Medicare Secondary Payer Questionnaire

Beneficiary Information:
Medicare Beneficiary: _____ Patient Account #_____
HIC#: _____ DCN#: _____ Provider #: _____
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 claim 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, does the patient want the DVA to be contacted for authorization of these services? ____Yes ____No

4. Public Health Service (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 responsible injured party: _____ Claim Number: _____

6. Employer Group Health Plan (EGHP):
Is the patient covered by *any* EGHP, including Federal Employee Health Benefits or *any* retirement policy?
(If no, this questionnaire is complete. If yes, please continue). ____Yes ____No

7. Working Aged:
Is the patient 65 years or older? ____Yes ____No
(If no, please continue with Question #8)
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: _____

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 patient or spouse is employed by an employer of 20 or more employees, is the patient covered by the EGHP?
____Yes ____No
Mailing Address: _____

City: _____ State: _____ Zip: _____
Policy #: _____ Group Identification #: _____
Name of Policyholder: _____ 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)
Note: If the patient is covered through their own or a spouse's EGHP of 20 or more employees, the EGHP should be primary. Please go on to the ESRD/Dual Entitlement questions. (Please continue with Question #9)

8. Disability:
Is the patient under the age of 65? ____Yes ____No
(If no, please continue with Question #9)
If yes, is the patient entitled to Medicare due to a disability other than End Stage Renal Disease? ____Yes ____No
(If no, please continue with Question #9)
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: _____
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 Large Group Health Plan (LGHP)? ____Yes ____No
Name of Insurance Company: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Policy #: _____ Name of Policy Holder: _____
Relationship to the Patient: _____ Group identification #: _____
Note: If the patient is covered by their own or a family member's LGHP of 100 or more employees, the LGHP should be primary. Please go on to the ESDR/Dual Entitlement questions. (Please continue with Question #9)

9. End Stage Renal Disease (ESRD):
Is the patient entitled to Medicare due to End Stage Renal Disease? ____Yes ____No
(If no, please continue with Question #10)
Is the patient covered by any EGHP through a current or former employer of any size? ____Yes ____No
Name of group health plan: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Policy #: _____ Name of Policy Holder: _____
Relationship to the Patient: _____ Group identification #: _____
Name of Employer: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Is the patient within 30-month coordination of benefits period? ____Yes ____No
What is the month/year of the first regular dialysis? _____(MM/CCYY)
If the patient participated in a self-dialysis training program, provide date training started: _____(MM/CCYY)
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 of benefits period, the GHP should be primary. (Please continue with Question #10.)

10. 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 Working Aged or MSP Disability 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 COB period.

What is the month/year of the first regular dialysis?_____

If patient answers "Yes" to questions 5A, please complete the following:

1. Is the patient related to the responsible party? ____Yes ____No

2. Does the patient believe that his/her future safety is at risk? ____Yes ____No

3. Does the patient believe that the safety of others in the home is at risk? ____Yes ____No

4. Would the patient like to talk to someone about the concerns? ____Yes ____No
(That is, to have a referral for an evaluation of the patient's situation by a licensed Social Worker)

Patient Phone number: _____

Best time to contact: _____