

(Medicare recipients only)

Provider Name: WESTARM Therapy Provider #: 396548

NAME: \_\_\_\_\_ Medicare # \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

1. Have you received any nursing or therapy services in your home within the past 90 days? Yes / No  
If yes, name of agency: \_\_\_\_\_ Telephone # \_\_\_\_\_

2. Are you or your spouse employed & covered by a group health plan? Yes / No  
A. Does the employer employ 20 or more employees? Yes / No  
Give approximate number of employees: \_\_\_\_\_  
B. If retired, list retirement date: Patient \_\_\_\_\_ Spouse \_\_\_\_\_

3. Is the patient under the age of 65? Yes / No  
A. Is the Medicare entitlement due to:  
1. ESRD Yes / No  
If yes, 1<sup>st</sup> date of dialysis treatment. \_\_\_\_\_  
Date of kidney transplant \_\_\_\_\_  
2. Disability Yes / No  
If yes, are you considered an active employee? Yes / No  
B. Are you covered through a spouse's or other family members employer group health plan? Yes / No

4. Was the illness/injury due to a work-related accident/condition? Yes / No  
Date of accident \_\_\_\_\_

5. Do you have coverage through VA? \_\_\_\_\_ Black Lung? \_\_\_\_\_  
Federal/State Agency (not including Medicaid, Medical Assistance, Welfare) \_\_\_\_\_

6. Briefly describe the reason for your visit to this facility:  
\_\_\_\_\_  
\_\_\_\_\_

IF YOU HAVE ANSWERED **YES** TO ANY OF THE ABOVE QUESTIONS PLEASE CONTINUE BELOW.

Name of Working Person \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_ Claim # \_\_\_\_\_ SS # \_\_\_\_\_

Name of Insurance Involved:  
Employer Group Health \_\_\_\_\_  
Workman's Compensation \_\_\_\_\_  
Automobile \_\_\_\_\_  
Black Lung \_\_\_\_\_  
VA \_\_\_\_\_  
Other \_\_\_\_\_

I HAVE COMPLETED THIS FORM TO THE BEST OF MY ABILITY, I AUTHORIZE WESTARM THERAPY TO BILL THE INSURANCE INDICATED ABOVE AS MY PRIMARY CARRIER.

Signature of Patient/Representative \_\_\_\_\_

Date \_\_\_\_\_