Palo Alto Medical Foundation
A Sutter Health Affiliate

MSPQ Medicare Secondary Payer Questionnaire

Patient's Name _____MRN _____

Spouse Name _____

1) Are you employed? ( ) Yes ( ) No

Name of employer: _____

Address: _____City: _____State: _____Zip: _____

2) Is your spouse/other family member employed? ( ) Yes ( ) No

Name of employer: _____

Address: _____City: _____State: _____Zip: _____

3) Are you covered by employer group health plan (EGHP) from own or family member's current or former employment?

( ) Yes, covered by former employer's EGHP
( ) Yes, covered by current employer's EGHP
( ) No

- If you marked yes, does your employer sponsoring EGHP have 20 or more employees? ( ) Yes ( ) No

Name of GHP: _____

Phone Number: _____

Address: _____City: _____State: _____Zip: _____

Policy ID number: _____ Group ID number: _____

Name of insured: _____ Relationship to patient:_____

4) Are you or your spouse retired?

( ) Yes ( ) No - Your retirement date _____
( ) Yes ( ) No - Spouse retirement date _____

5) Are you entitled to Medicare because of end stage renal disease (ESRD)? ( ) Yes ( ) No

6) Are you entitled to Medicare because of disability, other than ESRD? ( ) Yes ( ) No

- If you marked yes, does your employer sponsoring EGHP have 100 or more employees? ( ) Yes ( ) No

7) Are you entitled to benefits through the Department of Veterans Affairs? ( ) Yes ( ) No

8) If your answer was yes on question #7, would you like the VA to be contacted for authorization? ( ) Yes ( ) No

9) Are you entitled to benefits under the Federal Black Lung Program? ( ) Yes ( ) No

Federal BL Program: _____

Phone Number: _____

Address: _____City:_____ State: _____ Zip: _____

Policy/ID number: _____ Date benefits began: _____

10) Is this illness/injury covered by a workers' compensation claim? ( ) Yes ( ) No

Name of WC Plan: _____ Policy/ID number: _____

Phone Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Name and address of employer _____

11) Is this illness/injury covered by a non worker related accident? ( ) Yes ( ) No

12) If you answered yes on question #11, what type of accident caused the illness/injury?

_____ Automobile

_____ Non-Automobile

_____ Other

Name of no-fault or liability insurer: _____

Address: _____ City:_____ State: _____Zip:_____

Phone Number: _____

Name of insured party: _____

Policy/ID number: _____ Insurance claim number: _____

13) Are services covered by a Public Health Service or Research Program? ( ) Yes ( ) No

Information Supplied by _____ Relationship to patient _____

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Patient's Representative (If Patient is unable to sign) Date