ADMISSION FORM

Beneficiary Name: _____
HIC #: _____
Date: _____

All questions; indicate YES or NO in the space provided. If any question is answered YES complete ALL information in the Appropriate section below. If all questions are answered NO Medicare may be primary payer.

Questions:

1. Do you or your family work for a company that provides you with health insurance? YES ____ NO ____

2a. Is the hospitalization or treatment caused by an auto accident? YES ____ NO ____

2b. Is the treatment for an injury or illness which another party could be held responsible? YES ____ NO ____

3. Is this hospitalization or treatment related to an accident at work or are you entitled to Black lung medical benefits? YES ____ NO ____

4. Are you entitled to disability benefits solely on the basis of End Stage Renal Disease (ESRD) and covered by an employer or Group Plan? YES ____ NO ____

5. Are you eligible for coverage under the VA or other governmental agency? YES ____ NO ____

I. Employer Group Plan
(questions 1 & 4)

1. Insurance Company:
_____
2. Insured's Name:
_____
3. Patient's relation to insured:
_____
4. Claim or Policy #:
_____
5. Name of group or plan:
_____
6. Employer Name and Location
_____
7. # of Employees
Over 19____ Over 99____
8. Date dialysis began: _____
Kidney transplant date: _____

II. Auto Medical or Liability Insurance
(questions 2a-2b)

1. Insurance Company Responsibility:
_____
2. Name of Insured:
_____
3. Claim or Policy #:
_____
4. Date of Accident:
_____

III. Workers Comp or Black Lung
(question 3)

1. Insurance Company:
_____
2. Claim # or Policy #:
_____
3. Name of Employer:
_____
4. Employer Location:
_____

IV. VA Certification # or Governmental Agency Name (question 5)
_____
Retirement date of patient/beneficiary:_____
Retirement date of spouse: _____

*Please have this information transferred to the UB92 when billing Medicare