MEDICARE SECONDARY PAYER QUESTIONNAIRE

Person Giving Information: _____ Relationship to Patient: _____
Patient Name: _____
HIC Number: _____
Patient Age _____ Patient Sex _____
Basis for Patient Entitlement to Medicare
_____ Age _____ Disability _____ End Stage Renal Disease (ESRD)

Group Health Plan Information

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

If Yes, continue.
Is patient or spouse employed?
Are there: _____ 1. Less than 20 employees
_____ 2. More than 100 employees

Is employee actively working? _____ Yes _____ No

Insurance Company: _____
Policy Number: _____ Claim Number: _____
Insurance Plan Name: _____
Plan Identification Number: _____
Is the patient employed? _____ Yes _____ No Full Time? _____ Part Time? _____
Employer Name: _____
Employer Address: _____
City _____ State _____ Zip Code _____
Employer Identification Number: _____

Automobile, No Fault or Liability Insurance Information

2. Is the illness/injury due to an accident (auto included)? _____ Yes _____ No
If Yes, continue.
Type of non-work-related accident: _____ Automobile _____ Other (describe) _____
Date of Accident: _____
Insurance Situation: _____ Liable _____ Not Liable
Name of Policy Holder: _____
Address of Policy Holder: _____
Policy Number or Claim identification Number: _____
Name of Insurance Company: _____
Address of Insurance Company: _____
Name of Patient's Legal Representative for the case if any: _____
Phone Number of Legal Representative: _____

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Workers Compensation Insurance Information

3. Was the patient involved in a work-related accident? _____ Yes _____ No
   If Yes, continue.

Date of Accident: _____
Is the patient working? _____ Yes _____ No Full Time? _____ Part Time? _____
Employer Name: _____
Employer Address: _____
City _____ State _____ Zip Code _____
Employer Identification Number: _____
Name of Insurance Company: _____
Name of Person or Company Insured: _____
Insurance Company Claim or Policy Number: _____
Workers Compensation Claim Number: _____
Name of Workers Compensation Agency where claim was filed: _____
Address of Agency: _____
Has the case been settled? _____ Yes _____ Date _____ No
Name of Patient's Legal Representative for the case if any: _____
Phone Number of 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 these 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 the treatment of Black Lung Disease? _____ Yes _____ No

_____
Patient Signature Date

_____
Witness Signature Date

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