The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. Are you receiving benefits from any of the following programs?

Black Lung ☐YES (Long form Part I) ☐ NO

Research Grant ☐ YES (Long form Part I) ☐ NO

Veteran Affairs ☐ YES (Long form Part I) ☐ NO

2. Was illness/injury due to a work-related accident/condition?

☐ YES ☐ NO

If YES, answer the following:

☐Work related accident (complete Part I of long form)
☐Non-work-related accident (complete Part II of long form)

3. Is the patient currently employed?

☐ YES (answer next question) ☐ NO

If YES, do you have group health plan (GHP) coverage? This is insurance coverage through your employer. ☐ YES ☐ NO

4. Is the patient's spouse currently employed?

☐ YES (answer next question) ☐ NO

If YES, does your spouse have group health plan (GHP) coverage? ☐ YES ☐ NO

If YES, are there under or over 20 employees?

☐ YES ☐ NO

☐ OVER OR ☐ UNDER

5. Is the patient entitled to Medicare benefits as a result of: Age ☐ End Stage Renal (Kidney) Disease? ☐ Disability? ☐ YES OR ☐ NO

6. Are you currently a patient in a skilled nursing facility such as a nursing home? (Long form not required, ALERT: If yes bill SNF not Medicare) ☐ YES ☐ NO

☐ **I confirm that the above information is correct.**

Patient Signature : ________________________________ Date : ____________________