

MEDICARE QUESTIONNAIRE FOR DISABLED BENEFICIARIES

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

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 NO (If NO, go to SECTION B)

Please use your insurance card to provide the following information if available:

Rx GROUP
2PRX521178 Rx PCN

MEMBER ID
424424242 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 NO (If NO, STOP, go to Section C)

SECTION B - INFORMATION ABOUT YOUR FAMILY MEMBER, CONTINUED

Family Member's Name Middle
FIRST Initial Family Member's Social Security Number
J O H N J 9 9 9 - 8 8 - 7 7 7 7
LAST
S M I T H

2) How many employees work for your family member's employer?
Don't know 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
A C M E D Y N A M I T E C O

ADDRESS
3 4 5 F A R A W A Y S T R E E T

ADDRESS

CITY STATE ZIP
S A T U R N M E 5 5 5 5 5

NAME OF GROUP HEALTH PLAN
G O O D H E A L T H I N C

ADDRESS
7 8 9 T H I R D A V E N U E

ADDRESS
S U I T E 6

CITY STATE ZIP
M A R S M E 6 6 6 6 6

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

3) Does your family member's employer's group health plan cover prescription drugs? YES 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 Rx PCN
Z P R X 5 2 1 1 7 8

MEMBER ID Rx BIN
4 2 4 4 2 4 2 4 2 4 4 3 3 2 2

SECTION C - MORE INFORMATION ABOUT YOU

- 1) Are **YOU** receiving **Black Lung** Benefits? YES NO
- 2) Are **YOU** receiving **Worker's Compensation** Benefits? YES 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 NO



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

MEDICARE QUESTIONNAIRE FOR DISABLED BENEFICIARIES, CONTINUED

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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 occurred on the job, for which **YOU** have or will file a **Workers' Compensation** claim, print the date of the illness or injury.

0	4						
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 SOMEWHERE AVE

ADDRESS

CITY

NEW YORK

STATE

NY

ZIP

01000

POLICY or CLAIM NUMBER

UHPIS432109

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

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 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

PHONE NUMBER

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