Dear Patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Physician Care - Madison for your primary medical care and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website should help answer any questions about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please call the office to schedule your new patient appointment prior to completing the New Patient Forms. Bring the completed forms with you on your appointment date, along with your identification cards, insurance cards, medication bottles, as well as your co-payments and/or deductibles.

We ask that all new patients arrive 30 minutes prior to your appointment time, so you can be seen by the doctor at your scheduled time.

If you are unable to keep your appointment for any reason or if you are going to be 15 minutes or more late, please call our office as soon as possible. We will be happy to reschedule a more convenient time for you.

Sincerely,

Sherry Fussell
Practice Administrator
Huntsville Hospital Physician Care - Madison
Patient information

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Referred by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>SS#</th>
<th>Sex</th>
<th>D.O.B.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email Address</th>
<th>Sex</th>
<th>D.O.B.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s Occupation</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer’s Address</th>
<th>Employer’s Phone</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse’s Name</th>
<th>Spouse’s D.O.B.</th>
<th>Spouse’s SS #</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse’s Occupation</th>
<th>Spouse’s Employer</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Employer’s Address</th>
<th>Employer’s Phone</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Notify in case of emergency</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

If patient is a minor, list persons other than responsible party above, who have permission to bring child to office for treatment:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Primary insurance to file

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Group #</th>
<th>Insured’s Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Insured’s SSN# or ID#</th>
<th>Insured’s Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Secondary insurance to file

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Group #</th>
<th>Insured’s Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Insured’s SSN# or ID#</th>
<th>Insured’s Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

PERSON RESPONSIBLE FOR THIS ACCOUNT

PHONE

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney’s fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH Physician Care concerning my illness, treatment and payments (including workmen’s compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature ___________________________ Date ___________________________ Time ___________________________
Appointment today with:

Khan  Katoch  McAdams
Hartwig  Prentice  Shrode
Southwood  Whitney

Date: _________________
Name: __________________________________________________ Date of birth: _____________ Age: ____________

What other doctors/specialists do you see? Name/Specialty: _________________________________________________
_____________________________________________________________________________________________________

Reason for visit: _______________________________________________________________________________________

Any new or worsening problems? If yes, please describe: ____________________________________________________
_____________________________________________________________________________________________________

**PAST MEDICAL HISTORY** *(Please check if you have any of the below.)*

- Asthma
- Atrial Fibrillation
- Anemia
- Anxiety
- Autoimmune Disease (Lupus)
- Biliary Cirrhosis
- Blood Transfusion
- Brain Tumor
- Cerebrovascular Disease (Stroke)
- Cirrhosis
- CVA/Stroke
- COPD (Lung Disease)
- Colon Cancer
- Coronary Heart Disease
- Crohn’s Disease
- Chronic Renal Failure
- Depression
- Diabetes - Juvenile Onset
- Diabetes - Adult Onset
- Diverticulitis
- DVT (Blood Clot in Legs)
- GI Bleed
- Gerd (Acid Reflux)
- Hemochromatosis
- High Blood Pressure
- High Cholesterol
- Hypothyroidism
- Hyperthyroidism
- Goiter
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Infertility
- Kidney Disease
- Kidney Stones
- Liver Disease
- MI (Heart Attack)
- Neurological Disorder
- Ostearthritis
- Osteoporosis
- PVD
- PUD (Stomach Ulcers)
- Rheumatoid Arthritis
- Seizure Disorder
- Thyroid Disorder
- Tuberculosis
- Valvular Heart Disease
- UTI - Recurrent
- Varicose Veins/Phlebitis
- Abnormal Pap Smear
- Breast Disease
- Breast Cancer
- Cervical Cancer
- Des Exposure
- Gestational Diabetes
- Rh Sensitized
- Sleep Apnea
- Using a CPAP?   Yes / No

**PAST SURGICAL HISTORY**

- Amputation
- AV Fistula Creation
- AV Graft
- Aortic Valve Replacement
- Aortic Valve Replaced
- Appendectomy
- Both Legs Bypassed
- Back Surgery
- Bronchoscopy (Lung Scope)
- CABG (Heart Bypass)
- Carotid Endarterectomy
- Colon Resection
- Craniotomy
- Gastric Bypass
- Hemorrhoidectomy
- Hip Replacement
- Invasive Pain Procedure
- Kidney Transplant
- Knee Arthroscopy
- Knee Replacement
- Kyphoplasty
- Lumpectomy
- Mastectomy
- Mitral Valve Replaced
- Nephrectomy
- Pacemaker Implanted
- Parathyroidectomy
- Pneumonectomy
- PTCA (Angioplasty)
- Rotator Cuff Repair
- ABD Hysterectomy
- Hysterectomy/Ovaries
- Ovaries Removed Yes / No
- Prostate Surgery
- Shoulder Surgery
- Sleep Apnea Surgery
- Thyroid Surgery
- Tonsil’s Removed
- Vascular Surgery
- Breast Augmentation Right / Left
- Mastectomy Right / Left
- Lumpectomy Right / Left

Other

Other
### FAMILY HISTORY

<table>
<thead>
<tr>
<th>Condition</th>
<th>Father</th>
<th>Mother</th>
<th>Brother</th>
<th>Sister</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Heart Artery Disease/Heart Attack</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kidney Disease (Chronic)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stroke</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Asthma</td>
<td>☐</td>
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<tr>
<td>Arthritis</td>
<td>☐</td>
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<tr>
<td>Thyroid Disorder</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Cancer (Type)</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

### SOCIAL HISTORY (Check or circle appropriate)

- Married ☐ Single ☐ Divorced ☐ Widowed ☐
- Work ☐ Part-Time ☐ Full-Time ☐ Retired ☐ Disabled ☐ Occupation: ____________________________
- Children: Yes / No ☐ Religious Affiliation: ____________________________

### ALLERGIES OR MEDICATION REACTIONS

- Allergic to: ____________________________
- Reaction: ____________________________

### RISK FACTORS (Check or circle appropriate)

- Current tobacco use ☐ Year started: __________
  - Caffeine Use: Yes / No
  - Type of tobacco: Cigarettes / Cigars / Snuff / Vapor
  - How many drinks per day: __________

- Former tobacco use ☐ Year quit: __________
  - Alcohol use: Yes / No
  - How many per day: __________
  - Type: __________

- Never smoked ☐
  - Second hand smoke: Yes / No
  - Exercise: Yes / No
  - Times per week: __________
  - Type: __________

- Do you wear a seat belt? Yes / No

### CURRENT MEDICATIONS (Refer to list or bottles)

Please include the dose and how often you take the medication.

(No need to list below if you brought a list or bottles)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>How many times per day?</th>
<th>As Needed (PRN)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Pharmacy Name: ____________________________ Phone #: ____________________________

Location: ____________________________
Patient name: ________________________________  DOB ____________________

**MEDICAL PROBLEMS** Have you had any recent or persistent problems with the following?

### General
- Weight Gain/Loss
- Diabetes
- Back Pain
- 

### Mouth
- Dentures
- Hoarseness
- Gums
- Last dental exam:

### Skin
- Rashes
- Nail/Hair Problems
- Abdominal moles
- 

### Heart
- Chest Pain
- Hypertension
- High Cholesterol
- Congestive Heart Failure
- Heart Murmur
- Palpitations
- Last EKG:

### Extremities
- Joint Pain
- Gout
- Varicose Veins
- Leg Swelling
- 

### Gastrointestinal
- Trouble Swallowing
- Reflux/GERD
- Vomiting
- Diarrhea
- Constipation
- Bloody/Black Stool
- Hemorrhoids
- Hepatitis
- Last Colonoscopy:

### Urinary
- Frequency
- Trouble starting or stopping
- Urinary pain
- Urinate at night
- Leakage
- Blood In Urine
- Kidney stones
- Infections
- Prostate trouble

### Neuro
- Headache
- Head injury
- Blackouts/Dizzy
- Seizures/Tremors
- Memory Loss
- Depression/Anxiety
- 

### ENT
- Allergies
- Sinus Trouble
- Glasses/Contacts
- Blurred Vision
- Ringing
- Last eye exam:

### Lungs
- Persistent Cough
- Cough Up Blood
- Emphysema/Bronchitis
- Shortness of Breath
- Pneumonia
- 

### Women
- Irregular Periods
- Pelvic Pain
- Birth Control Pills
- Nipple Discharge
- Lumps In Breasts
- Self Breast Exam
- 

### Extremities
- Joint Pain
- Gout
- Varicose Veins
- Leg Swelling
- 

### Gastrointestinal
- Trouble Swallowing
- Reflux/GERD
- Vomiting
- Diarrhea
- Constipation
- Bloody/Black Stool
- Hemorrhoids
- Hepatitis
- Last Colonoscopy:

### Urinary
- Frequency
- Trouble starting or stopping
- Urinary pain
- Urinate at night
- Leakage
- Blood In Urine
- Kidney stones
- Infections
- Prostate trouble

### Sexual
- Problems with sex
- Multiple Partners
- History Of Std
- HIV

Please enter the most recent date and results of the following:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date</th>
<th>Results</th>
<th>Performed by (who/where)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap Smear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone Density Scan</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Menstrual Period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSA (Prostate Screen)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When was your last vaccine on the following:

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Date</th>
<th>Would you like one?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu Vaccine</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>Tetanus Vaccine</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>Pneumonia Vaccine</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>Shingles Vaccine</td>
<td></td>
<td>Yes / No</td>
</tr>
</tbody>
</table>
Name of Organization/Person _______________________________________________________
Address  Adam ___________________________________________________________________
Fax/Phone  ________________________________________________________________

Huntsville Hospital Requests Information for the Following Patient:
Patient Name  ___________________________________________________________________
SS# (Optional) ___________________________ Date of Birth ____________________________
Address  Adam ___________________________________________________________________
Phone  ________________________________________________________________
Signature  ___________________________ Date of Service ____________________________

Patient Number  Adam

<table>
<thead>
<tr>
<th>Requested information for treatment, payment, or operations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Discharge Summary</td>
</tr>
<tr>
<td>□ History and Physical</td>
</tr>
<tr>
<td>□ Operative Note</td>
</tr>
<tr>
<td>□ Pathology Report</td>
</tr>
<tr>
<td>□ Consultation Report</td>
</tr>
<tr>
<td>□ EKG Report</td>
</tr>
<tr>
<td>□ Nurses’ Notes</td>
</tr>
<tr>
<td>□ Progress Notes</td>
</tr>
<tr>
<td>□ Physicians’ Orders</td>
</tr>
<tr>
<td>□ Outpatient Record</td>
</tr>
<tr>
<td>□ Emergency Dept Record</td>
</tr>
<tr>
<td>□ Laboratory Results</td>
</tr>
<tr>
<td>□ Imaging Results</td>
</tr>
<tr>
<td>□ Other _______________</td>
</tr>
</tbody>
</table>

Please send to:
Dr. Khan/
J. Southwood, CRNP
HH Physician Care
Madison
8371 Hwy 72 West,
Suite 104
Madison, AL 35758
(256) 265-5970
Fax: (256) 265-5969

Dr. McAdams/K. Shrode,
CRNP/S. Whitney, CRNP
HH Physician Care
Madison
8371 Hwy 72 West,
Suite 206
Madison, AL 35758
(256) 265-5640
Fax: (256) 265-5647

D. Hartwig, CRNP/
G. Prentice, CRNP
HH Physician Care
Madison
44 Hughes Road,
Suite 1200
Madison, AL 35758
(256) 265-5970
Fax: (256) 265-5971

Dr. Katoch
HH Physician Care
Madison
44 Hughes Road,
Suite 1300
Madison, AL 35758
(256) 265-5970
Fax: (256) 265-5974

Signature _____________________________________________ Date __________________

Relationship to Patient __________________________________________

Witness ____________________________________________________________

08/17

ROI32A
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name __________________________________________ SS Number (Optional)________________________________________
Date of Birth __________________________________________ Address  _________________________________________
Phone Number (_____)________________Date(s) of Service________________

I authorize the use or disclosure of the above named individual’s health information as described below:

1. Huntsville Hospital Physician’s Network is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows:  (include dates where appropriate)

- All /Entire Record
- Visit/Encounter Notes
- Laboratory Results
- X-Ray and Imaging Reports
- Problem list
- Medication List
- Allergies List
- EKG Report
- Pathology Report
- Consultation Report
- Operative Report
- Immunization Record
- Drug and Alcohol Treatment
- HIV/AIDS/STD Treatment
- Registration Record
- Other ________________________

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: _______________________________________________________________________________________________
   Address: _____________________________________________________________________________________________

5. For the purpose of ________________________________________________________________________________________

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _______________________________________________________________________________________________________

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

    Or
    I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
    Treatment Enrollment in the health plan
    Eligibility for benefits

SIGNATURE                                          DATE                                     TIME
_______________________________________________________ ____________________________      ____________     ____________
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE  OF WITNESS       DATE                 TIME

*For Office Use Only*

Any portion of the record request found in paper chart? YES NO (Please circle one)
Patient Name: __________________________    Patient DOB: __________________

Patient DOS: __________________________

Part I

1. Are you receiving Black Lung Benefits?
   □ No
   □ Yes – (Date Benefits began: ____________________) Black Lung is Primary Only for
     Claims Related to Black Lung

2. Are the services to be paid by the government program such as research grant?
   □ No
   □ Yes – Government Program will be Primary

3. Has the Department of Veterans Affairs authorized and agreed to pay for care at this
   facility?
   □ No
   □ Yes – Department of Veterans Affairs is Primary

4. Was the illness or injury due to work related accident or condition?
   □ No – Go to Part II
   □ Yes – (Date of Injury/Illness:_________________) Worker’s Comp is Primary Go to Part III

Part II

1. Was illness or injury due to non-work related accident?
   □ No – Go to Part III
   □ Yes – (Date of Accident:____________________)

2. What type of accident caused the illness or injury?
   □ Automobile – Motor Vehicle Insurance is Primary
   □ Non-Automobile – Go to question 3

3. Was another party responsible for this accident?
   □ No – Go to Part III
   □ Yes – Liability Insurance Carrier is Primary

Part III

1. Are you entitled to Medicare based on:
   □ Age – 65 and over – Go to Part IV
   □ Disability – Go to Part V
   □ Dialysis (End Stage Renal Disease) – Go to Part VI
Patient Name: ________________________________           Patient DOB: ______________________
Patient DOS: ________________________________

Part IV – Age

1. Are you currently employed?
   □ No (Date of Retirement: _________________)
   □ Never Worked
   □ Yes
   Employer Name: ____________________________________________
   Employer Address: _________________________________________

2. Is your spouse currently employed?
   □ No (Date of Retirement: _________________)
   □ Never Worked
   □ Yes
   Employer Name: ____________________________________________
   Employer Address: _________________________________________

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or a spouse’s current employment?
   □ No – Stop
   □ Yes – Go to Question 4

4. Does the employer that sponsors your Group Health Plan employ 20 or more employees?
   □ No – Stop
   □ Yes – Stop Group Health Plan is Primary

Part V – Disability

1. Are you currently employed?
   □ No (Date of Retirement: ______________________)
   □ Yes
   Employer Name: ____________________________________________
   Employer Address: _________________________________________

2. Is a family member currently employed?
   □ No
   □ Yes
   Employer Name: ____________________________________________
   Employer Address: _________________________________________

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or family member’s current employment?
   □ No – Stop
   □ Yes – Go to Question 4

4. Does the employer that sponsors the Group Health Plan employ 100 or more employees?
   □ No – Stop Medicare is Primary
   □ Yes – Stop Group Health Plan is Primary
Part VI – Dialysis (End Stage Renal Disease)

1. Do you have Group Health Plan coverage?
   □ No – Stop Medicare is Primary
   □ Yes
     Employer Name: ________________________________
     Employer Address: ______________________________

2. Have you received a kidney transplant?
   □ No
   □ Yes (Date of Transplant: ______________________)

3. Have you received maintenance dialysis treatments?
   □ No
   □ Yes (Date Dialysis Began: _____________________)
     If you participated in a self dialysis training program provide date training started: ______________________

4. Are you within 30 month coordination period?
   □ No – Stop Medicare is Primary
   □ Yes

5. Are you entitled to Medicare on the basis of either End Stage Renal Disease and age or End Stage Renal Disease and Disability?
   □ No – Stop Group Health Plan is Primary During the 30 Month Coordination Period
   □ Yes

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on End Stage Renal Disease?
   □ No – Initial entitlement based on age or disability
   □ Yes – Stop Group Health Plan Continues to Pay Primary During 30 Month Coordination Period

7. Does the working aged or disability Medicare Secondary Payer apply (i.e. is the Group Health Plan primary based on age or disability entitlement)?
   □ No – Medicare Continues to Pay Primary
   □ Yes – Group Health Plan Continues To Pay Primary During 30 Month Coordination Period