Insurance Eligibility Questionnaire

To help our office determine who is responsible for coverage of your medical expenses, please circle **YES** or **NO** beside each of the following questions and fill in additional information in the blanks provided where you have circled **YES**.

1. Is your injury/illness due to:

   A work related accident or condition? **YES** **NO**

   A condition covered under the Federal Black Lung Program? **YES** **NO**

   An automobile accident? **YES** **NO**

   An accident other than an automobile accident? **YES** **NO**

   What were the circumstances of the condition/injury?____

   ____

   The fault of another party? **YES** **NO**

   What were the circumstances of the condition/injury?____

   ____

2. Are you eligible for coverage under the Veteran's Administration? **YES** **NO**

3. Are you eligible for coverage under the United Mine Workers or American (UMWA)? **YES** **NO**

4. Are you employed? **YES** **NO**

   Do you have coverage under an Employer Group Health Insurance? **YES** **NO**

5. Is your spouse employed? **YES** **NO**

   Do you have coverage under your spouse's Employer Group Health Insurance? **YES** **NO**

1. Are you a dependent covered under a parent's / guardian's Employer Group Health Insurance? **YES** **NO**

Signature:____

Date:______/____________/________

Thank You.

- Original to Chart
- Copy to Billing Department

MEDICARE

LIFETIME AUTHORIZATION DATE____________________________

Northwest Gastroenterology Associates	
PHYSICIAN/SUPPLIER	PATIENT'S NAME
1135 116th Avenue NE Suite 560	
STREET	HEALTH INSURANCE CARRIER
Bellevue, WA 98004	
CITY & ZIP	PATIENT'S STREET ADDRESS
PATIENT'S ACCOUNT NUMBER	PATIENT'S CITY/STATE/ZIP CODE

I request that payment of authorized M E D I C A R E benefits be made either to me or on my behalf to Dr. ____ for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for related services.

____

SIGNATURE (See #1 & #2 below)

TO BE VALID THE LIFETIME AUTHORIZATION MUST BE PROPERLY SIGNED

LIFETIME AUTHORIZATION

1.) The patient, if physically and mentally competent, must sign on his own behalf. If he cannot sign for himself, a representative payee as designated by the Social Security Administration, or a legally appointed guardian may sign. The source of the signatory's authority should be stated, e.g., social security appointed representative payee, court appointed guardian, etc.

2.) This form, is used in lieu of the patient's signature on the "Request for Payment" form HCFA 1500 and is therefore, an extension of that form. Anyone who misrepresents or falsifies essential information in making MEDICARE claims, may, upon conviction, be subjected to fine and imprisonment under Federal Law.