Insurance Information

Please provide all health insurance on this form even if the policy is not primary. The completed form can be sent to PPHPC Finance Department by email to finance@pikespeakhospice.org or by fax to 719.457.8144. **Please include both sides when faxing or emailing.**

Patient Name: _____ Date:_____

Patient SS#:_____ DOB: _____

I currently do not have health insurance. _____

I would like assistance in applying for Medicaid or other benefits. _____

I have applied for Medicaid, and my application is *Pending* ____ *Denied* _____ *Not Sure* _____

Medicare #: _____ Medicaid #: _____

Insurance Company: _____

Benefits Telephone Number for Providers (if available): _____

Policy #:_____Group #: _____

Is this policy a Medicare Advantage, supplement, or replacement policy? Yes ____ No ____

If yes, please make sure you provided your original Medicare number on this form. We will not be able to bill without the original Medicare number.

2nd Insurance Company: _____

Benefits Telephone Number for Providers (if available): _____

Policy #:_____Group #: _____

Is this policy a Medicare Advantage, supplement, or replacement policy? Yes ____ No ____

If yes, please make sure you provided your original Medicare number on this form. We will not be able to bill without the original Medicare number.

Completed by (please print): _____

Contact information (Phone #):_____

I understand that I must contact the Pikes Peak Hospice & Palliative Care Finance Department at 719.633.3400 if there are any changes to the insurance information on this form, including policy cancellations or additions, prior to the effective date of the change.

Signature of person completing this form: _____

(**Please complete questions on reverse side if you have Medicare, a Medicare Advantage Plan, Medicare supplement or replacement policy, or if you may qualify for Medicare)**

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Medicare Secondary Payor Questionnaire

1) Are you or your spouse currently employed? Yes No
   - If yes: Are you covered by a group health insurance plan through that employment? Yes No

2) Is your need for services related to a work injury or illness? Yes No
   - If yes: Is your care being covered by a workers comp claim or insurance claim? Yes No

3) Is your need for service related to a Motor vehicle accident? Yes No
   - If yes: Is your care being covered by an insurance claim? Yes No

4) Are you entitled to Black Lung Benefits? Yes No

5) Are you entitled to Medicare solely because of SSA Disability? Yes No

6) Are you entitled to Medicare solely because of End Stage Renal Disease? Yes No

7) Are you enrolled in the VA Fee Basis Program? Yes No

If you answered "NO" to all questions above then Medicare may be your primary payor.

If you answered "YES" to any of the questions above then Medicare may be a secondary payor.

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