Platte Valley Medical Clinic, P.C.
MSP Screening Questionnaire

PATIENT'S NAME ______________________________

MEDICARE# __________________________________

1. Are you covered by Veterans Administration, Black Lung Program or Worker's Compensation? ( ) Yes ( ) No

2. Is this illness or injury due to any type of accident? ( ) Yes ( ) No

3. Are you age 65 or older and employed, or is your spouse employed at this time? ( ) Yes ( ) No

4. Are you age 65 or older and employed by any Employer Group Health Plan or another large Group Health Plan? ( ) Yes ( ) No

Authorization Statement and Payment Agreement

I declare under penalty of perjury that I do not have another primary insurance carrier to pay for medical care rendered to me by the Platte Valley Medical Clinic, P.C. and that all information with regard to residence, employment, and income is correct to the best of my knowledge.

I request that payment of authorized Medicare benefits be made to this facility for any services furnished to me by it medical provider.

I understand that my signature requests that payment be made and that it authorizes release of medical information necessary to pay the claims (s). If a secondary insurance carrier is involved, my signature also authorizes releasing information to the insurer or agency shown.

In Medicare assigned cases, the medical provider agrees to accept the charge determined by the Medicare carrier as full charge, and the patient is responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determined by the Medicare carrier.

______________________________ ____________

Signature – Patient/Authorized Rep Date

______________________________ ____________

Witnessed by Date