

# -PIONEER- PHYSICAL THERAPY

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## MEDICARE ADMITTING QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medicare requires that we ask these questions of you on each admission. This is to identify whether there are any other primary payers responsible for this visit. Please answer the following questions so that we can comply with Medicare's regulations. Thank you!

**1. ARE YOU RECEIVING BLACK LUNG BENEFITS?** Yes / No

If yes; date benefits began: \_\_\_\_\_

\*\*BLACK LUNG IS PRIMARY ONLY FOR CLAIMS RELATING TO BLACK LUNG.

**2. ARE THE SERVICES TO BE PAID BY A GOVERNMENT PROGRAM OR RESEARCH GRANT?**

Yes / No

If yes; which program? \_\_\_\_\_

**3. HAS THE DEPARTMENT OF VA AUTHORIZED AND AGREED TO PAY FOR CARE**

**HERE?** Yes / No

If yes; DVA is primary for these services.

**4. WAS ILLNESS/INJURY DUE TO A WORK-RELATED ACCIDENT/CONDITION?** Yes / No

A. If yes; Date of injury/illness: \_\_\_\_\_

B. Name, address, policy/claim number of Workman's Compensation plan: \_\_\_\_\_

\*\*WC IS PRIMARY PAYER ONLY FOR WORK RELATED INJURY OR ILLNESS.

**5. WAS ILLNESS/INJURY DUE TO A NON-WORK RELATED ACCIDENT?** Yes / No

A. If yes; Date of accident: \_\_\_\_\_

B. What type of accident caused the illness/injury? \_\_\_\_\_

C. Was another party responsible for this accident? Yes / No

D. Description of accident: \_\_\_\_\_

Name, address and claim number of no-fault or liability insurer: \_\_\_\_\_

\*\*NO FAULT INSURER IS PRIMARY PAYER ONLY FOR RELATED CLAIMS

**6. ARE YOU ENTITLED TO MEDICARE BASED ON:**

Age: Yes / No

Disability: Yes / No

\*ESRD: Yes / No

**\*END STAGE RENAL DISEASE (ESRD) INFORMATION**

**A. IF RECEIVING MEDICARE BENEFITS DUE TO ESRD, HAVE YOU RECEIVED A**

**KIDNEY TRANSPLANT?** Yes / No If yes; Date of transplant: \_\_\_\_\_

1. Have you received dialysis treatment? Yes / No

If yes; Date dialysis began: \_\_\_\_\_

2. Did you participate in a self-dialysis-training program? Yes / No

If yes; Date began: \_\_\_\_\_

3. Are you within the 30-month coordination period? Yes / No

4. Are you entitled to Medicare based on ESRD & age or ESRD & disability? Yes / No

\*\*A GROUP HEALTH PLAN IS PRIMARY FOR THE 30 MONTH COORDINATION PERIOD

**EMPLOYMENT INFORMATION**

**7. ARE YOU OR YOUR SPOUSE CURRENTLY EMPLOYED?** Yes / No

A. If yes; Name of employer: \_\_\_\_\_

B. Employer address: \_\_\_\_\_

C. **IF NO; DATE OF RETIREMENT:** Yourself \_\_\_\_\_ Spouse \_\_\_\_\_

D. Do you have a group health insurance plan from your or your spouse's employment? Yes / No

a. If yes; number of employees: [ ] 20-99 or [ ] 100 or more

b. Name of group health plan: \_\_\_\_\_ \*\*IF NO; MEDICARE IS

PRIMARY. \*\*IF ON MEDICARE DUE TO AGE; A GHP IS PRIMARY IF 20 OR MORE EMPLOYEES. \*\*IF ON MEDICARE DUE TO **DISABILITY**, GHP PRIMARY ONLY IF 100 OR MORE EMPLOYEES.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_