Notifier(s):

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

Clinic: ______________

Date: ______________

Patient Name:	RMT Number:

Referring Provider:

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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:

Attorney name:	Address:	Phone:

6. Are you entitled to Medicare based on:
   Age (65 & over) – go to question 7
   Disability – go to question 7
   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:

Insurance Company:	Address:
Policy/Cert #:	Group Name& #:

Patient Signature:	Date:
Responsible Party:	Relationship: