Medicare Questionnaire

Home Health/Hospice · Skilling Nursing Facility · Therapy Services · Auto Accident

(This form must be completed at each visit. Please complete all questions)

Are you **currently** enrolled in home health or hospice? Yes ❒ No ❒

Have you been discharged from home health Therapy? Yes ❒ No ❒

If yes, discharge date from therapy_____.

Have you been discharged from home health/hospice Medical Services? Yes ❒ No ❒

If yes, discharge date from medical services _____.

Name of home health/hospice and phone number_____

Are you **currently** in a skilled nursing facility (nursing home/rehab) Yes ❒ No ❒

Have you been discharged from skilled nursing facility? Yes ❒ No ❒

If yes, discharge date from skilled nursing facility_____.

Name of nursing facility and phone number_____

Have you had any outpatient therapy at any other location this year? Yes ❒ No ❒

If yes, where_____?

Auto Accident

Was this injury due to an automobile accident? Yes ❒ No ❒

If yes, date of accident _____

State in which accident occurred _____

Name of insurance company _____

Telephone number of insurance company _____

Agent or contact person _____

Is this your insurance or someone else's? Yes ❒ No ❒

If someone else's insurance please explain _____

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____