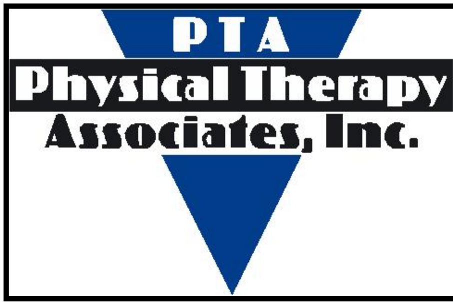

MEDICARE
SECONDARY PAYER QUESTIONNAIRE

PATIENT NAME: ______________________________________ **AGE:** ____________________

CIRCLE ONE:

1. Is this illness/injury covered by Worker's Compensation? Y N
   If yes, please put employer's or insurer's name, address, and claim number, if available, in #10 below.

2. Is this illness/injury covered under the Federal Black Lung Program? Y N
   If yes, bill should be sent to Federal Black Lung Program, PO Box 828, Lanham-Seabrook, MD 20703-0828.

3. Is this illness/injury the result of an auto accident? Y N
   If yes, enter the responsible auto insurer in #10 below.

4. Is another party's liability insurance responsible for this illness/injury? Y N
   Name of responsible party ______________________________
   Name of liability party ______________________________
   Name of insurer/attorney ______________________________

5. Is this patient covered by any employer group health plan (EGHP), including Federal Employee Health Benefits? Y N
   If no, Medicare is primary. If yes, move to #6 below.

6. Is this patient or his/her spouse actively employed by an employer of 20 or more employees? Y N
   If yes, enter the EGHP date in #9 below. If no, Medicare is primary.

7. Is the patient under age 65 and entitled to Medicare due to a disability? Y N
   If no, move to #8 below. If yes, is the patient or his/her spouse or parent actively employed by an employer of 100 or more employees (LGHP)? If yes, enter the LGHP data in #9 below. If no, Medicare is primary.

8a. Is the patient entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)? Y N
   If no, move on to question #9 below. If yes, answer question #8b; Medicare is primary.

8b. If Yes to 8a, has the patient completed the ESRD coordination period? Y N

9: EMPLOYER:

Name of Insurance Company:

____

Insured's Name and Policy Number:

____

Insurer's Address:

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