

# AMBULATORY EEG RECORDINGS, LLC

## Medicare Information Addendum

(To be completed with the Registration Form)

### PATIENT MEDICARE INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Do you have any group health plan coverage based upon your current employment?

Yes            No

Do you have any group health plan coverage based upon your former employment?

Yes            No

Do you have any group health plan coverage based on your spouse's or another family member's current employment?

Yes            No

Do you have any group health plan coverage based upon your spouse's or another family member's former employment?

Yes            No

Are you receiving Black Lung benefits?

Yes            No

Are you receiving Worker's Compensation benefits?

Are you receiving treatment for an injury or illness for which another party could be held liable or is covered under automobile no-fault insurance?

Yes            No

Signature \_\_\_\_\_ Date

Patient or Guardian