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

QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE FOR BENEFICIARIES 65 OR OVER

NAME	DATE OF BIRTH	MEDICARE NUMBER
JOHN Q. PUBLIC	7/23/1935	987654321X

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) On 7/21/2000, will **YOU** be working? **YES** [X] **NO** [ ] (If **NO**, go to **SECTION B**)

2) Do **YOU** have any group health plan coverage through your current employer?
YES [X] **NO** [ ] (If **NO,** go to **SECTION B**)

3) How many employees, including yourself, work for your employer?
[ ] **Don't know** [X] **20 or more** [ ] **Less than 20** (If less than 20, **STOP,** go to **SECTION B**)

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

EMPLOYER NAME
MEGACONGLOMERATE INC.

ADDRESS
123 MAIN STREET

ADDRESS
ASTRA BUILDING

CITY
ANYTOWN

STATE
NY

ZIP
00000

NAME OF GROUP HEALTH PLAN
ABC INSURANCE CO

ADDRESS
456 FIRST AVE

ADDRESS

CITY
GOTHAM CITY

STATE
NY

ZIP
99999

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
ZPQR522113

Rx PCN

MEMBER ID
5976120733

Rx BIN
995544

SECTION B - INFORMATION ABOUT YOUR HUSBAND/WIFE

1) On 3/23/2005, will you be receiving any group health plan coverage through the current employment of your husband/wife? **YES** [ ] **NO** [X] **N/A** [ ] (If **NO** or **N/A, STOP**, go to **SECTION C**)

Husband/Wife's First Name

Husband/Wife's Social Security Number

Husband/Wife's Middle Initial

Husband/Wife's Last Name

SECTION B - INFORMATION ABOUT YOUR HUSBAND/WIFE, CONTINUED

2) How many employees work for your husband/wife's employer? (Please include your husband/wife).

Don't know ☐ 20 or more ☐ less than 20 ☐ (if less than 20, **STOP**, go to **SECTION C**)

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

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

3) Does your husband/wife's employer's group health plan cover prescription drugs? **YES** ☐ **NO** ☐

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

Please use your husband/wife's insurance card to provide the following information if available:

Rx GROUP Rx PCN

MEMBER ID Rx BIN

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 responsible 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 D.**
If you answered **NO** to all of these questions, sign and return only this page.

Your Signature John Public

AREA CODE 212 PHONE NUMBER 212-2121

Sample

(CONTINUED ON NEXT PAGE)

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

QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE FOR BENEFICIARIES 65 OR OVER, CONTINUED

NAME	DATE OF BIRTH	MEDICARE NUMBER
JOHN Q PUBLIC	07/23/1935	987654321K

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.

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

Sample

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

AREA CODE **PHONE NUMBER** – –