband/wife, other family member) [X]

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME
ACME DYNAMITE CO

ADDRESS
345 FARAWAY STREET

ADDRESS

CITY
SATURN

STATE
ME

ZIP
55555

NAME OF GROUP HEALTH PLAN
GOOD HEALTH INC

ADDRESS
789 THIRD AVENUE

ADDRESS
SUITE 6

CITY
MARS

STATE
ME

ZIP
66666

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

4) Does your employer group health plan cover prescription drugs? **YES** [X] **NO** [ ] (If **NO**, go to **SECTION B**)
Please use your insurance card to provide the following information if available:

Rx GROUP
ZPRX52111178

Rx PCN

MEMBER ID
4244242422

Rx BIN
443322

SECTION B - INFORMATION ABOUT YOUR FAMILY MEMBER

1) On 4/01/2003 , will YOU be receiving any group health coverage through the current employment of a family member?

YES [X] **NO** [ ] (If **NO, STOP**, go to **Section C**)

Sample

SECTION B - INFORMATION ABOUT YOUR FAMILY MEMBER, CONTINUED

Family Member's Name

FIRST: JOHN | Middle Initial: J | Family Member's Social Security Number: 999-88-7777

LAST: SMITH

2) How many employees work for your family member's employer?

Don't know [X] 100 or more [ ] less than 100 [ ] (If less than 100, **STOP**, go to **Section C**)

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME: ACME DYNAMITE CO

ADDRESS: 345 FARAWAY STREET

ADDRESS:

CITY: SATURN | STATE: ME | ZIP: 55555

NAME OF GROUP HEALTH PLAN: GOOD HEALTH INC

ADDRESS: 789 THIRD AVENUE

ADDRESS: SUITE 6

CITY: MARS | STATE: ME | ZIP: 66666

GROUP IDENTIFICATION NUMBER:

POLICY NUMBER:

3) Does your family member's employer's group health plan cover prescription drugs? **YES** [X] **NO** [ ]

(If **NO**, **STOP**, go to **SECTION C**)

Please use your family member's insurance card to provide the following information if available:

Rx GROUP: ZPRX521178 | Rx PCN:

MEMBER ID: 424242424 | Rx BIN: 443322

SECTION C - MORE INFORMATION ABOUT YOU

1) Are **YOU** receiving **Black Lung** Benefits? **YES** [ ] **NO** [X]

2) Are **YOU** receiving **Worker's Compensation** Benefits? **YES** [X] **NO** [ ]

3) Are **YOU** receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault or auto insurance? **YES** [X] **NO** [ ]

STOP

If you answered **YES** to any of these questions, go to **SECTION D**.
If you answered **NO** to all of these questions, sign and return only this page.

Your Signature

AREA CODE – **PHONE NUMBER** –

(CONTINUED ON NEXT PAGE)

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MARY SMITH	5/10/54	123456789A

SECTION D - MORE INFORMATION ABOUT YOU, CONTINUED

1) If **YOU** are getting **Black Lung** (Coal Miner's) Medical Benefits, print the date the benefits began.

M M – D D – Y Y Y Y

2) If **YOU** are now getting any medical services related to an illness or injury which occured on the job, for which **YOU** have or will file a **Workers' Compensation** claim, print the date of the illness or injury.

04 – 20 – 2000
M M – D D – Y Y Y Y

Please provide information about the employer, insurance carrier, and attorney in the spaces below:

EMPLOYER NAME
ACME DYNAMITE CO

ADDRESS
345 FARAWAY STREET

ADDRESS

CITY
SATURN

STATE
ME

ZIP
55555

NAME OF INSURANCE CARRIER
UNITED HEALTHY PEOPLES INC

ADDRESS
11 SOMEWHARE AVE

ADDRESS

CITY
NEW YORK

STATE
NY

ZIP
01000

POLICY or CLAIM NUMBER
UHPI54321099

NAME OF ATTORNEY (If Applicable)
MIGUEL CRUZ ESQ

ADDRESS
125 MAIN STREET

ADDRESS

CITY
JACKSONVILLE

STATE
FL

ZIP
12345

BRIEF DESCRIPTION OF ILLNESS OR INJURY
HURT MY HIP AND MY BACK

(TURN PAGE OVER)

SECTION D - MORE INFORMATION ABOUT YOU, CONTINUED

3) If **YOU** are now getting any treatment for an illness or injury for which another party could be held liable, please print the date of illness or injury: M M — D D — Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

4) If **YOU** are now getting any treatment for an illness or injury which could be covered under **no-fault** or **automobile insurance**, print the date the of illness or injury: M M — D D — Y Y Y Y

NAME OF INSURANCE CARRIER:

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

Your Signature Mary Smith

AREA CODE 777 – **PHONE NUMBER** 777 – 5545