

PT#: _____ - _____ MR#: _____ __/__/__

MEDICARE SECONDARY PAYER QUESTIONNAIRE

PART 1 - BL, VA, WC.

1. Are you receiving Black Lung (BL) Benefits?

_ Yes; Date benefits began: __/__/____ _ No.

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL

2. Are the services to be paid by a government program such as a research grant?

_ Yes; Government Program will pay primary benefits for these services.
_ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for at this facility?

_ Yes; DVA IS PRIMARY FOR THESE SERVICES. _ No.

4. Was the illness/injury due to a work related accident/condition?

_ Yes; Date of injury/illness: __/__/____ _ No; GO TO PART 2.

Name and address of WC plan: _____

Policy or identification number: _____

Name and address of your employer: _____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART 3.

PART 2 - NON WORK RELATED ACCIDENT.

1. Was illness/injury due to a nonwork related accident?

_ Yes; Date of accident: __/__/____ _ No; GO TO PART 3.

2. What type of accident caused the illness/injury?

_ Automobile _ Non-Automobile _ Other

Name and address of no-fault or liability insurer:

Insurance claim number: _____

NO FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART 3.

3. Was another party responsible for this accident?

_ Yes; Name and address of any liability insurer. _ No; GO TO PART 3.

Insurance claim number: _____

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT GO TO PART 3.

PART 3

1. Are you entitled to Medicare based on?

_ Age; Go to part 4. _ Disability; Go to Part 5. _ ESRD; Go to Part 6.

COMPLETED BY: _____ __/__/__

VERIFIED BY: _____ __/__/__

REVISED BY: _____ __/__/__

Verification Comments:

PT#: _____ - _____ MR#: _____ /____/____

MEDICARE SECONDARY PAYER QUESTIONNAIRE

PART 4 - AGE

1. Are you currently employed?

Yes; Name and address of your employer: _____

No; Date of retirement: ____/____/____ No; Never employed

2. Is your spouse currently employed?

Yes; Name and address of spouse's employer:

No; Date of retirement: ____/____/____ No; Never employed

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLE THE PATIENT ANSWERED YES TO QUESTIONS IN PART 1 (BL,VA,WC) OR PART 2 (NON WORK RELATED ACCIDENT) DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

Yes.

No; STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART 1 (BL,VA,WC) OR PART 2 (NON WORK RELATED ACCIDENT).

4. Does the employer that sponsors your GHP employ 20 or more employees?

Yes; STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING:

Name and address of GHP: _____

Policy identification number: _____

Group identification number: _____

Name of policy holder/named insured: _____

Relationship to patient: _____

Membership number: _____

No; STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART 1 (BL,VA,WC) OR PART 2 (NON WORK RELATED ACCIDENT).

PT#: _____ - _____ MR#: _____ /____/____

MEDICARE SECONDARY PAYER QUESTIONNAIRE

PART 5 - DISABILITY

1. Are you currently employed?

Yes; No; Date of retirement: ____/____/____ No; Never employed.
Name and address of your employer:

2. Is a family member currently employed?

Yes; No; Date of retirement: ____/____/____ No; Never employed.

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART 1 (BL,VA,WC) OR PART 2 (NON WC). DO NOT PROCEED ANY FURTHER.

3. Do you have a group health plan (GHP) coverage based on your own, or a family member's current employment?

Yes.
 No; STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART 1 (BL,VA,WC) OR PART 2 (NON WORK RELATED ACCIDENT).

4. Are you covered under the group health plan of a family member other than your spouse?

Yes; No.
Name and address of family member's employer:

5. Does the employer that sponsors your GHP, employ 100 or more employees?

Yes; STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION:

Name and address of GHP: _____

Policy identification number: _____

Group identification number: _____

Name of policy holder/named insured: _____

Relationship to the patient: _____

Membership number: _____

No; STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART 1 (BL,VA,WC) OR PART 2 (NON WORK RELATED ACCIDENT).

PT#: _____ - _____ MR#: _____ __/__/__

MEDICARE SECONDARY PAYER QUESTIONNAIRE

PART 6 - ESRD.

1. Do you have group health plan (GHP) coverage?

Yes;

Name and address of GHP: _____

Policy identification number: _____

Group identification number: _____

Name of policy holder/named insured: _____

Membership number: _____

Relationship to the patient: _____

No; STOP. MEDICARE IS PRIMARY.

Name and address of employer, if any, from which you receive GHP coverage:

2. Have you received a kidney transplant?

Yes; Date of transplant: __/__/____ No.

3. Have you received maintenance dialysis treatments?

Yes; Date dialysis began: __/__/____ No.

If you participated in a self dialysis training program, provide date training started: __/__/____

4. Are you within the 30 month coordination period which starts __/__/____?

Yes. No; STOP. MEDICARE IS PRIMARY.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

Yes. No; STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

Yes; STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

No; INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

Yes; GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

No; MEDICARE CONTINUES TO PAY PRIMARY.