

# MEDIGAP AUTHORIZATION FORM

I hereby authorize payment of my Medigap benefits to

\_\_\_\_\_  
Doctor/Supplier

for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

**BENEFICIARY SIGNATURE:**

\_\_\_\_\_

**MEDICARE NUMBER:**

\_\_\_\_\_

**MEDIGAP INSURER:**

\_\_\_\_\_

**ADDRESS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**TELEPHONE NUMBER:**

\_\_\_\_\_

37-122 5/91

# MEDICARE SECONDARY PAYER QUESTIONNAIRE

(To be completed for ALL Medicare Patients)

Name: \_\_\_\_\_ IDX Account No. \_\_\_\_\_

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

To our Medicare patients:

Medicare requires us, as your healthcare provider, to determine if any other insurance should be primary to Medicare (responsible before Medicare). The following questionnaire was developed by Medicare and must be answered by the patient or appropriate family member.

Thank you for helping us to comply with Medicare requirements.

	YES	NO
1. Is the patient a Veteran?	_____	_____
a. Did the VA refer you here for treatment?	_____	_____
b. Does the patient have a VA "fee basis ID Card"?	_____	_____
<b>(If "YES", Section #1 must be completed on Page 2)</b>		
2. Do you have a Federal Black Lung card?	_____	_____
<b>(If "YES", Section #2 must be completed on Page 2)</b>		
3. Is this medical condition due to an accident of any kind?	_____	_____
If yes, was it: Work related      Auto      Injured in own home      Other		
<b>(If "YES", Section #3 must be completed on Page 2 and Page 3)</b>		
4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (Not retiree coverage)	_____	_____
<b>(If "YES", Section #4 must be completed on Page 4)</b>		
5. Is the patient retired?	_____	_____
<b>(If "Yes", please provide retirement date. _____ / _____ / _____)</b>		

\_\_\_\_\_  
Signature of Patient (or family member completing questionnaire)