FOR MEDICARE PATIENTS ONLY
Medicare Secondary – Payer Questionnaire
(To be completed for ALL Medicare patients at each initial visit)

NAME_________________________________________Medicare#____________________

Is the patient a veteran?______________Date_________

1. Did the VA refer you here for treatment?.................................................... YES NO
2. Does the patient have a VA “Fee Basis ID” card?................................. YES NO
3. Do you have a “Federal Black Lung” card?........................................... YES NO
4. Is the patient covered by an employer’s health insurance plan through their own employment or that of a spouse or other family member?
   (Not retiree coverage)................................................................. YES NO
5. Is your Medicare entitlement based on End Stage Renal Disease?........ YES NO

If you answered “yes” to any of the above questions, please answer the following questions:
a. Does the patient authorize you to bill VA?......................................... YES NO
b. Are the services you are receiving today related to lung disease?......... YES NO

If the answer is “yes,” submit claims to:
Federal Black Lung Program
P O Box 828
Lanham-Seabrook, MD 20703-0828

6. Is this medical condition due to an accident of any kind?..................... YES NO
   If yes, was it:
   Work Related___  Auto___  Injured in own home___  Other___

7. Are the services to be paid for by a Government Research Program?..... YES NO

For Medicare Patients Only
MEDICARE AUTHORIZATION
I request that payment of authorized Medicare benefits be made to Robert D. Plambeck, MD, PC for any services furnished to me by their providers. I authorize my holder of medical information about me to release to the Center for Medicaid and Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

SECONDARY INSURANCE BENEFITS AUTHORIZATION
I hereby authorize payment of my Medigap and/or Secondary Insurance benefits to Robert D. Plambeck, MD, PC for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient or Authorized Signature___________________Relationship________Date____

For Office Use Only:

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<th>Date</th>
<th>Initials of Associate who reviewed questions with the patient</th>
<th>Changes to Questionnaire</th>
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