MEDICARE MSPQ

Name_____ Date of Birth_____/_____/_____ SS#_____

Part I

1. Are you receiving Black Lung Benefits? **YES NO**
2. Are the services to be paid by a government research program? **YES NO**
3. Are you entitled to benefits through the Department of Veterans Affairs? **YES NO**
4. Was the illness/injury due to a work-related accident/condition? **YES* NO**

   *If you answered yes, please see the front desk specialist before going further on this form to give worker's compensation info; otherwise proceed to Part II.

Part II

1. Was the illness/injury due to a non-work related accident? **YES** ** **NO**

   **If you answered yes, please complete the following questions, otherwise proceed to Part III.

   Is a no-fault insurance available? **YES NO**-if you answered yes, please complete the following questions; otherwise proceed to Part III.

   No fault insurance plan name:_____

   Plan Address: _____

   _____

   City:_____ST:_____ZIP:_____

   Is additional no-fault insurance available? **YES NO**

   No-fault policy owner name:_____

   Policy Owner Address:_____

   _____

   City:_____ST:_____ZIP:_____

Part III

1. Are you entitled to Medicare based on age? **YES NO**-If yes, proceed to Part IV.
2. Are you entitled to Medicare based on a Disability? **YES NO**-If yes, proceed to Part V
3. Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)?

   YES NO-if yes, proceed to Part VI.

MEDICARE MSPQ

Name_____ Date of Birth_____/_____/_____ SS#_____

Part IV-Age

1. Are you currently employed? **YES NO** (Date of Retirement____/____/____)
   If yes, then answer the following questions; otherwise proceed to question #2.
   Employer Name:_____
   Employer Phone #:_____
   Employer Address:_____
   City: _____ST:_____ZIP:_____
2. Do you have a spouse who is currently employed: **YES NO**
   (Date of retirement___/___/___) if yes, then answer the following questions; otherwise proceed to question #3.

3a. Do you have group health plan (GHP) coverage based on your own current employment? **YES NO**

3b. Do you have group health plan (GHP) coverage based on your spouse's current employment? **YES NO**

Part V-Disability

1. Are you currently employed? **YES NO** (Date of Retirement____/____/____)
   If yes, then answer the following questions; otherwise proceed to question #2.
   Employer Name: _____
   Employer Phone #:_____
   Employer Address: _____
   City: _____ST:_____ZIP:_____
2. Do you have a spouse who is currently employed: **YES NO**
   (Date of retirement___/___/___) if yes, then answer the following questions; otherwise proceed to question #3.

3a. Do you have group health plan (GHP) coverage based on your own current employment? **YES NO**

3b. Do you have group health plan (GHP) coverage based on your spouse's current employment? **YES NO**

4. Are you covered under a GHP based on the current employment of a family member other than your spouse? **YES NO**
5. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 100 or more employees? **YES NO**
6. If you have GHP coverage based on your spouse's current employment, does the employer that sponsors or contributes to the GHP employ 100 or more employees? **YES NO**

MEDICARE MSPQ

Name_____ Date of Birth_____/_____/_____ SS#_____

7. If you have GHP coverage based on a family member's current employment, does the employer that sponsors or contributes to the GHP employ 100 or more employees? **YES NO**

Part VI-ESRD

1a. Do you have group health plan coverage (GHP) based on your own current or former employment? **YES NO**
1b. Do you have GHP coverage through your spouse? **YES NO**
1c. Do you have GHP overage through a family member other than your spouse? **YES NO**
2. Have you received a kidney transplant? **YES NO**
3. Have you received maintenance dialysis treatments? **YES NO**
4. Are you within the 30-month coordination period? **YES NO**

Signature:_____ Date:_____