PINNACLE
DERMATOLOGY

# Medicare Questionnaire:

**(Complete this section only if you have Medicare coverage)**

| | | |
|---|---|---|
| YES | NO | Is your Medicare through a Medicare HMO, such as Health Spring, Humana, United Healthcare, Secure Plus, AARP Medicare Complete, Blue Cross Blue Shield Ruby/Garnet/Diamond, etc.? |
| YES | NO | Do you or your spouse work in a company which has more than 200 employees and have coverage through the insurance at that job? |
| YES | NO | Are you covered by an insurance which makes Medicare Secondary? |
| YES | NO | Is this illness covered by the VA (Veteran's Administration) ? |
| YES | NO | Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program? |
| YES | NO | Is this illness due to an automobile accident? |
| YES | NO | Is this illness due to an injury at work? |
| YES | NO | Are you Receiving Medicaid? |
| YES | NO | Do you have TriCare for Life? If so Name and ID number of the Sponsor: |
| | | (Sponsor Name) (ID Number) |
| YES | NO | Was this appointment set up by your Primary Care Provider or did your doctor ask you to come to our clinic? If yes, please provide the full name and telephone number of your doctor. |
| | | (Doctor's Name) (Phone Number) |

We are required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

*I authorize any holder of medical or other information about me release to the Social Security Administration and Centers for Medicare Services (CMS) or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I give permission to MDC and its agents to contact me at any cell phone numbers provided.*

_____ _____

Signature as it appears on Medicare Card Date

_____

Printed Patient Name

If you have a supplemental policy and it is MEDIGAP policy to which your Medicare carrier automatically "crosses over" we are required to keep a separate signature on file.

*I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.*

_____ _____

Signature as it appears on Medigap Card Date

_____

Printed Patient Name