Ability Health Services & Rehabilitation, LP
Medicare Secondary Payor Questionnaire Form

Patient Name: _____ ***Person completing form:*** _____

*****Note: If you are currently receiving Home Health Care (whether it is in home therapy or Nursing), Medicare WILL NOT cover your outpatient therapy here at Ability Rehab. You will need to contact Medicare at 800-999-1118 to coordinate your benefits. STOP at this point and talk with our Front Office regarding your benefits with Medicare. We are here to help!***

1. **Are you <u>currently</u> receiving Home Health Care? (Nurse or Therapy)** **NO____** **YES____**
   (If you answered YES, please check with our front office immediately)

2. **Have you received any Home Therapy in the last 3 months?** **NO____** **YES____**
   (If you answer YES, provide the following below)

Name Of Home Health Agency:_____ **Date Last Seen:**_____

3. **Have you received ANY therapy in or out of the state of Florida?** **NO____** **YES____**
   (If you answer YES, provide the following below)

Name Of Therapy Provider:_____ **Date Last Seen:**_____

4. **A government program such as a Research Grant will pay for my therapy here.** **NO____** **YES____**
   (If you answer YES, provide the following below) *****STOP! Medicare is NOT Primary*****

Name Of Government Agency:_____ **Policy/Claim #:**_____

5. **Has the Department of Veterans Affairs approved and agreed to pay for your therapy?** **NO____** **YES____**
   (If you answer YES, provide the following below) *****STOP! Medicare is NOT Primary*****

Authorization #:_____ **STOP here and speak to the Front Office Coordinator.**

6. **Are you here for therapy due to a Work related Accident?** **NO____** **YES____**
   (If you answer YES, provide the following below)

Name of Insurance Company:_____ **Claim #:**_____

7. **Are you here due to a fall or other form of accident?** **NO____** **YES____**
   (If you answer YES, provide the following below)

Date of Injury:_____ **Describe: (how & when)** _____

8. **You have Medicare due to (please check)**

____Age ____Disability ____ESRD (end stage renal disease) **Date of Retirement:**_____ **Date of Disability:**_____

9. **Are you currently employed?** **NO____** **YES____**
   (If you answer Yes, provide the following below)

Employer Name:_____

10. **Is spouse employed?** **NO____** **YES____**

11. **Does your spouse have group health insurance?** **NO____** **YES____**
    *(If you answer Yes, **STOP!**)*

****Medicare is not Primary and we will need the employer group health plan coverage. Please provide to the front office****

_____ _____ _____ _____

Patient Signature ***Date*** ***Witness Signature*** ***Date***

ACCOUNT #:_____ FD Initial:_____