MEDICARE SECONDARY PAYER QUESIONNAIRE

Person Providing Information: _____ Relationship to Patient: _____

Patient Name: _____

HIC Number: _____ Patient Age: _____ Patient Sex: _____

Basis for patient entitlement to Medicare: Age _____ Disability _____ Renal Disease _____

GROUP HEALTH PLAN INFORMATION

Is the patient or patient's spouse currently employed? Yes _____ No _____
If no: Retirement date of patient: _____ Retirement date of spouse: _____

If Yes, Is patient or spouse employed at a company: Less than 20 employees _____
More than 100 employees _____

Is employee actively working? Yes_____ No_____
Is employment: Full-Time _____ Part-Time _____

Insurance Company: _____ Policy #: _____

Claim #: _____ Plan Name: _____
Plan Identification # (PIN) :_____

Employer Name: _____
Employer Address: _____
City: _____ State:_____ Zip Code:_____
Employer Identification Number (EIN): _____

AUTOMOBILE, NO FAULT OR LIABILITY INSURANCE INFORMATION

Is the illness/injury due to an accident (auto included)? Yes_____ No _____ If yes, continue

Type of non-work related accident: Automobile_____ Describe, Other _____

Date of accident: _____ Insurance Situation: Liable _____ Not Liable _____

Name of policy holder:_____

Address of policy holder: _____

Name of legal representative, if any: _____

Phone number for legal representative: _____

WORKER'S COMPENSATION INSURANCE INFORMATION

Was the patient involved in a work related accident? Yes_____ No_____

Date of accident: _____ Is the patient working? Yes_____ No_____
If yes, Full-Time_____ Part-Time_____

Employer Name: _____
Employer Address: _____
City: _____ State:_____ Zip Code:_____
Employer Identification Number (EIN): _____

Name of Insurance Company: _____
Name of Person/Company Insured: _____
Insurance Company Claim or Policy #: _____
Worker's Compensation Claim #: _____
Name of Woker's Compensation Agency where claim was filed: _____
Address of Agency: _____
Has the case been settled? Yes_____ No_____
Name of legal representative, if any: _____
Phone number for legal representative: _____

VETERAN'S ADMINISTRATION (VA) AUTHORIZATION INFORMATION

Does the patient have a VA fee service card? Yes_____ No_____
Has the VA issued a special authorization for those services? Yes_____ No_____
Does the patient authorize you to bill the VA? Yes_____ No_____

BLACK LUNG INSURANCE INFORMATION

Is the patient entitled to benefits under the Department of Labor's Black Lung Program?
Yes_____ No_____

Are the services provided on the Department of Labor's list of approved procedures for treatment of Black Lung Disease? Yes_____ No_____

_____
Patient Signature Date

_____
Witness Signature Date