

Name: _____

DOB: _____

Medicare Questionnaire

If you are covered under Medicare please complete the following questions. This information is needed to complete your registration. If you have any questions please contact one of Emerson Hospital's Center for Sports Rehabilitation and Specialty Services Clinical Office Coordinator at 978-287-8200 (Concord) or 978-589-6850 (Westford).

1. Are you receiving Black Lung (BL) Benefits?
 - a. Yes
 - b. No
2. Are the services to be paid by a government program such as a research grant?
 - a. Yes
 - b. No
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
 - a. Yes
 - b. No
4. Was the illness/injury due to a work related accident/condition?
 - a. Yes
 - b. No
5. Was the illness/injury due to a non-work related accident?
 - a. Yes Date of Accident: _____
 - b. No
6. Are you entitled to Medicare because of (please check one):
 - a. Age: _____
 - b. Disability: _____
 - c. End Stage Renal Disease: _____
7. Are you employed?
 - a. Yes If retired please provide date of retirement: _____
 - b. No If employed please provide Name and Address of Employer
8. Is your spouse employed?
 - a. Yes If retired please provide date of retirement: _____
 - b. No If employed please provide Name and Address of Employer
9. Are you covered under your employers insurance?
 - a. Yes
 - b. NoName of Insurance Carrier: _____
Policy Number: _____