Arch Health Partners

Patient Name: _____
DOB: _____
MRN: _____

Center for Physical Therapy and Exercise

Determination of Primary Insurance when Patient is Entitled to Medicare Part B

Medicare wants to know which ONE statement is true for YOU:

I am **OVER** 65, married, and:

1. ☐ My spouse and I are both fully retired. — Medicare is primary for me.
2. ☐ I work full or part-time (my spouse is retired) for a company with:
   a. ☐ LESS than 20 employees. — Medicare is primary for me.
   b. ☐ MORE than 20 employees. — Medicare is secondary for me.
3. ☐ My spouse works full or part-time (I am retired) for a company with:
   a. ☐ LESS than 20 employees. — Medicare is primary for me.
   b. ☐ MORE than 20 employees. — Medicare is secondary for me.

I am **OVER** 65, not married (includes widowed), and:

4. ☐ I am fully retired. — Medicare is primary for me.
5. ☐ I work full or part-time for a company with:
   a. ☐ LESS than 20 employees. — Medicare is primary for me.
   b. ☐ MORE than 20 employees. — Medicare is secondary for me.

I am **UNDER** 65, **DISABLED**, and:

6. ☐ I (have / do not have) health care coverage through a LGHP with an employer who has 100 or more employees.

7. ☐ I (have / do not have) health insurance coverage through anyone else.

Check any Additional Conditions:

8. ☐ I have End Stage Renal Disease. — Medicare is secondary for me.
9. ☐ I am entitled to Black Lung Benefits. — Medicare is secondary for me.
10. ☐ I am entitled to Veteran's Adm. Benefits. — Medicare is secondary for me.
11. ☐ COBRA Benefits apply. — Medicare is secondary for me.
12. ☐ I was injured in an accident. — Medicare is secondary for me.
    Type of Accident: ☐ Auto ☐ Work Related ☐ Other
    Date of Accident _____ Description _____
    _____

If none of the above describes your situation, please explain:

_____
_____

_____ _____ _____
Print Name of Beneficiary/Patient Date Signature of Beneficiary/Patient