Medicare Payer Questionnaire
(To Be Completed For All Medicare Patients)

Name: _____

Today's Date: _____

(If any answer to questions 1a through 4 is yes, the corresponding section of the "Other Insurance" form must be filled out completely.)

	Yes	**No**
1. Is the patient a Veteran?	_____	_____
a. Did the VA refer you here for treatment?	_____	_____
b. Does the patient have a VA "fee basis ID Card"	_____	_____
2. Do you have a Federal Black Lung card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____

If yes was it: _____ Work Related _____ Auto
_____ Injured in own home _____ Other

4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (Does not include retiree coverage) _____ _____

One Time Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. David Harden, or Erin Thornton, PA-C**, or **Casey Jankord, PA-C** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
Do Not Mail This Form In - Retain in Patients File in your office

_____ _____

Patient's Signature **Date Signed**