Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare____Medicaid____Champus___CampVA____
   Group Health Plan____ Other____Insured's ID Number______
2. Patient Name:____
3. Insured's Name (as it appears on the insurance card):________________________
4. Patient's Address:____
   City__________________________State_______ Zip________Tel #_____________________
5. Insured's Address (if same as patient put "same"):____
   City____________________State_______ Zip________Tel #____________________________
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable):____
   Other Insured's Policy or Group Number:____
   Other Insured's Date of Birth:_____________________ Male________Female_______
   Employer's Name or School Name:____
   Insurance Plan Name or Program Name:_______________________________________
8. Is the condition we are treating related to current or previous employment? Yes____ No____
9. Is the condition we are treating related to an auto accident? Yes____ No____
10. Is the condition we are treating related to another type of accident? Yes ____ No____
11. Insured's Policy Group or FECA Number:____
    Insured's Date of Birth:_________________________Male_______Female_______
    Employer Name or School Name:____
    Insurance Plan Name or Program Name:_________________________________
12. Is there another health benefit plan? Yes____ No____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: ____Date:________________

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to __________________ for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: ____Date:_________________

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___
4. Is this illness or injury the result of an accident or other injury? Yes___No___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes__ No__
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___
7. Do you have a Medicare Medigap Policy? Yes___ No___Name of Company__________________________
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___