Barrington Rehabilitation
Should Medicare Be Secondary?

Name ______________________________________

Please read and respond to each question:

1. Is your condition due to an automobile accident, liability accident, or work-related? **Yes No**
2. Are you receiving Medicare benefits under the Black Lung Program? **Yes No**
3. Are you receiving Medicare benefits under the VA Program? **Yes No**
4. Are you entitled to Medicare benefits due to End Stage Renal Disease? **Yes No**
5. If you are under 65, are you receiving Medicare benefits due to a disability? **Yes No**
6. Are you currently employed or is your spouse currently employed? **Yes No**
   If yes, do you or your spouse have insurance through the employer? **Yes No**
   If yes, does the employer employ more than 20 employees? **Yes No**
   If you are retired, what was the date of your retirement? ____/____/________

Medicare Patient Certification:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

Medicare Beneficiary Signature ____ **Date** ____________________

COMPLETE ONLY IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS
Please list your other insurance information below:

Group Health Insurance______________________Address________________________________Phone ________________
Name of Policy Holder ______________________________Policy Holder's Employer________________________________
ID Number ____ Group Number ______________________________________

Auto Insurance Name and Address____
Accident Date ____/____/______ Claim #_______________________________ Adjuster_________________________

Liability Insurance Name and Address____
Accident Date ____/____/______ Claim #_______________________________ Adjuster_________________________

Worker Compensation Insurance Name and Address____
Accident Date ____/____/______ Claim #_______________________________ Adjuster_________________________