

Medicare Secondary Payor Questions

Patient Name:
MRN:
Birth Date:

Patient Name:
Admit Date:

Visit Number:
Discharge Date:

PART I

- 1. Are you entitled to Medicare? []
- 2. Do you have Part B benefits? []
If "NO" to #1 & 2 or "NO" to #2 Only, No Need to Continue.
- 3. Are you receiving Black Lung Benefits? []
*BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.
Date benefits began: _____
- 4. Are the services to be paid by a government program? []
*GOVERNMENT PROGRAM WILL PAY PRIMARY FOR THESE SERVICES.
- 5. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? []
*DVA IS PRIMARY FOR THESE SERVICES.
- 6. Was the illness/injury due to a work related accident/condition? []
*If no, Go to Part II, If yes, WC is primary payer only for claims related to work related injuries or illness. Go to Part III.
Date of injury/illness: _____
Name of WC Plan: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____
Policy or ID No: _____
Name of employer: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____

PART II

- 1. Was illness/injury due to a nonwork related accident? []
Date of accident: _____
*If no, go to Part III.
- 2. What type of accident caused the illness/injury (A/N/O)? []
-Automobile -Non-automobile -Other
Give no-fault or liability insurer information:
Insurer name: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____
Insurance Claim Number: _____
No-fault insurer is primary only for those claims related to the accident. go to Part III.
- 3. Was another party responsible for this accident? []
*If no, go to Part III. If yes, liability insurer is primary only for those claims related to the accident. Go to Part III.
Liability Insurer name: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____
Insurance Claim Number: _____

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PART III

- 1. Does someone from a home health care agency to your home to assist you? []
*If yes, complete homehealth care information.
Agency name: _____
Address: _____
City, State: _____ Zip: _____
Telephone: _____
Contact person: _____
- 2. Are you entitled to Medicare based on age (Over 65)? []
*If yes, Part IV must be completed.
- 3. Are you entitled to Medicare based on disability? []
*If yes, Part V must be completed
- 4. Are you entitled to Medicare based on ESRD (End Stage Renal Disease)? []
*If yes, Part VI must be completed

PART IV - Age

- 1. Are you currently employed? [] Date of retirement: _____
Employer Name: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____
- 2. Is your spouse currently employed? [] Date of retirement: _____
Employer Name: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____
- 3. Do you have group health plan (GHP) coverage based on your own, or a spouses, current employment? []
*If no stop.
- 4. Does the employer that sponsors your GHP employ 20 or more employees? []
*If yes, group health plan is primary, collect:
Name of GHP: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____
Policy Identification Number: _____
Group Identification Number: _____
Name of Policy Holder: _____
Relationship to patient: _____

PART V - Disability

- 1. Are you currently employed? [] Date of retirement: _____
Employer Name: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____
- 2. Is a family member currently employed? []
Employer Name: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____

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3. Do you have group health plan (GHP) coverage based on your own, or a spouses, current employment? []
*If no stop.

4. Does the employer that sponsors your GHP employ 100 or more employees? []
*If yes, group health plan is primary, collect:

Name of GHP: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____
Policy Identification Number: _____
Group Identification Number: _____
Name of Policy Holder: _____
Relationship to patient: _____

PART VI - ESRD (End Stage Renal Disease)

1. Do you have group health plan (GHP) coverage? []
*If no stop. Medicare is primary. If yes, continue.

Name of GHP: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____
Policy Identification Number: _____
Group Identification Number: _____
Name of Policy Holder: _____
Relationship to patient: _____

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

Employer Name: _____
Address: _____
Address: _____
City, ST: _____ Zip: _____

2. Have you received a kidney transplant? []
Date of Transplant: _____

3. Have you received maintenance dialysis treatments? []
Date dialysis began: _____

If you participated in a self dialysis training program, provide date training started: _____

4. Are you within the 30-month coordination period? []
*If no, stop. Medicare is primary

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability? []
*If no, stop. GHP is primary during the 30-month coordination period.

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? []
*If no, initial entitlement based on age or disability. If yes, stop

7. Does the working aged or disability MSP provision apply (ie, is the GHP primary based on age or disability entitlement)? []
*If no, Medicare continues to pay.