MEDICARE QUESTIONNAIRE

Patient's Name: _____ Account Number: _____

HOME HEALTH/SKILLED NURSING FACILITY

Are you currently enrolled in home health care? ☐ YES ☐ NO

Are you currently enrolled in a skilled nursing facility (nursing home/rehab) ☐ YES ☐ NO

Are you currently enrolled in hospice? ☐ YES ☐ NO

Name of nursing facility or home health agency: _____

Telephone number of nursing facility or home health agency: _____

Start date of home health: _____

Admit date to skilled nursing facility: _____

Have you been discharged? ☐ YES ☐ NO If yes, discharge date: _____

AUTO/OTHER ACCIDENT

Was this injury due to an automobile/other accident? ☐ YES ☐ NO

If yes, date and type of accident: _____

State in which accident occurred: _____

Name of insurance company: _____

Telephone number of insurance company: _____

Agent or contact person: _____

Are you (or your spouse) the guarantor on insurance information listed above? ☐ YES ☐ NO

If no, please list guarantor: _____

Today's Date: _____ Patient's Signature: _____