

# Insurance Questionnaire

**The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.**

1. Type of insurance: Medicare\_\_\_ Medicaid\_\_\_ Champus\_\_\_ CampVA\_\_\_  
Group Health Plan\_\_\_ Other\_\_\_ Insured's ID Number\_\_\_\_\_
2. Patient Name:\_\_\_\_\_
3. Insured's Name (as it appears on the insurance card):\_\_\_\_\_
4. Patient's Address:\_\_\_\_\_
- City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_ Tel #\_\_\_\_\_
5. Insured's Address (if same as patient put "same"):\_\_\_\_\_
- City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_ Tel #\_\_\_\_\_
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable):\_\_\_\_\_
- Other Insured's Policy or Group Number:\_\_\_\_\_
- Other Insured's Date of Birth:\_\_\_\_\_ Male\_\_\_\_\_ Female\_\_\_\_\_
- Employer's Name or School Name:\_\_\_\_\_
- Insurance Plan Name or Program Name:\_\_\_\_\_
8. Is the condition we are treating related to current or previous employment? Yes\_\_\_ No\_\_\_
9. Is the condition we are treating related to an auto accident? Yes\_\_\_ No\_\_\_
10. Is the condition we are treating related to another type of accident? Yes\_\_\_ No\_\_\_
11. Insured's Policy Group or FECA Number:\_\_\_\_\_
- Insured's Date of Birth:\_\_\_\_\_ Male\_\_\_\_\_ Female\_\_\_\_\_
- Employer Name or School Name:\_\_\_\_\_
- Insurance Plan Name or Program Name:\_\_\_\_\_
12. Is there another health benefit plan? Yes\_\_\_ No\_\_\_

**Patient's or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Insured's or Authorized Person's Signature:** I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICARE ONLY

*All doctors have been instructed to ask the following questions of all Medicare patients.*

1. Do you or your spouse work for a company that provides you with health insurance? Yes\_\_\_ No\_\_\_
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes\_\_\_ No\_\_\_
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes\_\_\_ No\_\_\_
4. Is this illness or injury the result of an accident or other injury? Yes\_\_\_ No\_\_\_
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes\_\_\_ No\_\_\_
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes\_\_\_ No\_\_\_
7. Do you have a Medicare Medigap Policy? Yes\_\_\_ No\_\_\_ Name of Company\_\_\_\_\_
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes\_\_\_ No\_\_\_