Pacific Sports
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at MultiCare

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Promoting Active Healthy Lifestyles

MEDICARE FORM PATIENT NAME:____________________

1.) Name of spouse____

2.) Is the patient employed? YES NO

3.) Is spouse or other family member employed? YES NO

4.) Does patient have employer group health plan (EGHP) coverage based on own or a family member's current or former employment? YES NO

5.) Does the employer that sponsors the EGHP have 20 or more employees? YES NO

6.) Is the patient retired? YES NO Is the spouse retired? YES NO
Patient retirement date:_______________ Spouse retirement date:_______________

7.) Is patient entitled to Medicare because of end stage renal disease (ESRD)? YES NO

8.) Is patient entitled to Medicare because of disability other than ESRD? YES NO

9.) Does employer that sponsors patient's GHP have 100 or more employees? YES NO

10.) Is patient entitled to benefits through the Department of Veterans Affairs? YES NO

11.) Does the patient want the VA to be contacted for authorization? YES NO

12.) Is patient entitled to benefits under the federal Black Lung Program? YES NO

13.) Is this illness/injury covered by a workers compensation claim? YES NO

14.) Is this illness/injury the result of a non-work related accident? YES NO

15.) Are services covered by a Public Health service or research program? YES NO

INFORMATION SUPPLIED BY:____

RELATIONSHIP TO PATIENT: SELF SPOUSE OTHER:_________________________