CENTRAL KANSAS ORTHOPEDIC GROUP

All Medicare patients are required to complete this form reflecting your current situation

Patient Name__________________________________ DOB_________________

1. If you have received Home Health Care of any kind in the past 60 days, please provide the name and phone number of the Home Health Facility. ____ YES ____ NO

   Name____Phone_________________

2. If you are entitled to benefits under Black Lung Program, Department of Veteran Affairs or other government programs please provide ____ YES ____NO

   Program Name____
   Address____
   Phone__________________ (This program will be primary to Medicare)

3. Is your injury due to an accident on someone else's property, auto or work comp? ____YES ____NO
   If yes please explain____
   Provide the contact information of their liability insurance
   Insurance Name____
   Address____
   Phone____________________ Contact Person ____
   (Medicare requires us to file with the liability insurance before filing with Medicare)

4. Do you intend to file a liability claim or lawsuit in connection with this illness/injury? If yes please provide your attorney's information. ____YES ____NO
   Name____
   Address____
   Phone_____________________

5. Have you received a kidney transplant or are you currently receiving dialysis for end stage renal disease? Date_______________ If the date is less than 30 months ago, are you currently covered under group insurance provided by your spouse or a family member's employer? ____YES ____NO

6. If none of the above applies to you and your medicare coverage is due to age or disability, do you have group insurance coverage through your spouse or a family member's employer? ____YES ____NO

   If you answered yes to question 5 or 6 please provide the group insurance information.

   Insurance Name ____
   Address____
   Phone_______________________Employer____
   Insured's Name ____

_______________________________________ _______________________

Patient Signature Date

____

Signature of Witness