



**FOR OFFICE USE ONLY:**

**Check if the information below is different than CWF On-line3 Medicare Screen.**

## MEDICARE ELIGIBILITY QUESTIONNAIRE

Name (Last, First): \_\_\_\_\_ DOB: \_\_\_\_\_ MR #: \_\_\_\_\_

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. Please answer the following questions regarding your Medicare eligibility.

### **PART I: Are you entitled to Medicare benefits because of:**

- 1. Your age?  Yes  No
- 2. A Disability?  Yes  No
- 3. End Stage Renal Disease (ESRD)? If Yes, Please complete Part V.  Yes  No

Date of Medicare Eligibility: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **PART II: Are the services you are seeking related to:**

- 1. Black Lung?  Yes  No  
Note: Black Lung is primary only for claims related to Black Lung
- 2. Veteran's Administration Program?  Yes  No  
Note: Department of Veteran's Administration is primary for these services.
- 3. Government Program or Research Grant?  Yes  No  
Note: Government Program is primary for these services.
- 4. Accidental Injury? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Yes  No  
Cause of Injury:  Automobile  Liability  Worker's Comp  
***If Yes, please complete insurance information in Part VI below.***

### **PART III: Employment - Self**

- Are you employed?  Yes  No If No, indicate Retirement Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- If Yes, are you covered under your employer's Group Health Plan (GHP)?  Yes  No  
If yes, does your employer have at least 20 employees?  Yes  No  
If yes, does your employer have at least 100 employees?  Yes  No

***If yes to any of the above questions, please complete insurance information in Part VI below.***

### **PART IV: Employment – Spouse or Other Family Member** Not Applicable

- Is your spouse employed?  Yes  No If No, indicate Retirement Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- If Yes, are you covered under your spouse's employer Group Health Plan (GHP)?  Yes  No  
If yes, does the employer have at least 20 employees?  Yes  No  
If yes, does the employer have at least 100 employees?  Yes  No
- Are you covered under a family member's GHP (other than spouse)?  Yes  No  
If yes, does the employer have at least 20 employees?  Yes  No  
If yes, does the employer have at least 100 employees?  Yes  No

***If yes to any of the above questions, please complete insurance information in Part VI on next page.***



## MEDICARE ELIGIBILITY QUESTIONNAIRE

### **PART V: For End Stage Renal Disease (ESRD) Only**

- Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and Disability?  Yes  No  
*If No, Group Health Plan is primary during the 30 month coordination period.*
- Are you within the 30 month coordination period?  Yes  No
- Have you received a kidney transplant?  Yes  No  
If Yes, Date of Transplant: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you received maintenance dialysis treatments?  Yes  No  
If Yes, Date Dialysis began: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?  Yes  No  
If No, initial entitlement based on age or Disability applies.

### **PART VI: Group Health Plan or Other Insurance Information**

- Name & Address of Insurance Company:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Insurance Company Phone Number / Name of Contact:  
\_\_\_\_\_
- Name of Policy Holder:  
\_\_\_\_\_
- Relationship to Policy Holder: \_\_\_\_\_ Policy Number / Group Number: \_\_\_\_\_
- Policy Holder's Employer's Name & Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Other Insurance Information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medicare Benefits for Outpatient Rehab Services

### Your Medicare benefits in 2009.

Effective January 2009, Medicare placed a financial limit on outpatient physical therapy, speech-language and occupational therapy services available to each beneficiary. The financial "cap" on therapy services is applicable to all outpatient therapy providers other than hospital outpatient departments. Hospital based outpatient departments are exempt from the law. Benefits are paid after the 2009 Part B deductible of \$135 is met. Medicare pays 80% of approved charges and patients (or their secondary plans) are responsible for 20%.

### How did this happen?

In 1997, Congress passed legislation to limit Medicare's coverage of outpatient therapy services for each beneficiary. In 2004 & 2005, Congress imposed a moratorium preventing this cap on therapy services from being applied. However, each year since 2006 Congress has reinstated the therapy cap. As a result, Medicare rehabilitation services, including both physical and speech therapy, will be capped at \$1840.00 per beneficiary for 2009. A separate cap of \$1840.00 is in place for Occupational Therapy services. Your co-pay counts as part of these caps.

### What if I need more than \$1840.00 in therapy care?

If you have a secondary insurer, we will ask if they will cover services provided above the cap amount. If approved, your secondary insurer will be billed for services provided which exceed the cap.

The law provides for certain exceptions to the therapy cap. Exceptions to the therapy cap may be granted by Medicare in certain circumstances, for certain conditions or complexities, and when medically necessary skilled treatment is required and will exceed the cap:

- Certain diagnoses may qualify for exceptions to the cap based on the individual's condition and medical need.
- Certain complex situations may qualify an individual for an exception to the cap, including:
  - the beneficiary is discharged from a skilled nursing facility within 30 days of starting an outpatient episode of care;
  - the beneficiary requires both physical and speech therapy services concurrently and the combined & concurrent services will require the cap to be exceeded;
  - the beneficiary had a prior episode of outpatient therapy during the calendar year for a different condition causing the cap to be exceeded;
  - the beneficiary does not have access to hospital based outpatient therapy services (this includes individuals for whom transportation to the hospital is a physical hardship or those who lack the availability of therapy services at a hospital in their county);
  - other medically necessary situations and reasons, specific to your rehab needs and care, which your therapist can discuss with you.

If you or your loved ones need more than the cap limit on your therapy care and you do not qualify for a therapy exception, you have the following options if you choose to continue care:

- You may choose to pay out-of-pocket for the necessary rehabilitation services that exceed the \$1840.
- You may choose to travel to a hospital-based outpatient clinic to continue your rehabilitation.

We are committed to providing the highest possible quality of care and look forward to working with you.