HOAG MEMORIAL HOSPITAL PRESBYTERIAN

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: _____

MEDICARE MESSAGE

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