IVYREHAB
PHYSICAL THERAPY

# *Medicare Questionnaire*

Date: _____

Patient Name: _____

Is patient employed? Yes / No

Retirement date: _____ Is patient covered by Health Ins provided by employer? Yes / No

Is patient's spouse employed? Yes / No Has spouse ever been employed? Yes / No

How many employees? 1 = Spouse's employer has less than 20 employees
2 = Spouse's employer has 20 – 99 employees
3 = Spouse's employer has 100 or more employees

Spouse's retirement date? _____ (Enter date if applicable)

Is patient covered by spouse's health insurance? Yes / No

Does patient have Black lung coverage? Yes / No

Is patient a veteran? Yes / No

Are you a member of an HMO? Yes / No

Is this a Workman's Comp claim? Yes / No

Is treatment related to a disability? Yes / No Is treatment related to ESRD? Yes / NO
(End Stage Renal)

Is patient covered by insurance from previous employer? Yes / No

Employer Name: _____Number of Employees: _____

Relationship of policy subscriber to the patient: _____

Will services be paid by a government program (research grant)? Yes / No

Name of government grant: _____

Have you been admitted to a hospital within the last 60 days? Yes / No

If Yes name of Hospital: _____ Date of Hospital Stay: _____

Have you had any Physical Therapy, Speech Therapy or Chiropractic Services in 2006? Yes or No

If "Yes" where _____and how many visits _____?