Medicare Secondary Payer Questionnaire

Patient Name:_____ Date:_____

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions:

1. Is your injury/illness due to:

____ No ____Yes A work-related accident/condition?
____ No ____ Yes Condition covered under the Federal Black Lung Program?
____ No ____ Yes An Automobile accident?
____ No ____ Yes An accident other than an automobile accident?
____ No ____ Yes The fault of another party?

If your answer is "yes" to any of the above please provide us with the following info:

Name of insurance or liability insurer _____ Policy, ID # or claim #: _____

Accident date: _____ Accident location: _____

2. Are you entitled to Medicare based on:

_____ Age _____ Disability _____End stage renal disease

3. _____ No _____ Yes Are you currently employed?
_____ No _____ Yes Is your spouse currently employed?
_____ No _____ Yes Are you covered under your spouse's Employer group health?
_____ No _____ Yes Are you a dependent covered under a parent/guardian employer group health plan?
_____ No _____ Yes Are services to be paid by a government research Program?

If your answer is "yes" to any of the above please provide us with the following info:

Employer or Insurer name and address _____

Policy # _____ Group # _____

Does your employer or spouse's employer employ 20 or more employees? Yes / No

Does your employer or spouse's employer employ 100 or more employees? Yes / No

4. Are you eligible for coverage under the Veteran Administration? Yes / No
5. _____ No _____ Yes Have you received a kidney transplant?
_____ No _____ Yes Have you received maintenance dialysis treatments?
_____ No _____ Yes Are you within the 30-month coordination period?

If your answer is "yes" to any of the above please provide us with the following info:

Date of transplant or date dialysis began: _____

_____ _____

Patient or Patient's Agent Date