ADVANTAGE
Therapy Centers

Please complete this form if you have Medicare as your Primary Insurance Carrier

Medicare Primary Payer Questionnaire

The questions listed below are for beneficiaries or older, and is used to comply with Medicare Regulations 42 CFR 489.20 (F)

1. Are you currently working full or part time? Yes No

2. If married, is your spouse working full or part time? Yes No

3. Are you currently under any employer group health plan? Yes No
   If yes, please provide the following information:
   Name of Insured: _____
   Relationship to Patient: _____
   Name of Employer: _____
   Name of Insurance Carrier: _____
   Group/Policy#: _____

4. Are you entitled to Black Lung Benefits? Yes No

5. Is the service for treatment work related? Yes No

6. Is this service for treatment related to an auto injury? Yes No

7. Are benefits for services being submitted to any other party for reimbursement consideration? Yes No

Patient Name _____ Date _____

Patient Signature _____