

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient's Name: _____ Date: _____

Question	Circle one
#1 Is the patient covered by an employer group health plan (EGHP) either through themselves or through a family member? If yes , please fill out # 13 below.	Yes No
#2 Is the patient or spouse actively employed? If yes , name of employer: _____ If yes , does the employer have 20 or more employees?	Yes No Yes No
#3 Is the patient retired? If yes , Retirement date: _____	Yes No
#4 Is the spouse retired? If yes , Retirement date: _____	Yes No
#5 Is the patient entitled to Medicare due to Age?	Yes No
#6 Is the patient entitled to Medicare due to Disability? If yes , list date of disability: _____	Yes No
#7 Is the patient entitled to Medicare due to End Stage Renal Disease (ESRD)? If yes , list first date of dialysis: _____ Has the patient completed the 30 month Coordination of Benefits period? Has the patient had a kidney transplant? If yes , Date: _____	Yes No Yes No Yes No
#8 Is this illness/injury a result of a work related accident/condition? If yes , please alert staff for proper billing purposes	Yes No
#9 Is this illness/injury the result of an auto accident? If yes , please alert staff for proper billing purposes Is another party's liability insurance, non-liability insurance, or no-fault insurance paying for this injury/illness? If yes , please alert staff for proper billing purposes.	Yes No Yes No
#10 Is the Department of Veterans Affairs (DVA) authorizing and paying for this illness/injury?	Yes No
#11 Is a government research grant paying for this illness/injury?	Yes No
#12 Is this illness/injury covered under the Federal Black Lung Program?	Yes No
#13 Name of Insurance Company: _____ Name of Subscriber/Insured: _____ Date of Birth of Subscriber/Insured: _____ Patient's relationship to Subscriber/Insured: _____ Policy/Claim Number: _____	

Patient Signature: _____

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