MEDICARE SECONDARY PAYER QUESTIONNAIRE

Place
Patient Identification
Label Here

1. **Is the patient receiving Black Lung benefits**? Yes No Date Began:______________
2. **Are these services covered by a government program such as a research grant?** Yes No
3. **Has the Department of Veteran Affairs authorized and agreed to pay for these services?** Yes No
4. **Is this illness/injury accident related?** Yes No If yes, complete the accident information below
   Type of accident: ☐ Auto ☐ Crime ☐ Employment ☐ Other
   Accident Date:_______ Accident Time: _________ Place/Location of Accident: ______________________
   Description of Accident: ____
5. **Was the illness/injury due to a work-related accident/condition?** Yes No
   If , yes: Please complete questions sections
   Worker's Comp Employer: _____________________ Worker's Comp Insurance:_________________________
   Worker's Comp Policy #: ______________________ Claim's Address:_________________________________
6. **Did an automobile accident cause the illness/injury?** Yes No
   If , yes: Please complete sections below
   No-Fault/Liability Insurance Name: ___________________________ Policy #: __________________________
   Name of Insured:____________________________ Claim's Address: ___________________________________
7. **Is the Patient entitled to Medicare based on (A)ge, (D)isability, or (E)SRD-End Stage Renal Disease**? _________
   If Medicare is based on ESRD entitlement, complete questions below:
   Has the patient received a kidney transplant? Yes No Transplant Date:______________________
   Has the patient received dialysis: Yes No Date Started: _____________________
   Date Self Dialysis Training Program Started:______________________
   Is the patient within the 30-month coordination period? Yes No
   Is patient entitled to Medicare based on ESRD and Age or ESRD and Disability? Yes No
   Was the patient's initial entitlement to Medicare based on ESRD? Yes No
   Does the working aged or disability MSP provision apply? Yes No
8. **Is the patient currently employed?** Yes No
   Employer Name: ____
   Employer Address: ____
9. **Is the patient retired?** Yes No Retired Date ______________
10. **Patient's spousal information:** Married/Separated Divorced/Widowed/Single
    If Married or Separated, complete the sections below
    Is patient's spouse/family member currently employed? Yes No
    Spouse's/Family member's Employer Name: _________________________
    Employer Address: ____
    ____

    If Retired, Retirement date:____

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11. **Does patient have group health plan coverage based on his own, or spouse's current employment**? Yes No
    Group Health Plan Name: ____
    Policy Number: ____
    Policy Holder: _____________ Group#:_______________ Relative: _________________________

12. **If Entitlement is based on Age, (per question #7)**
    Does the group health plan employer employ 20 or more employees? Yes No

13. **If Entitlement is based on Disability, (per question #7)**
    Does the group health plan employer employ 100 or more employees? Yes No

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____ _____________________

Patient's /Auth Rep. Signature Date

Document date patient information was verified and updated.

Signature (employee)	Date	Signature (employee)	Date