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

QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE for BENEFICIARIES WITH CHILDHOOD DISABILITIES

NAME	DATE OF BIRTH	MEDICARE NUMBER
THEODORE PUBLIC	3/5/1974	123456781

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 AND YOUR FAMILY

1) Are **YOU** getting group health coverage through your employment, or a family member's employment?

YES [X] **NO** [ ] (If **NO,** go to **SECTION B**)

2) How many employees, including yourself or family member, 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**)

Please provide information about the family member, the employer that provides the group health benefits and information about the plan below:

INSURED FAMILY MEMBER'S NAME

FIRST: JOHN | Middle Initial: Q | Family Member's Social Security Number: 123-45-6789

LAST NAME: PUBLIC

RELATIONSHIP TO YOU: FATHER

EMPLOYER NAME: BRAXTON INC

ADDRESS: 135 MAIN STREET

ADDRESS:

CITY: KALAMAZOO | STATE: MI | ZIP: 49006

NAME OF GROUP HEALTH PLAN: BLUE HORIZONS

ADDRESS: 390 WEST MAIN ST

ADDRESS: SUITE 400

CITY: KALAMAZOO | STATE: MI | ZIP: 49016

GROUP IDENTIFICATION NUMBER: 123

POLICY NUMBER: 123456789

Sample

(TURN PAGE OVER)

SECTION A - INFORMATION ABOUT YOU AND YOUR FAMILY, CONTINUED

3) Does your family member's employer's group health plan cover prescription drugs? **YES** ☐ **NO** ☐
(If **NO, STOP**, go to **SECTION B**)

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

Rx GROUP: UXPA54321

Rx PCN:

MEMBER ID: 456129876

Rx BIN: 654321

SECTION B - 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, automobile, or liability insurance? **YES** ☐ **NO** ☒

STOP

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

Your Signature Theodore Public

AREA CODE 987 – **PHONE NUMBER** 654 – 3210

Sample

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QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE for BENEFICIARIES WITH CHILDHOOD DISABILITIES, Continued

NAME	DATE OF BIRTH	MEDICARE NUMBER
THEODORE PUBLIC	03/05/1974	12345678C1

SECTION C - 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.

M M — D D — Y Y Y Y

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

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

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

(TURN PAGE OVER)

SECTION C - 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

AREA CODE – **PHONE NUMBER** –