PATIENT NAME: Is patient under 65? Is the patient eligible for Medicare based on disability? Is the patient eligible for Medicare solely due to ESRD? How many months has the patient been on dialysis? Date Started: Covered by government program/research grant? Covered by an HMO? Date Enrolled Date Disenrolled Name of HMO Covered by Black Lung? Pets No Covered by War Lebets to take Medicare coverage instead of VA? Covered by Workmen's Compensation? Name Insured/Name Insurance Co./address/phone/contact person/policy #/claim #: Is illness/injury due to an accident that involves a motor vehicle? Date patient own a car? If "Yes", always obtain patient's auto insurance information** Was the patient a passenger, driver or pedestrian? Date of accident/injury: (If patient passenger or pedestrian also get info on that car/driver)** Name Insured/Name Insurance Co./address/phone/contact person/policy #/claim #: Is illness/injury due to a NON motor vehicle accident? Name Insured/Name Insurance Co./address/phone/contact person/policy #/claim #: Is illness/injury due to a NON motor vehicle accident? Name Insured/Name Insurance Co./address/phone/contact person/policy #/claim #: Is illness/injury due to a NON motor vehicle accident? Yes No Date of accident/injury: Was it reported? Yes No (If "No", have patient report) Location (address) of accident/injury Name Insured/Name Insurance Co./address/phone/contact person/policy #/claim #: Is illness/injury due to a NON motor vehicle accident? Yes No Date of accident/injury: Was it reported? Yes No (If "No", have patient report) Location (address) of accident/injury Name Insured/Name Insurance Co./address/phone/contact person/policy #/claim #: Is the patient employed? Yes No No No No No No No No No No No No No No No N						
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Covered by Black Lung? Dept. of Labor Black Lung #						No
Dept. of Labor Black Lung #	Date Enrolled	_ Date Disenrolled	Name of H	MO		
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Date of Retirement: Is the patient married? Yes No						-
Is the patient married? Yes No					169	NO
•				Va	s No	
is the patient's spouse employed?	•	anloyad?		16.		No
If No: Date of spouse's retirement:		• •			169	INO

Yes No

Is patient covered by a Group Health Plan via spouse, parent or guardian?

Name Insured/Name Insurance Co./address/phone/contact person/policy #/cert #: _____

Intake Coordinator Signature: ______ Date: _____