MEDICARE SECONDARY PAYER QUESTIONNAIRE

Name of Beneficiary: ___________________________________ HIC #::___________________________

Date(s) of Service: ________________________ Provider #:________________________

SECTION I (Employment)

A. Are you currently working? ☐ Yes ☐ No ☐ No, Never Employed
Date of Retirement, if applicable:______________________
Employer:___________________ Insurance Co:_____________________ Policy #:___________________
Address:________________________ City:__________________ State:_________ Zip: _____________

B. Are you covered by an Employer Group Health Plan? ☐ Yes ☐ No
Employer:___________________ Insurance Co:_____________________ Policy #:___________________
Address:________________________ City:__________________ State:_________ Zip: _____________

C. Is your spouse currently working? ☐ Yes ☐ No ☐ No, Never Employed
Date of Retirement, if applicable:_______________________
Employer:___________________ Insurance Co:_____________________ Policy #:___________________
Address:________________________ City:__________________ State:_________ Zip: _____________

D. Are you covered under an employed spouse or family member: ☐ Yes ☐ No
Employer:___________________ Insurance Co:_____________________ Policy #:___________________
Address:________________________ City:__________________ State:_________ Zip: _____________

SECTION II (Disability)

A. Are you entitled to Medicare Benefits SOLELY because of a disability? ☐ Yes ☐ No
If yes, date of disability:_________________ Describe Disability:___________________________________

SECTION III (Accident/Injury)

A. Was your illness/accident related to a WORK injury, past or present? ☐ Yes ☐ No
Employer:___________________ Insurance Co:_____________________ Policy #:___________________
Address:________________________ City:__________________ State:_________ Zip: _____________
Name of Workers Compensation Carrier:___________________________ Attorney:___________________

B. Was your illness/injury related to an AUTOMOBILE accident? ☐ Yes ☐ No
Date of accident:_____________________ Location:____
How did accident occur:____
Automobile medical or no-fault insurance:_____________________________ Claim/Policy #:________________
Address:________________________ City:__________________ State:_________ Zip: _____________

C. Was your illness/injury related to an accident, OTHER than an automobile accident? ☐ Yes ☐ No
Date of accident:_____________________ Location:____
How did accident occur:____
Automobile medical or no-fault insurance:_____________________________ Claim/Policy #:________________
Address:________________________ City:__________________ State:_________ Zip: _____________
Can payment be made by third party liability insurance: ☐ Yes ☐ No
Third party liability or attorney:____
Address:________________________ City:_________________ State:_________ Zip: _____________

SECTION IV (VA/Black Lung)

A. Are you entitled to any Veteran's Administration Benefits for a service related illness or injury? ☐ Yes ☐ No
VA Plan Name:____ Claim/Policy #:___________________
Address:________________________ City:__________________ State:_________ Zip: _____________

B. Are you entitled to any Black Lung Benefits? ☐ Yes ☐ No
Black Lung Policy Name:_____________________________________ Claim/Policy #:_________________
Address:________________________ City:__________________ State:_________ Zip: _____________

SECTION V (End Stage Renal Disease (ESRD))

A. Are you entitled to Medicare ONLY because of End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If yes, did you have self dialysis training or a kidney transplant 3 months prior to Medicare Entitlement?
☐ Yes ☐ No
Date of first dialysis or kidney transplant:____

B. Are the services to be paid by a program such as a government research grant? ☐ Yes ☐ No

OBTAIN BENEFICIARY OR OTHER REPRESENTATIVES' SIGNATURE IF POSSIBLE. IF UNABLE TO OBTAIN A SIGNATURE, PLEASE INDICATE HOW THE INFORMATION WAS OBTAINED.

Beneficiary/Resp. Party Signature (Optional):_____________________________________ Date: ___________

Facility Witness Signature:____ Date: ___________