MEDICARE SECONDARY PAYER QUESTIONNAIRE

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 <u>any</u> 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 <u>work-related</u> accident or condition?
If YES, enter the date of illness or injury: _____
Provide the name of your employer on the Patient Registration Form.

☐ Yes ☐ No 4. Was your illness or injury due to a <u>non-work-related</u> 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?
If YES, provide your employer's information on the Patient Registration form.
If NO, enter your retirement date: _____ ☐ Never Employed

☐ 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 form.
If NO, enter your spouse's retirement date: _____ ☐ Never Employed

☐ 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 the date of the kidney transplant: _____ ☐ No Transplant
If YES, enter date that dialysis began: _____ ☐ No Dialysis

☐ Yes ☐ No 9. Are you receiving Black Lung (BL) Benefits?
If YES, enter date 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.

_____ _____
Signature of Patient/Representative **Date**

Effective 1/1/08