

# ATTENTION MEDICARE PATIENTS ONLY

**\*\*TO BE COMPLETED FOR ALL MEDICARE PATIENTS\*\***

Dr. Matthew H. Conrad 1700 Waterfront Pkwy Bldg 200 Wichita, KS 67206

NAME \_\_\_\_\_ DATE OF SERVICE \_\_\_\_\_

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident, Workman's Compensation or other? Yes \_\_\_ No \_\_\_
2. Is illness covered by the Black Lung Program or Veterans Administration program? Yes \_\_\_ No \_\_\_
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? Yes \_\_\_ No \_\_\_
- 4a. If under age 65, is your Medicare coverage due to disability? Yes \_\_\_ No \_\_\_
- 4b. Is patient covered by a large group health plan through patient's employer or spouse's current employer? Yes \_\_\_ No \_\_\_
5. If 65 and over, is patient covered by Employer Group Health Plan through patient or spouses' current employer? Y \_\_\_ N \_\_\_
6. Are the services to be paid by a Government Research Program? Yes \_\_\_ No \_\_\_
7. Has the Department of Veteran Affairs authorized and agreed to pay for your care at this facility? Yes \_\_\_ No \_\_\_

## REGISTRAR NOTES:

- A. If patient responds "NO" to questions 1-7, Medicare is primary.
- B. If patient responds "YES" to any questions, Medicare is secondary and primary insurance information must be obtained.

## ONE TIME AUTHORIZATION

I request that payment of authorized Medicare Benefits be made to me or on my behalf to Dr. Matthew H. Conrad, for any services furnished to me. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(PATIENT OR GUARDIAN IF PATIENT IS A MINOR)