Demographics

Place Patient Label Here

DERMATOLOGY SPECIALISTS OF OMAHA

Medicare Secondary Payer Questionnaire

Name: _____ Date of Birth: _____

Medicare Number: _____

	YES	NO
1. Is the patient a veteran?	☐	☐
a. Did the VA refer you here for treatment?	☐	☐
b. Does the patient have a VA "Fee Basis ID Card?"	☐	☐
2. Do you have a Federal Black Lung Card?	☐	☐
3. Is this medical condition due to an accident of any kind?	☐	☐

If Yes, was it: ( ) Work-related ( ) Auto
( ) Injured in own home ( ) Other

4. Is the patient covered by an employer's health insurance plan through their own employment or through that of a family member? (Not retiree coverage)	☐	☐

_____ _____
Signature Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made to Dermatology Specialists of Omaha, LLC. for my services furnished to me by Dermatology Specialists of Omaha, LLC. I hereby authorize Dermatology Specialists of Omaha, LLC. to release any medical information necessary to Medicare and its agents to determine these benefits or the benefits payable for related services. This form needs signed annually.

_____ _____
Signature Date