

Medicare Secondary Payer Questionnaire

To be completed for all Medicare patients

Last Name _____ First Name _____ M.I. _____
Appointment Date _____ Location _____
YYYY-MM-DD

PART I

Are you receiving Black Lung (BL) Benefits? Yes No

· If yes, you can **STOP NOW**. BL will pay primary benefits for these services.

Please provide date benefits began: _____

Are the services to be paid by a government program such as a research grant? Yes No

· If yes, you can **STOP NOW**. The government program will pay primary benefits for these services.

Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? Yes No

· If yes, you can **STOP NOW**. DVA will pay primary benefits for these services.

Was the illness or injury due to a work-related accident or condition? Yes No

· If yes, you will need to fill out **Part III** at your appointment check-in. This form is not available online.

Was the illness or injury due to a non-work related accident? Yes No

· If yes, you will need to fill out **Part IV** at your appointment check-in. This form is not available online.

Are you entitled to Medicare based on:

- Age - Please continue to **Part II**.
- Disability - You will need to fill out **Part V** at your appointment check-in. This form is not available online.
- ESRD - You will need to fill out **Part IV** at your appointment check-in. This form is not available online.

Are you receiving any of the following?

Skilled Nursing Services..... Yes No

Hospice Care..... Yes No

Home Health Service..... Yes No

· If you answered Yes to any of the above, we will require the following information about your service provider:

Name: _____


Address: _____

Phone: _____

If you do not need to proceed to Part II, you can submit your form now.

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 Save

 Submit

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PART II - AGE

Are you currently employed? Yes No

· If yes, please provide the following information about your employer:

Name: _____

Address: _____

· If you are retired, please provide date of retirement: _____

Is your spouse currently employed? Yes No

· If yes, please provide the following information about your spouse's employer:

Name: _____

Address: _____

· If your spouse is retired, please provide date of retirement: _____

If you answered No to both of the above questions, do not proceed any further.
Medicare is the primary, unless you answered Yes to questions in Part I.

Do you have group health plan (GHP) coverage based on your own, or your spouse's current employment? Yes No

· If no, do not proceed further. Medicare is the primary, unless you answered Yes to questions in Part I.

Does the employer that sponsors your GHP employ 20 or more people? Yes No

· If yes, do not proceed further. Group Health Plan is primary.


Please obtain the following information about your GHP:


Name: _____

Address: _____

· If no, do not proceed further. Medicare is the primary, unless you answered Yes to questions in Part I.

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