The Neurology Center
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MEDICARE COB QUESTIONNAIRE FORM

PATIENT NAME: _____ AGE_____

******Medicare requires that all questions be answered in order to confirm that Medicare is the primary payer of your medical bills.***

1. Was this injury due to a work related accident? Yes____ No____
   If yes, date of injury/illness: _____
2. Was this injury/illness related to an auto/any other type of accident? Are you intending to file a liability suit or litigation is pending? Yes___ No___

   If yes, please provide: Attorney's Name: _____
   Address: _____
   Phone Number: _____
3. Are you on Medicare due to End Stage Renal Disease? Yes___ No___
   *****If NO, continue with question #4*****
   Do you have group health plan coverage? Yes____ No____
   Are you within the 30 month coordination period? Yes____ No____
4. Are you currently employed? Yes___ No___ (Date of Retirement:___/____/____)
   Is your spouse currently employed? Yes____ No____
   If yes, could your spouse's employment policy be primary to yours? Yes____ No ____

Are you receiving "Skilled Nursing Care" at home or in a facility? Yes ___ No ___

IF YOU ANSWERED **YES** TO QUESTIONS, PLEASE COMPLETE THE FOLLOWING INFORMATION.

Insurance Company: _____

Address: _____

Phone Number: _____

Policy Number: _____ Group#:_____

_____ ____/_____/_____
Patient's Signature Date