Medicare Authorization Form

Please show your Medicare Card and any other insurance ID Card so we can make a copy.

I authorize the release of any medical or other information necessary to process claims for services provided by Lincoln Family Medical Group, P.C. I also request payment of government funds either to myself or to Lincoln Family Medical Group, P.C. if they accept assignment.

______________________________________ ______________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE DATE

Medicare Questionnaire

Medicare requires all patients to complete this questionnaire

Patient's Name ______________________________________

Current Marital Status: ❑ MARRIED ❑ SINGLE (Never Married, Widowed, Divorced)

Date of Service ________________

Please check YES or NO for each question	YES	NO
1) Is the patient a veteran? If YES…		
a) Did the VA refer you here for treatment?		
b) Does the patient have a VA "fee basis ID Card?"		
If (a) or (b) is YES, do you authorize us to bill the VA?		
2) Does the patient have a Federal Black Lung Card?		
3) Is the patient covered by an employer health insurance plan through their own employment or that of a family member? (does not include retiree coverage)		
4) Is this medical condition due to an accident of any kind? If your answer is YES, check one box below…		
a) Work related …………………………………………		
b) Motor vehicle ………………………………………		
c) Injury in your own home ……………………………		
d) Other ____		

OFFICE USE ONLY

Provide details for any **YES** answers below

Group Health Plan (question 3) through: ☐ Patient's Employer ☐ Spouse's Employer

Employer Sponsoring Health Plan		Does this employer have more than 20 employees? ☐ Yes ☐ No

Patient Account Number		Primary insurance if Medicare 2nd	