

Notifier(s):



Central Billing Office
8930 Four Winds Dr., Ste. 109
San Antonio, TX 78239
(888) 590-4002

Clinic: _____

Date: _____

Patient Name: _____

Medicare Number: xxxxx-

Provider: _____

- 1. Do you receive Veteran's benefits? Yes No
2. Are you receiving benefits under the Black Lung Program? Yes No
If yes, date benefits began
If yes, are the services you will be receiving related to a non-black lung condition? Yes No
3. Was this injury/illness due to a work related accident/condition? Yes No
If yes, date of injury/illness
4. Was this injury/illness related to an automobile accident? Yes No
If yes, date of accident
5. Was this injury/illness related to an accident in which you intend to file a liability suit or litigation is pending? Yes No

If you answered Yes, please provide:

Table with 3 columns: Attorney name, Address, Phone

- 6. Are you entitled to Medicare based on: Age (65 & over), Disability, End Stage Renal Disease
Do you have group health plan (GHP) coverage? Yes No
Are you within the 30-month coordination period? Yes No
7. Are you currently employed? Yes No Date of retirement:
a) Is your spouse currently employed? Yes No Date of retirement:
b) Do you have a group health plan (GHP) as primary coverage based on your own or a spouse's current or former employment? Yes No
c) Does the employer that sponsors your GHP employ 20 or more employees? Yes No

If you answered Yes to questions #3, #4 or #7 above, please complete the following information:

Table with 2 columns: Insurance Company, Policy/Cert #, Address, Group Name & #

Table with 2 columns: Patient Signature, Responsible Party, Date, Relationship