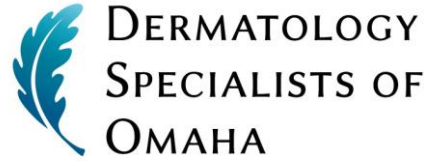




Demographics

Place Patient Label Here



Medicare Secondary Payer Questionnaire

Name: _____ Date of Birth: _____

Medicare Number: _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Is the patient a veteran? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Did the VA refer you here for treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Does the patient have a VA "Fee Basis ID Card?" | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a Federal Black Lung Card? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is this medical condition due to an accident of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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) | <input type="checkbox"/> | <input type="checkbox"/> |

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