

MEDICARE SUPPLEMENTAL FORM

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4. Yes No Do you feel that you have a right to compensation by a party that caused the injury or illness?

5. Yes No If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness.

If yes: please provide your attorney's information.

Attorney name: _____ Phone Number: _____

Address: _____

City, State and Zip: _____

6. Yes No Have your received a kidney transplant or are currently receiving dialysis for End Stage Renal Disease. Date of transplant or start of dialysis: _____

If less than 18 months, are you currently covered under group insurance provided by your or a family member's employer?

Yes The group insurance will be primary

No Medicare will be primary

7. Yes No If you answered "No" to questions 1-6, do you have a group insurance coverage through your or a family member's employer?

Yes The group insurance will be primary

No Medicare will be primary

If you answered "Yes" to either #6 or #7, please provide the following:

Insurance name: _____ Insured Name: _____

Address: _____

City, State and Zip: _____

Phone number: _____ Employer: _____

PATIENT'S SIGNATURE: _____ DATE: _____