NIRVANA SPORTS MEDICINE AND REHABILIIATION SERVICES, LLC

INSURANCE PAYOR QUESTIONAIRE FORM

Nirvana Sports Medicine and Rehabilitation Services, LLC will file with your insurance company according to the information that you provide. The accuracy of the provided information is highly important in order for your insurance to pay on your account. In order to ensure that we are filing the correct insurance, please answer the following questions.

1. Are you currently or have you had ANY type of Home Health Service? Yes No
   Home Health Agency:_____ Date Discharged:_____

2. Was this injury/illness a work related incident? Yes No
   If yes, name of employer:_____
   Employer phone:_____ Contact Person:_____
   Carrier's name:_____ Claim Number:_____
   Are you currently employed? Yes No
   Name of current employer, if different:_____

3. Was this injury related to an auto accident? Yes No
   Do you have an attorney representing you for your claim? Yes No
   Attorney's name: _____ Phone:_____

   Is your auto insurance currently exhausted? Yes No
   Do you have a letter of exhaustion from your auto carrier? Yes No
   Do you have regular medical health insurance? Yes No
   Insurance Carrier's Name:_____
   Phone Number:_____ Policy ID:_____
   Primary Insured Name:_____

4. Was this injury a result of a fall or other form of accident? Yes No
   If yes, please describe how and where accident happened:
   _____
   _____

5. Have you had therapy for this same condition within the last year Yes No
   If yes, name of facility:_____ Dates Seen:_____

6. Is there anyone else involved in paying for your care? Yes No
   If yes, Name:_____ Phone:_____

7. Are you currently on Medicare? Yes No

8. Who is your Primary Care Provider (PCP):_____ Phone Number:_____

_____ _____
Patient/Guardian Signature Relationship to Patient

_____ _____
Print Patient Name Date