ENGLEWOOD HOSPITAL
AND MEDICAL CENTER

MEDICARE PATIENT INSURANCE INFORMATION

Patient Label

1. Do you, your spouse, or family member work for a company that provides you with health insurance?
   ❑ NO ❑ YES (If YES, go to #6)
2. Is this hospitalization caused by an automobile accident, work-related, or other accident?
   ❑ NO ❑ YES (If YES, go to #4)
3. Are you covered by Black Lung or Veterans' Administration benefits?
   ❑ NO ❑ YES (If YES, go to #11)

STOP HERE IF ALL 3 ANSWERS ARE "NO"

4. What type of accident? ❑ Work Related (go to #5 and #11)
   ❑ Auto (go to #11)
   ❑ Other: (Explain) _____

_____

5. List attorney's information if intent is to file a law suit: Name: _____
   Address: _____ Phone: _____
6. Check the patient's relationship to the Employee:
   Patient is: ❑ Employee ❑ Spouse ❑ Mother ❑ Father
7. Employee's Name: _____
8. Employer's Name and Address: _____
   _____
9. How many people work for the Employer: ❑ Under 20 ❑ 20 - 100 ❑ 100 and Over
10. On what basis is the patient entitled to Medicare?
    ❑ End Stage Renal Disability ❑ Disability (Under 65) ❑ Age (65 and Over)
11. Name and Address of Auto/Workers' Compensation/or Health Plan Carrier:
    _____
    _____
    Policy I.D. Number(s): _____

I HAVE ANSWERED THE ABOVE QUESTIONS TO ASSURE THAT I AM BILLED CORRECTLY, AND I HAVE RECEIVED A COPY OF THE "MEDICARE PATIENT RIGHTS FORM" WHICH IS INCLUDED IN THE PATIENT INFORMATION PACKAGE.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON **DATE/TIME**