MSP Questionnaire

Thank you for your completion of these questions. Medicare regulations require that we verify this information at each visit. At subsequent visits, we will ask about changes to the information to keep our information current.

1. You are entitled to Medicare based on: (Please check one)

   ____ Age ____ Disability ____ End-Stage Renal Disease (ESRD)

   Please note that both Age and ESRD OR Disability and ESRD may be selected simultaneously. Age and disability may not be checked simultaneously.

2. Are you receiving Black Lung Benefits? ____Yes ____ No
   If yes, date benefits began _____
   (Month/Date/Year)

3. Are the services to be paid by a government research program? ____ Yes ____ No

4. Has the Department of Veterans Affairs authorized and agreed to pay for your care at this facility? ____ Yes ____ No

5. Was the illness or injury due to a work-related accident or condition?
   ____ Yes ____ No

6. If you are seeking treatment for an injury, was another party responsible for the the injury? ____ Yes ____ No

7. Are you currently employed? ____ Yes ____ No ____ No. Never employed.
   Date of retirement, if applicable: _____
   (Month/Date/Year)

8. Do you have a spouse who is currently employed?
   ___ Yes ___ No ___ No. Never employed.
   Date of retirement, if applicable: _____
   (Month/Date/Year)

9. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment? ____ Yes, both ____ Yes, self ____ Yes, spouse ____ No

10. Do you carry any other insurance? ____ Yes ____ No
    If yes, please list company name, address, agent, and policy number:

    1. _____
    _____
    _____
    Policy Number: _____

    2. _____
    _____
    _____
    Policy Number: _____

Name: _____ **Date of Birth:** _____
PLEASE PRINT

Signature: _____ **Date:** _____