

Medicare Secondary Payer Questionnaire

DATE:

Part I

1. Are you receiving Black Lung (BL) Benefits?

Yes: Date benefits began: (CCYY/MM/DD)

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

No

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

Yes; Government Program will pay primary benefits for these services

No.

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

Yes.

DVA IS PRIMARY FOR THESE SERVICES.

No.

4. Was the illness/injury due to a work related accident/condition?

Yes; Date of injury/illness: (CCYY/MM/DD)

Name and address of WC plan:

Policy or identification number:

Name and address of your employer:

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.

No.

(GO TO PART II.)

Part II

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

Yes; Date of accident: (CCYY/MM/DD)

No. GO TO PART III

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

Automobile.

Non-automobile.

Name and address of no-fault or liability insurer:

Insurance claim number:

NO FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

Other

3. Was another party responsible for this accident?

Yes; Name and address of any liability insurer:

Insurance claim number:

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

No. (GO 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?

Yes. Name and address of your employer:

No. Date of Retirement: (CCYY/MM/DD)

No. Never Employed

2. Is your spouse currently employed?

Yes. Name and address of spouse's employer:

No. Date of Retirement: (CCYY/MM/DD)

No. Never Employed

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

Yes.

No.

STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your GHP employ 20 or more employees?

Yes.

STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

Policy identification number:

Group identification number:

Name of policyholder:

Relationship to patient:

No.

STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part V - Disability

1. Are you currently employed?

Yes. Name and address of your employer:

No. Date of Retirement: (CCYY/MM/DD)

2. Is a family member currently employed?

Yes. Name and address of your employer:

No.

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3.

4. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?

Yes.

No.

STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

5. Does the employer that sponsors your GHP employ 100 or more employees?

Yes. STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of your GHP:

Name and address of GHP:

Policy identification number:

Group identification number:

Name of policyholder:

Relationship to patient:

Membership Number:

No.

STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part VI - ESRD

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

Name and address of GHP:

Policy identification number:

Group identification number:

Name of policyholder:

Relationship to patient:

Name and address of employer, if any, from which you receive GHP coverage:

No.

STOP. MEDICARE IS PRIMARY.

2. Have you received a kidney transplant?

Yes. Date of Transplant (CCYY/MM/DD)

No.

3. Have you received maintenance dialysis treatments?

Yes. Date dialysis began: (CCYY/MM/DD)

If you participated in a self-dialysis training program, provide date training started: (CCYY/MM/DD)

No.

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

Yes

No.

STOP. MEDICARE IS PRIMARY.

Part VI - ESRD *continued*

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

Yes

No.

STOP. GHP IS PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

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

Yes.

STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

No.

INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.

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

Yes.

STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.

No.

MEDICARE CONTINUES TO PAY PRIMARY.