Madonna
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Conditions of Admission: Attachment B Medicare

(Please Complete All Questions on This Form)

Patient Name_____ Patient Account #_____
Medicare # _____ Effective Date: _____

Please provide your Medicare card so that a copy can be made for your record.

1. Are you receiving Black Lung Benefits?
   ___ No
   ___ Yes Date Benefits began _____ (Mo/Day/Yr)

2. Are services to be paid by a Government Program such as a research grant?
   ___ No
   ___ Yes Agency _____
   Contact Person _____
   Phone # _____

3. Has the Department of Veterans Affairs authorized and agreed to pay for services?
   ___ No
   ___ Yes Contact Person _____
   Phone # _____

4. Are you receiving services as a result of a work related accident?
   ___ No
   ___ Yes Employer at the time of injury _____
   Work Comp Carrier _____
   Date of Injury _____
   Claim Number _____

5. Are you receiving services as a result of a non-work related accident?
   ___ No
   ___ Yes Type: ___ Automobile ___ Other: _____
   (i.e. fell off roof, slipped on ice, burn, tractor rollover)
   Date of Accident _____
   Location of Accident _____
   Was another party involved? ___ Yes ___ No
   Claim Number _____

6. Are you receiving Medicare based on:
   ____ Age (if yes, please skip to question 9)
   ____ Disability (if yes, please skip to question 9)
   ____ Renal Disease

7. Did you initially receive Medicare based on Kidney Disease (even if you were of age or disabled at the same time)?

___ No

___ Yes Have you received a kidney transplant? ___Yes ___No

If yes, date of transplant _____

Are you receiving dialysis treatments? ___Yes ___No

If yes, date dialysis treatments started _____

Type of dialysis: ___Hemodialysis ___ C.A.P.D.

Are you within the 30-month coordination period? ___Yes ___No

Coordination Period	
For Transplant Patients	30 months after transplant date
For Hemodialysis Patients	33 months after first dialysis treatment
For C.A.P.D. Patients	30 months after first dialysis treatment

8. Are you receiving Medicare on the basis of either Kidney disease **and** Age **OR** Kidney disease **and** Disability? ___ No ___ Yes

Are you employed?

___ Retired Date of Retirement _____(Mo/Day/Yr)

___ No Never Employed

___ Yes Full Time Part Time

Employer _____

Address _____

Phone _____

Are there more than 20 people employed at this company? Yes No

Are there more than 100 people employed at this company? Yes No

9. Do you have Group Health Insurance coverage based on your employment?

___ No

___ Yes Insurance Company _____

Policy Number _____

Group Number _____

Membership Number _____

Please present insurance card to Registrar

10. What is your current marital status?

___Single ___Married ___Divorced ___Widowed ___Other: _____

If you are married, is your spouse employed?

___ Retired Date of Retirement _____(Mo/Day/Yr)

___ No Never Employed

___ Yes Full Time Part Time

Employer _____

Address _____

Phone _____

Are there more than 20 people employed at this company? Yes No

Are there more than 100 people employed at this company? Yes No

11. If you are married, do you have Group Health Insurance coverage based on your spouse's employment?

___ No

___ Yes

Insurance Company _____

Policy Number _____

Group Number _____

Membership Number _____

Please present insurance card to Registrar

12. Are you covered under Group Health Insurance of a family member other than your spouse?

___ No

___ Yes

Family Member's Name _____

Family Member's Employer _____

Employer Address _____

Employer Phone # _____

Insurance Company _____

Policyholder's Name _____

Relationship to Patient _____

Policy Number _____

Group Number _____

Membership Number _____

Please present insurance card to Registrar

13. Are you currently receiving any of the following services?

			Name of Agency / Facility
Home Health Care	___ Yes	___ No	_____
Hospice Care	___ Yes	___ No	_____
Resident of Nursing Care Facility	___ Yes	___ No	_____

Note: In order for Medicare to cover services provided by Madonna Rehabilitation Hospital, this information is required. You will be responsible for payment of services if Medicare does not cover them.

_____ _____

Patient / Representative Signature Date

Madonna

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