MEDICARE SECONDARY PAYER QUESTIONNAIRE

What is the Medicare Secondary Payer questionnaire?

MEDICARE SECONDARY PAYER	A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.
	Use: Completion required for any situation where another payer or insurer pays your medical bills before Medicare.

We ask that you complete this form with either a "**Y**" for yes or "**N**" for No, dates and address required where indicated.

Part I

Government Program Coverage:

1. Is the patient receiving Black Lung Benefits? _____
   Date benefits began:_____/_____/_____
2. Are services covered by a government program (research)? _____
3. Has Dept of Veteran Affairs agreed to pay for care? _____
4. Was illness due to work related accident/condition? _____
   If yes, name and address of workers compensation plan:
   _____
   _____
   _____

(Please note: If you answered "yes" to any questions, then that plan is primary to Medicare. If you answered "no" to all, then go to the next section).

Part II

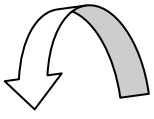
Accident Related Injuries:

1. Was illness/injury due to non-work related accident? _____
   If "No", then go to the next section
   If "yes, date:_____/_____/_____
2. Was accident caused by automobile_____, non-automobile _____
   or another party? _____
   If yes, provide name, address, phone, claim # of no-fault or liability insurer:
   _____
   _____
   _____

Part III

Reasons for Medicare Benefits:

1. Is beneficiary entitled to Medicare benefits based on
   Age:_____
   Disability: _____; if yes, go to **Part V**
   End Stage Renal Disease: _____, if yes, go to Part VI
2. Is beneficiary part of a Medicare HMO? _____
   If yes, then the HMO replaces Medicare.



Turn Over to Complete

Part IV

Employment Status:

1. Does patient have current employment status? _____
   if no, what was the Date of retirement?_____/_____/_____
   (**Office use only**: If yes, provide the named and address of employer on registration screens. If no, record the date of retirement on the occurrence code).
2. Does patient's spouse have current employment status? _____
   if no, what was the spouse's Date of retirement ?_____/_____/_____
   (**Office use only**: If yes, provide the named and address of spouse's employer on registration screens. If no, record the spouse's date of retirement on the occurrence code).
   If no to both questions, then Medicare is primary. If health insurance exists through employment and there are 20 or more employees, health insurance is primary.
   If unable to obtain retirement date, note why?
   _____

Part V

Disability:

Is patient RETIRED disability? _____
If yes, date of disability retirement _____/_____/_____
(Medicare is primary unless spouse employed with benefits)

If disability, does patient or spouse have current employment status? _____
(**Office use only**: If yes, provide the named and address of employer on registration screens. If no to employment questions, Medicare is primary. If health insurance exists, plan is primary).

Part VI

End Stage Renal Disease:

Does patient have current insurance coverage? _____
(**Office use only**: if yes, record information on insurance screens, that plan becomes primary).
Has patient received a kidney transplant? _____
If yes, date of transplant: _____/_____/_____
Has patient received dialysis? _____
If yes, date dialysis began: _____/_____/_____
If self dialysis, date of training: _____/_____/_____
Is patient within the 30 month coordination period? _____
If yes, insurance is primary until 30 months is up.
Was patient's initial entitlement to Medicare based on ago or disability? _____
(**Office use only** If yes, Medicare primary. In no, insurance coverage primary until 30 months is up).