MEDICARE SECONDARY PAYER QUESTIONAIRE

There may be situations where Medicare is not your primary payer or Medicare coverage policies vary.
Medicare law requires that we investigate all possible situations where other insurance, besides Medicare, might be the primary payer.
We appreciate your help by completing this questionnaire.

Patient Name: ____ Account #: ____________________

Responses **Section I**

_ Yes _ No **1**. Are you currently receiving ***any*** Home Health Services *(including nursing, bathing or dressing assistance, injections or respiratory services)?*

_ Yes _ No **2**. Are you covered under a Medicare Part C (Medicare Advantage/ Medicare+Choice) program?
If YES, enter the name of the health plan: __________________________

_ Yes _ No **3**. Was your illness or injury due to a ***work-related*** accident or condition?
If YES, enter the date of the illness or injury: ________________________

_ Yes _ NO **4**. Was your illness or injury due to a ***non-work-related*** accident?
If YES, enter the date of illness or injury: ___________________________
If no-fault, auto, or liability insurance is available, enter information in Section II.

_ Yes _ NO **5**. If you are entitled to Medicare based upon ***Age*** or ***Disability***, are you currently employed?
__ Never Employed
If YES, provide your employer's information on the *Patient Registration.*
If NO, enter your retirement date: ________________________________

_ YES _ NO **6**. Do you have a spouse who is currently employed?
If YES, provide your spouse's employer's information on the *Patient Registration.*
__ Never Employed
If NO, enter your spouse's retirement date: _________________________

_ YES _ NO **7**. Do you have group health plan coverage based upon ***your own*** or ***your spouse's*** employment?
If YES, enter your and/ or your spouse's group health Plan information in Section II.

_ YES _ NO **8**. Are you entitled to Medicare due to ***End Stage Renal Disease (ESRD)?***
If YES, enter date of the kidney transplant: ______________________ __ No transplant
If YES, enter the date that Dialysis began: _______________________ __ No Dialysis

_ YES _ NO **9**. Are you receiving ***Black Lung (BL) benefits?***
If YES, enter the date that benefits began: _____________________

Section II **(Please provide us with your insurance card.)**

Type of Insurance Coverage: ___ Workers Compensation ___ No-fault, Auto or Liability ___ Group Health Plan

Insurance Name ____
Street Address ____
City, State, Zip ____
Phone Number ____
Policy Number ____
Group Number ____
Name of Policy Holder ____

If Group Health Plan, approximate number of employees: ___ 1-19 ___ 20-99 ___ 100 or more

I certify that all of the information provided herein is true and correct.

X____ _________________________
Signature of Patient/Representative **Date**