Tuscarawas County Health Department
Medical Clinic
Medicare Beneficiary Screening

This form must be completed by all Medicare beneficiaries at each and every medical visit. The completed form shall be scanned into the patient's medical chart upon completion.

Patient Name:_____ Date of Birth:_____
(As it appears on Insurance Card)

Part I: Information about Black Lung, Workers' Compensation, No-Fault and Liability

1. Are you receiving benefits under the Black Lung Benefits Act (BL)?
   _____ Yes, date black lung benefits began: _____/_____/_____
   NOTE: BL IS THE PRIMARY PAYER FOR CLAIMS RELATED TO BL.
   _____ No.

2. Was the illness/injury you are being seen for today due to a work-related accident/condition?
   _____ Yes; the following workers compensation information is required to submit claims appropriately:
   Name and address of employer:
   _____
   _____
   Name and address of insurance carrier:
   _____
   _____
   Policy or claim number:_____
   Date of the workplace injury or illness: _____/_____/_____
   NOTE: WORKERS COMP IS THE PRIMARY PAYER ONLY FOR SERVIVES RELATED TO WORK-RELATED INJURIES OR ILLNESSES.
   _____ No.

3. Are you receiving treatment for an injury or illness covered under no-fault (and/or medical-payment coverage) including premises or automobile?
   _____ Yes; the following no-fault/automobile insurance information is required to submit claims appropriately:
   Name and address of insurance carrier:
   _____
   _____
   Policy or claim number: _____
   Date of illness or injury: _____/_____/_____
   NOTE: NO-FAULT INSURNACE IS THE PRIMARY PAYER ONLY FOR SERVICES RELATED TO THE ACCIDENT.
   _____ No.

Patient Signature: _____ Date of Appointment:_____

4. Are you receiving treatment for an injury, or illness, which another party may be liable?
   _____ Yes; the following liability information is required to submit claims appropriately:
   Name and address of insurance carrier:
   _____
   _____
   Policy or claim number: _____
   Date of illness or injury: _____/_____/_____
   NOTE: LIABILITY INSURANCE IS THE PRIMARY PAYER ONLY FOR SERVICES RELATED TO THE LIABILITY SETTLEMENT, JUDGEMENT OR AWARD.
   _____ No.

Part II: Information About Medicare Entitlement and Group Health Plans

1. Are you entitled to Medicare based on Age, Disability or ESRD?
   _____ Age
   _____ Disability
   _____ End-Stage Renal Disease (ESRD)
   NOTE: IF ENTITLEMENT IS BASED SOLEY ON ESRD, SKIP PART II AND COMPLETE PART III. STOP AFTER COMPLETING PART II IF YOU ARE ENTITLED TO MEDICARE BASED ON AGE OR DISABILITY.

2. Do you have group health plan coverage based on your own current employment, or the current employment of either your spouse or another family member?
   _____ Yes. **THE EMPLOYER GROUP HEALTH PLAN MAY BE PRIMARY TO MEDICARE. CONTINUE BELOW.**
   _____ No. **STOP HERE AS MEDICARE IS PRIMARY.**

3. How many employees, including yourself or your spouse, work for the employer whom you have group health plan coverage?
   _____ 1-19
   _____ 20-99
   _____ 100 or more
   NOTE: IF YOU ARE AGED AND THERE ARE 20 OR MORE EMPLOYEES, YOUR GROUP HEALTH PLAN IS PRIMARY. IF YOU ARE DISABLED AND YOUR GROUP HEALTH PLAN HAS 100 OR MORE EMPLOYEES YOUR GROUP HEALTH PLAN IS PRIMARY.

   The following employer Group Health Plan information is required to submit claims appropriately:
   Name and address of the employer (your own or your spouse's/family member's) through which you receive group health plan coverage:
   _____
   _____

Patient Signature: _____ Date of Appointment:_____

Name and address of Group Health Plan:

_____

_____

Policy Number (sometimes referred to as health insurance benefit package number):

_____

Group Number: _____

Date coverage began: _____/_____/_____

Name of policyholder (if coverage is through your spouse/family member): _____

Relationship to patient (if other than self): _____

Part III. Information About the Patient if ESRD Medicare Entitlement Applies (Including Dual Entitlement: Age and ESRD or Disability and ESRD)

1. Do you have employer group health plan coverage through yourself, spouse, or family member if dually entitled based on disability and ESRD?
   _____ Yes. **THE EMPLOYER GROUP PLAN MAY BE PRIMARY TO MEDICARE. CONTINUE BELOW.**
   _____ No.

2. Have you had a kidney transplant?
   _____ Yes; Date of transplant: _____/_____/_____
   _____ No.

3. Have you received maintenance dialysis treatments?
   _____ Yes; Date dialysis began: _____/_____/_____
   _____ No.

4. Are you within the 30-month coordination period?
   _____ Yes.
   _____ No.

   NOTE: THE 30 MONTH COORDINATION PERIOD STARTS THE FIRST DAY OF THE MONTH AN INDIVIDUAL IS ELIGIBLE FOR MEDICARE (EVEN IF NOT YET ENROLLED IN MEDICARE) BECAUSE OF KIDNEY FAILURE (USUALLY THE FOURTH MONTH OF DIALYSIS) REGARDLESS OF ENTITLEMENT DUE TO AGE OR DISABILITY. IF THE INDIVIDUAL IS PARTICIPATING IN SELF-DIALYSIS TRAINING PROGRAM OR HAS A KIDNEY TRANSPLANT DURING THE 3-MONTH WAITING PERIOD, THE 30-MONTH COORDINATION PERIOD STARTS WITH THE FIRST DAY OF THE MONTH OF DIALYSIS OR KIDNEY TRANSPLANT.

5. Were you receiving Group Health Plan coverage prior to and on the date of Medicare entitlement due to ESRD?
   _____ Yes. **NOTE: THE GROUP HEALTH PLAN IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

   The following information is required to submit claims appropriately:
   Name and address of employer (your own or your spouse's/family member's) through which you receive group health plan coverage:
   _____
   _____
   Name and address of group health plan:
   _____
   _____
   Policy Number (sometimes referred to as health insurance benefit package number):
   _____
   Group Number: _____
   Date coverage began: _____/_____/_____
   Name of policyholder (if coverage is through your spouse/family member): _____
   Relationship to patient (if other than self): _____
   _____No.

Patient Signature: _____ Date of Appointment:_____