



# Medicare Secondary Payer Questionnaire

## Part I.

1. Are you receiving benefits from a Federal Black Lung (BL) Program?

No

**Yes – Federal BL Program is primary payer for claims related to BL. Obtain the following information:**

Federal BL Program: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy/ID number: \_\_\_\_\_ Date benefits began: \_\_\_\_\_

2. Are the services to be paid by a government program such as a research grant?

No

**Yes – Government Program is primary payer for claims related to these services.**

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

No

**Yes – DVA is primary payer for claims related to these services.**

4. Is the illness/injury due to a work related accident/condition and covered by a Workers' Compensation (WC) plan?

No

**Yes – WC plan is primary payer for claims related to these services. Obtain the following information and go to Part III.**

Name of WC Plan: \_\_\_\_\_ Policy/ID number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name and address of employer: \_\_\_\_\_

## Part II.

1. Was illness/injury due to a non-work related accident?

**NO – GO TO PART III.**

Yes – Date of Accident: \_\_\_\_\_

2. What type of accident caused the illness/injury?

- Automobile
- Non-Automobile
- Other

Name of no-fault or liability insurer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of insured party: \_\_\_\_\_

Policy/ID number: \_\_\_\_\_ Insurance claim number: \_\_\_\_\_

**No-fault insurer is primary payer for claims related to the accident. Go to Part III.**

3. Was another party responsible for this accident?

**NO – GO TO PART III.**

Yes

Name of liability insurer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of insured party: \_\_\_\_\_

Policy/ID number: \_\_\_\_\_ Insurance claim number: \_\_\_\_\_

**Liability insurer is primary payer for claims related to the accident. Proceed to Part III.**

### Part III.

1. Are you entitled to Medicare based on:

- Age – Go to Part IV.
- Disability – Go to Part V.
- ESRD – Go to Part VI.

### Part IV – Age

1. Are you currently employed?

No – Date of retirement: \_\_\_\_\_

No – Never employed.

Yes

Name of employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. Is your spouse currently employed?

No – Date of retirement: \_\_\_\_\_

No – Never employed.

Yes

Name of employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If the patient answered NO to both questions 1 and 2, Medicare is primary payer unless the patient answered YES to questions in Part I and II. DO NOT PROCEED ANY FURTHER.**

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?  
 **NO – STOP – Medicare is primary payer unless the patient answered YES to questions in Part I or II.**

Yes

4. Does the employer that sponsors your GHP employ 20 or more employees?  
 **NO – STOP – Medicare is primary payer unless the patient answered YES to questions in Part I or II.**

Yes – Group Health Plan (GHP) is primary. Obtain the following information:

Name of GHP: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy/ID number: \_\_\_\_\_ Group ID number: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### **Part V – Disability**

1. Are you currently employed?  
 No – Date of retirement: \_\_\_\_\_

Yes

Name of employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. Is a family member currently employed?

No

Yes

Name of employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If the patient answered NO to both questions 1 and 2, Medicare is primary payer unless the patient answered YES to questions in Part I or II. DO NOT PROCEED ANY FURTHER.**

3. Do you have group health plan (GHP) coverage based on your own or a family member's current employment?  
 **NO – STOP – Medicare is primary payer unless the patient answered YES to questions in Part I or II.**

Yes

4. Does the employer that sponsors your GHP employ 100 or more employees?  
 **NO – STOP – Medicare is primary payer unless the patient answered YES to questions in Part I or II.**

Yes – Group health plan (GHP) is primary. Obtain the following information:

Name of GHP: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy ID number: \_\_\_\_\_ Group ID number: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Part VI – ESRD**

1. Do you have group health plan (GHP) coverage?

**NO – STOP – Medicare is primary payer.**

Yes – Group health plan is primary. Obtain the following information:

Name of GHP: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy ID number: \_\_\_\_\_ Group ID number: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

2. Have you received a kidney transplant?

No

Yes – Date of transplant: \_\_\_\_\_

3. Have you received maintenance dialysis treatment?

No

Yes – Date dialysis began: \_\_\_\_\_

If you participated in a self-dialysis training program, provide date training started: \_\_\_\_\_

4. Are you within the 30-month coordination period?

**NO – STOP – Medicare is primary payer.**

Yes

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

**NO – STOP – GHP is primary during the 30-month coordination period.**

Yes

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ERSD?

No – Initial entitlement based on age or disability.

**Yes – STOP – GHP continues to pay primary during the 30-month coordination period.**

7. Does the working aged or disability MSP provision apply (i.e. if the GHP is primary payer based on age or disability entitlement)?

No – Medicare continues to be primary payer.

Yes – GHP continues to pay primary during the 30-month coordination period.

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Patient Signature

Date

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

Date