



**MEDICARE SECONDARY PAYOR
QUESTIONNAIRE**

IMPORTANT NOTICE TO PATIENT:
Please fill out this form in its entirety.
Failure to do so may result in a delay in
obtaining your Medicare benefits.

Patient Name _____ Patient Acct# _____

Medicare # (exactly as displayed on Red-White-Blue Government Medicare Card): _____

1. If you have received Home Health Care *of any kind* in the past 60 days, please provide the name and phone number of the Home Health Agency: _____
Not Applicable: _____ (Proceed to Question #2)
Home Health Agency: _____
Home Health Agency Phone Number: _____

2. Was your illness or injury due to a work-related accident or condition? Yes _____ No _____
If Yes – enter the date of illness or injury: ___/___/___

3. Are you covered under a Medicare Part C program (also known as a Medicare Replacement Insurance or Program)? _____ Yes – Please give your ID Card to the office staff to copy
_____ No – (Proceed to Question #4)

4. If you are entitled to benefits under Black Lung Program, Department of Veteran Affairs or other government program(s), please provide the name, address and phone number of that program. _____
Not Applicable: _____ (Proceed to Question #5)
Program Name: _____
Address: _____
City, State & Zip Code: _____
Phone #: _____

Note: This government program you've listed in question #4 will be primary to Medicare.

5. Was your illness/injury due to any of the following:
_____ Not Applicable(Proceed to Question #6)
_____ Work-Related Accident Date ___/___/___
_____ Automobile Accident Accident Date ___/___/___
_____ Accident on Property (other than your own) Accident Date ___/___/___
(Example: store, restaurant, etc.)

Please give details of the accident: _____

Please provide the name, address and contact information of the liability insurance: _____
Insurance Name: _____
Address: _____
City, State & Zip: _____
Phone #: _____
*Claim Number: _____ (*required for proper follow-up)

NOTE: Medicare regulations require us to file with the above liability insurance first, *even if they will not pay directly or immediately*. We must comply with this regulation before filing any claims with Medicare and appreciate your cooperation.

Patient Name: _____ Account Number _____

6. Do you feel you have a right to be compensated by a party who may have caused the injury or illness? _____ No (Proceed to Question #7)
_____ Yes (Continue Below)

If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness? _____ No (Proceed to Question #7)
_____ Yes (Continue below)

If yes, please provide the attorney's information:

Attorney name: _____
Name of Law Firm: _____
Address: _____
City, State & Zip: _____
Phone #: _____

7. If you have received a kidney transplant or care currently receiving dialysis for End Stage Renal Disease (ESRD), please give the date of the transplant or start of dialysis: DATE _____/_____/_____

Note: If the date is less than 30 months ago, are you currently covered under group insurance provided by your or a family member's employer? _____ Yes – the group insurance will be primary
_____ No – Medicare will be primary

8. Are you or your spouse currently employed?

Patient: _____ Yes – Does the employer employ more than 100 employees? _____ Yes / _____ No
_____ No – Date of retirement? _____/_____/_____
_____ Never Employed.

Spouse: _____ Yes - Does the employer employ more than 100 employees? _____ Yes / _____ No
_____ No – Date of retirement? _____/_____/_____
_____ Never Employed.

(If the Patient Answers "NO" to both parts of question #6, Medicare is Primary).

9. If none of the above applies to you (#1-6) and your Medicare coverage is due to age or disability, do you have group insurance coverage through another family member's current employer? _____ Yes-the group insurance will be primary
_____ No – Medicare will be primary

10. Do you have ANY benefits through Tricare (formerly Champus)? Yes _____ No _____

11. If you answered YES to questions 6, 7, or 8, please provide the group insurance information for proper billing of your account:

Policy Identification Number (This number is sometimes referred to as the health insurance benefit package number): _____
Group Identification Number: _____

Insurance Name: _____
Address: _____
City, State & Zip: _____
Phone: _____
Employer: _____
Insured's Name: _____

Patient's Signature _____ Date _____

Thank you for your cooperation.