

Patient Name: \_\_\_\_\_ Patient ID #: \_\_\_\_\_

**MEDICARE PATIENT HISTORY**

**If Medicare eligible you must answer all the following questions.**

1. Are you enrolled in a Medicare HMO (ex. Medicare Complete/Advantra)? Yes/No  
If yes: Medicare HMO ID# \_\_\_\_\_ Group # \_\_\_\_\_  
If no: Medicare ID# \_\_\_\_\_
2. In the last year have you resided in another state? Yes/No  
If yes: what state \_\_\_\_\_
3. Are you or your spouse currently employed? Yes/No
4. Do you carry insurance through that employer? Yes/No
5. If yes: Name of Insurance \_\_\_\_\_ ID# \_\_\_\_\_

**Are you a diabetic?** Yes/No \_\_\_\_\_

**Are you insulin dependent?** Yes/No \_\_\_\_\_

**Do you have a history of any of the following symptoms (circle all that apply):** amputation, foot ulcerations, pre-ulcerative callus, peripheral neuropathy, foot deformity or poor circulation

**Name & phone # of diabetic doctor:** \_\_\_\_\_

**Have you ever received similar supplies/equipment?** Yes/No \_\_\_\_\_

If yes, what item are we replacing \_\_\_\_\_

If yes, why being replaced \_\_\_\_\_

If yes, who was it purchased from \_\_\_\_\_

If yes, date of purchase \_\_\_\_\_

If yes, name of insurance carrier billed \_\_\_\_\_

**If patient answered yes or is unsure to above need to check the 3/5 yr rule and obtain signed ABN waiver.**

**By checking this box and signing below, I acknowledge receiving a copy of the Medicare Supplier Standards.**

**Patient Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_