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?

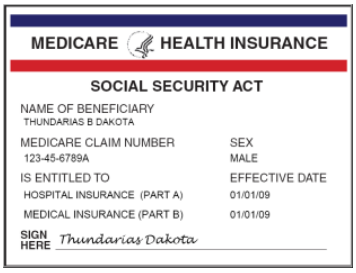
☐ **Yes**	Enter Healthcare Facility name: _____ Facility phone number: __(_____)_____
☐ **No**	Go to Question 5

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


MEDICARE HEALTH INSURANCE

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
THUNDARIAS B DAKOTA

MEDICARE CLAIM NUMBER
123-45-6789A

SEX
MALE

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL INSURANCE (PART A) 01/01/09

MEDICAL INSURANCE (PART B) 01/01/09

SIGN HERE Thundarias Dakota

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