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 Employer group health?
_____ No	_____ Yes	Are you a dependant 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 & 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? ____ No____ Yes

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: _____