



SEFR

Southeastern fitness and rehabilitation

Patient Name: _____ Date: _____

DOB: _____

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services; please answer the following questions:

- 1. Is the patient covered by Federal Black Lung Program? Y/N
- 2. Is the patient entitled to benefits through the VA due to having a service related injury? Y/N
- 3. Should the illness/injury be covered by workers comp? Y/N
- 4. Was this illness/injury due to a non-work related accident? Y/N
- 5. Is the Patient entitled to Medicare based on:
 - o Age Y/N
 - o Disability Y/N Date of Disability _____
 - o End Stage Renal Disease _____
- 6. Are services to be paid by a government program such as a research grant? Y/N

Is the patient currently employed? Y/N

If no: Date of retirement _____

If yes: Name of Employer _____

Address _____

City _____ State _____ Zip _____

Is the patient's spouse currently employed?

If no: Date of retirement _____

If yes: Name of Employer _____

Address _____

City _____ State _____ Zip _____

Is the patient covered by Employers Group Health Plan? (Enter Y if EGHP is primary, N if secondary) Y/N

If "Yes" number of employees 1-19 20-99 100 or more

Thank you for your cooperation in ensuring that your medical services will be billed properly.

Patient's Signature _____ Date: _____