Stones River Dermatology, PLC
Medicare Questionnaire

This Medicare Questionnaire contains additional questions regarding your Medicare insurance and benefits. Please answer these questions to help us in your care here at Stones River Dermatology, PLC.

Have your recently joined a Medicare HMO? YES NO

If yes, please identify ________________________________

Do you or your spouse have coverage through employment? YES NO

Are you covered by another insurance with Medicare as secondary? YES NO

If yes, please identify ________________________________

Are you eligible for Veteran's Administration benefits? YES NO

Are you covered by the End Stage Renal Disease Program? YES NO

Are your skin problems related to an automobile accident? YES NO

Are your skin problems related to an injury at work? YES NO

Do you receive Medicaid (TennCare)? YES NO

Did your physician make this appointment for you? YES NO

If yes, please identify ________________________________

Do you have Tricare for Life? YES NO

If yes, please identify the sponsor below:

Sponsor name _____________________________________

Sponsor ID number __________________________________

Please read and sign the following statement authorizing Stones River Dermatology to file claims to Medicare on your behalf and release protected medical information to Medicare and your insurance company for proper billing purposes. We need your signature on file to process your claims to Medicare.

I authorize Stones River Dermatology, PLC, to release medical or other information to the Social Security Administration and Health Care Financing Administration or its intermediaries and subcontractors any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request payments of medical insurance benefits to Stones River Dermatology for medical services rendered to me. I understand regulations pertaining to Medicare assignment of benefits will apply.

Signature ____ **Date** ______________________

If you have supplemental insurance (MEDIGAP), please read and sign this statement authorizing Stones River Dermatology to file claims to the supplemental MEDIGAP policy. We need your second signature on file to process your claims to MEDIGAP/supplemental insurance policies.

I request authorized MEDIGAP benefits be paid on my behalf for any services performed by Stones River Dermatology, PLC. I also authorize the release of any medical or other information to MEDIGAP/ supplemental insurance to support payment of benefits.

Signature ____ **Date** ______________________