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

QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE FOR BENEFICIARIES WITH END-STAGE RENAL DISEASE

NAME	DATE OF BIRTH	MEDICARE NUMBER
JOHN Q. PUBLIC	5/2/1963	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** receiving group health coverage through your current or previous employment?

YES ☐ **NO** ☒ (If **NO,** go to **SECTION B**)

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

2) 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 Rx PCN

MEMBER ID Rx BIN

SECTION B - INFORMATION ABOUT FAMILY MEMBER(S)

1) Are **YOU** getting any group health coverage through the current or previous employment of a family member?

YES ☐ **NO** ☒ (If **NO**, **STOP**, go to **Section C**)

If **YES**, please provide information about the family member, the employer that provides the group health benefits and information about the plan below:

FAMILY MEMBER'S NAME

FIRST Middle Initial

Sample

(TURN PAGE OVER)

SECTION B - INFORMATION ABOUT FAMILY MEMBER(S), CONTINUED

FAMILY MEMBER'S LAST NAME

FAMILY MEMBER'S RELATIONSHIP TO YOU

Family Member's Social Security Number ___ – ___ – ____

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

2) 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

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 liable?
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 Q Public

AREA CODE 555 – **PHONE NUMBER** 555 – 5555

Sample

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MEDICARE QUESTIONNAIRE FOR BENEFICIARIES WITH END-STAGE RENAL DISEASE, CONTINUED

NAME	DATE OF BIRTH	MEDICARE NUMBER
JOHN Q PUBLIC	05/02/1963	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.

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 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** – –