

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Person Giving Information: _____ Relationship to Patient: _____

Patient Name: _____

HIC Number: _____

Patient Age _____ Patient Sex _____

Basis for Patient Entitlement to Medicare

_____ Age _____ Disability _____ End Stage Renal Disease (ESRD)

Group Health Plan Information

1. Is the patient or patient's spouse currently employed? _____ Yes _____ No

If No: Retirement date of patient: _____

Retirement date of spouse: _____

If Yes, continue.

Is patient or spouse employed? _____

Are there: _____ 1. Less than 20 employees

_____ 2. More than 100 employees

Is employee actively working? _____ Yes _____ No

Insurance Company: _____

Policy Number: _____ Claim Number: _____

Insurance Plan Name: _____

Plan Identification Number: _____

Is the patient employed? _____ Yes _____ No Full Time? _____ Part Time? _____

Employer Name: _____

Employer Address: _____

City _____ State _____ Zip Code _____

Employer Identification Number: _____

Automobile, No Fault or Liability Insurance Information

2. Is the illness/injury due to an accident (auto included)? _____ Yes _____ No

If Yes, continue.

Type of non-work-related accident: _____ Automobile _____ Other (describe) _____

Date of Accident: _____

Insurance Situation: _____ Liable _____ Not Liable

Name of Policy Holder: _____

Address of Policy Holder: _____

Policy Number or Claim identification Number: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Name of Patient's Legal Representative for the case if any: _____

Phone Number of Legal Representative: _____

Workers Compensation Insurance Information

3. Was the patient involved in a work-related accident? _____ Yes _____ No
If Yes, continue.

Date of Accident: _____

Is the patient working? ___ Yes ___ No ___ Full Time? ___ Part time? _____

Employer Name: _____

Employer Address: _____

City _____ State _____ Zip Code _____

Employer Identification Number: _____

Name of Insurance Company: _____

Name of Person or Company Insured: _____

Insurance Company Claim or Policy Number: _____

Workers Compensation Claim Number: _____

Name of Workers Compensation Agency where claim was filed: _____

Address of Agency: _____

Has the case been settled? _____ Yes _____ Date _____ No

Name of Patient's Legal Representative for the case if any: _____

Phone Number of Legal Representative: _____

Veteran's Administration (VA) Authorization Information

Does the patient have a VA fee service card? _____ Yes _____ No

Has the VA issued a special authorization for these services? _____ Yes _____ No

Does the patient authorize you to bill the VA? _____ Yes _____ No

Black Lung Insurance Information

Is the patient entitled to benefits under the
Department of Labor's *Black Lung Program*? _____ Yes _____ No

Are the services provided on the Department of Labor's list of
approved procedures for the treatment of Black Lung Disease? _____ Yes _____ No

Patient Signature Date

Witness Signature Date