MEDICARE SECONDARY PAYER QUESTIONNAIRE (9/02)

MEDICARE PATIENT INFORMATION:

Patient Name: _____ Patient Account #: _____

HIC#: _____ DCN: _____ Provider #: **180013**

Dates of Service From: _____ Through: _____ Person who Supplied Information: _____

Relationship to Patient: _____ Provider Rep. Name: _____ Date: _____

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.)

3. Department of Veterans Affairs (DVA):

Is the patient entitled to benefits through the DVA? _____Yes _____ No

If yes, has the DVA authorized and agreed to pay for care at this facility? _____Yes _____ No

4. Public Health Services (PHS):

Are the services to be paid by a Government Program such as a Research Grant? _____Yes _____ No

If yes, the Government Program will pay primary benefits for these services.

What is the name of the PHS? _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

5. Accident:

Are these services the result of a non-work related accident? _____Yes _____ No

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.): _____

A. Non-liability Insurance:

Is non-liability insurance available (For example: premises medical, auto medical coverage, no-fault, homeowners premises)? _____Yes _____ No

If yes, name of the insurance company: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Who is listed as the insured: _____ Claim Number: _____

B. Liability Insurance:

Does the patient feel someone else is responsible for the accident/injury? _____Yes _____ No

If yes, name of responsible party's insurance company: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of the responsible insured party? _____ Claim Number: _____

6. Age:

Is the patient 65 years old or older? _____ Yes _____ No

(If no, please continue with Question #7.)

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: _____

IF THE PATIENT IS NO LONGER EMPLOYED, PLEASE GIVE A RETIREMENT DATE: _____ (MM/DD/CCYY)

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 SPOUSE IS NO LONGER EMPLOYED, PLEASE GIVE A RETIREMENT DATE: _____ (MM/DD/CCYY)

If the patient or spouse is employed by an employer of 20 or more employees, is the patient covered by that Group Health Provider (GHP)? ___Yes ___No

If yes, name of the GHP: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____ Group Identification Number: _____

Name of policy holder: _____ Relationship to the patient: _____

If the beneficiary is no longer employed, please give a retirement date: _____ (MM/DD/CCYY)

If the spouse is no longer employed, please give a retirement date: _____ (MM/DD/CCYY)

(Continue with Question #8)

7. Disability:

Is the patient under the age of 65? _____ *Yes* _____ No

(IF NO MOVE TO QUESTION #8)

If yes, is the patient entitled to Medicare due to a disability other than End Stage Renal Disease? _____ Yes _____ No

(IF NO MOVE TO QUESTION #8)

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: _____

IF THE PATIENT IS NO LONGER EMPLOYED, PLEASE GIVE A RETIREMENT DATE: _____ (MM/DD/CCYY)

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 Group Health Plan (GHP)? _____ Yes _____ No

If Yes, Name of GHP: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____ Group Identification Number: _____

Name of Policy Holder: _____ Relationship to the Patient: _____

(Continue with Question #8.)

8. End Stage Renal Disease (ESRD):

Is the patient entitled to Medicare due to end stage renal disease? _____Yes No

Is the patient covered by any GHP through a current of former employer of any size? _____Yes _____ No

If Yes, Name of Group Health Plan: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Policy #: _____ Name of Policy Holder: _____

Relationship to the patient: _____ Group Identification Number: _____

Name of Employer Sponsoring GHP: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Is the patient within the 30 month coordination of benefits period? _____Yes _____ No

Month/year of the first regular dialysis? _____ (MM/CCYY)

If the patient participated in a self-dialysis training program, provide date training started: _____

Has the patient had a kidney transplant? _____Yes _____ No If yes, date of transplant: _____ (MM/CCYY)

Note: If the patient is within the 30-month coordination period, the GHP should be primary.
(Please continue with Question #9.)

9. 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 Age or Disability MSP 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 coordination period.