Palo Alto Medical Foundation

A Sutter Health Affiliate

Menlo Park Surgical Hospital

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: _____

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FORM n0682 (March 2006)

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

I. 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.

_____

Patient Signature Date

_____

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