MEDICARE SECONDARY PAYER QUESTIONNAIRE

BENEFICIARY INFORMATION

Medicare Beneficiary _____ Patient Account # _____
Medicare # _____
Dates of Service From _____ through _____ Person who supplied information _____
Relationship to patient _____ Provider Rep. Name _____ Date _____
Is patient enrolled in Medicare Hospice? ___ Yes ___ No

1. WORKERS' COMPENSATION (WC)

Per the patient, should the illness/injury be covered by a WC claim? ___ Yes ___ No
If yes, this should be an MSP or Conditional Claim, not Medicare Primary. Please note, WC is primary only for claims related to *a WC injury.*
Original Date of Illness/Injury _____ Claim Number _____
Name of WC Plan _____
Mailing Address _____
City _____ State _____ Zip _____
Name of Employer _____
Mailing Address _____
City _____ State _____ Zip _____

2. FEDERAL BLACK LUNG (BL)

Is the patient covered by the BL program? ___ Yes ___ No
Date benefits began _____ (BL is primary only for claims related to BL).
If yes, are you able to determine at this time if the claim will be covered by the Dept. of Labor, per the acceptable diagnosis list?
___ Yes ___ No *If yes, this should be an MSP or Conditional Claim, not Medicare Primary.*

3. DEPARTMENT OF VETERANS AFFAIRS (DVA)

Is the patient entitled to benefits through the DVA? ___ Yes ___ No
If yes, does the patient want the DVA to be contacted for authorization of these services? ___ Yes ___ No

4. PUBLIC HEALTH SERVICES (PHS)

Are the services covered by a PHS, other than Medicare or Medicaid? ___ Yes ___ No
If yes, what is the name of the PHS? _____
Mailing Address _____
City _____ State _____ Zip _____
What was the time span of the study by the PHS? _____

5. ACCIDENT

Are these services the result of an accident? ___ Yes ___ No

A. NON-LIABILITY INSURANCE

If yes, what type of accident was this or give a description of the accident (for example, auto, slip and fall, malpractice, product liability, homeowners? _____
Date of Accident _____ Location of Accident (home, restaurant, etc.) _____
Is non-liability insurance available (i.e., premises medical, auto medical coverage, no-fault, homeowners premises)? __Yes _ No
If yes, name of insurance company _____
Mailing Address _____
City _____ State _____ Zip _____
Who is listed as the insured? _____

B. LIABILITY INSURANCE

Does the patient feel someone else is responsible for the accident/injury? ___ Yes ___ No
If yes, name of the patient's attorney or the responsible party's insurance company _____
Mailing Address _____
City _____ State _____ Zip _____
Name of responsible insured party _____

6. EMPLOYER GROUP HEALTH PLAN (EGHP)

Is the patient covered by ANY EGHP, including federal employee health benefits or ANY retirement policy? ___ Yes ___ No

If no, this questionnaire is complete.

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7. WORKING AGED

Is the patient 65 years old or older? ___ Yes ___ No
Is the patient currently employed by an employer of 20 or more employees? ___ Yes ___ No
If yes, name of the employer _____
Mailing Address _____
City _____ State _____ Zip _____
Is the spouse currently employed by an employer of 20 or more employees? ___ Yes ___ No
If yes, name of the employer _____
Mailing Address _____
City _____ State _____ Zip _____
If the patient or spouse is employed of 20 or more employees, is the patient covered by the EGHP? ___ Yes ___ No
If yes, name of the EGHP _____
Mailing Address _____
City _____ State _____ Zip _____
Policy # _____ Group Identification # _____
If the beneficiary is no longer employed, please give a retirement date if possible _____ (MM/DD/CCYY)
If the spouse is no longer employed, please give a retirement date if possible _____ (MM/DD/CCYY)
NOTE: If the patient is covered through their own or a spouse's EGHP of 20 or more employees, the EGHP should be primary. Please go on to the ESRD/Dual Entitlement questions.

8. DISABILITY

Is the patient under the age of 65? ___ Yes ___ No
If yes, is the patient entitled to Medicare due to a disability other than end-stage renal disease? ___ Yes ___ No
If yes, is the patient currently employed by an employer of 100 or more employees? ___ Yes ___ No
Name of employer _____
Mailing Address _____
City _____ State _____ Zip _____
Is a family member currently employed by an employer of 100 or more employees? ___ Yes ___ No
Name of employer _____
Mailing Address _____
City _____ State _____ Zip _____
Is the patient covered by that large group health plan (LGHP)? ___ Yes ___ No
Name of insurance company _____
Mailing Address _____
City _____ State _____ Zip _____
Policy # _____ Name of policy holder _____
Relationship to the patient _____ Group Identification # _____
NOTE: If the patient is covered by their own or a family member's LGHP of 100 or more employees, the LGHP should be primary. Please go on to the ESRD/Dual Entitlement questions.

9. END STAGE RENAL DISEASE (ESRD)

Is the patient covered by any EGHP through a current or former employer of any size? ___ Yes ___ No
Name of group health plan _____
Mailing Address _____
City _____ State _____ Zip _____
Policy # _____ Name of policy holder _____
Relationship to the patient _____ Group Identification # _____
Name of employer _____
Mailing Address _____
City _____ State _____ Zip _____
Is the patient within the 30-month coordination of benefits period? ___ Yes ___ No
What is the month/year of the first regular dialysis? _____ (MM/DD/CCYY)
Has the patient had a kidney transplant? ___ Yes ___ No
If yes, date of transplant _____ (MM/DD/CCYY)
NOTE: If the patient is within the 30-month coordination of benefits period, the GHP should be primary.

10. DUAL ENTITLEMENT

Is the patient entitled to Medicare on the basis of either ESRD and age or ESRD and disability? ___ Yes ___ No
Was the patient's initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? ___ Yes ___ No
Does the working aged or MSP Disability Provision apply (i.e., is the GHP primary based on the age or disability entitlement?
___ Yes ___ No
Note: If yes to the last question, the GHP remains primary for the 30-month COP period.

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