WEST MICHIGAN DERMATOLOGY
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MEDICARE PATIENT REGISTRATION QUESTIONNAIRE

Insurance Information:

Medicare Number, as it appears on Medicare card: _____

Do you have Medicare Part B (Medical) coverage? ☐ Yes ☐ No

Is Medicare your primary insurance carrier? ☐ Yes ☐ No

Please answer the questions below by placing a check in the appropriate column:

YES	NO	
☐	☐	Are you part of a Medicare Advantage Plan?
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you covered by a HMO/PPO which makes Medicare secondary?
☐	☐	Is this illness covered by the VA (Veteran's Administration)?
☐	☐	Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness due to an automobile accident?
☐	☐	Is this illness due to an injury at work?
☐	☐	Are you receiving Medicaid?

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____ / _____ / _____

Signature as it appears on Medicare Card Date