noridian
Healthcare Solutions

Coverage Screening Checklist

1. **Do you have any medical coverage other than Medicare?**
    - **Work insurance**
    - **Disability**
    - **Group Health Plan**
    - **No-fault**
    - **Worker's Comp**
    - **Spousal coverage**
    - **Liability**
    - **VA**

☐ **Yes**	Enter Company or Plan name: ____ Company or Plan phone number: __(_____)________________________
☐ **No**	Go to Question 2

2. **Are you currently enrolled/covered by a Health Maintenance Organization (HMO), Managed Care Organization, Medicare Advantage, or Part C plan?**

☐ **Yes**	Enter Company or Plan name: ____ Company or Plan phone number: __(_____)________________________
☐ **No**	Go to Question 3

3. **Do you currently reside in a nursing facility?**

☐ **Yes**	Enter Nursing Facility name: ____ Nursing Facility phone number: __(_____)________________________
	Are you receiving skilled care? ☐ Yes ☐ No
☐ **No**	Go to Question 4

4. Have you been admitted to the hospital or any other type of healthcare facility in the past 24 hours?

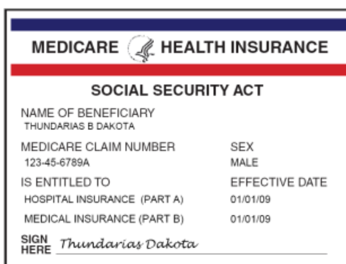
☐ **Yes**	Enter Healthcare Facility name: ______________________________ Facility phone number: __(_____)______________________________
☐ **No**	Go to Question 5

5. Do you currently receive any home health care?

☐ **Yes**	Enter Home Health provider name: ______________________________ Home Health phone number: __(_____)______________________________
☐ **No**	Go to Question 6

6. Are you currently under a hospice plan of care?

☐ **Yes**	Enter Hospice name: ______________________________ Hospice phone number: __(_____)______________________________
☐ **No**	Form is now complete



Please present your red, white and blue Medicare card with this form.