MEDICARE SECONDARY PAYER QUESTIONNAIRE

Person Giving Information: ______________ Relationship to Patient:__________________

Patient Name: ________________________________________________________________
HIC Number: _________________________________________________________________
Patient Age__________________________ Patient Sex ___________________________

Basis for Patient Entitlement to Medicare

________ Age________ Disability __________ End Stage Renal Disease (ESRD)

Group Health Plan Information

1. Is the patient or patient’s spouse currently employed? _______ Yes _______ No
   If No:       Retirement date of patient: _______________________
   Retirement date of spouse: _____________________________

   If Yes, continue.
   Is patient or spouse employed? ________________________________

   Are there:
   __________ 1. Less than 20 employees
   __________ 2. More than 100 employees

   Is employee actively working? ________ Yes ________ No
   Insurance Company:_____________________________________________________
   Policy Number: _________________________Claim Number: ___________________
   Insurance Plan Name:___________________________________________________
   Plan Identification Number: _____________________________________________

   Is the patient employed? ____ Yes ____ No      Full Time? ______  Part Time?______
   Employer Name: _______________________________________________________
   Employer Address: _____________________________________________________
   City ___________________________ State ________ Zi p Code _____________
   Employer Identification Number: _________________________________________

Automobile, No Fault or Liability Insurance Information

2. Is the illness/injury due to an accident (auto included)? _____ Yes _____ No
   If Yes, continue.
   Type of non-work-related accident: ______ Automobile ______ Other (describe) ______
   Date of Accident: ________________________
   Insurance Situation: ___________ Liable ___________ Not Liable
   Name of Policy Holder: ___________________________________________________
   Address of Policy Holder: _________________________________________________
   Policy Number or Claim identification Number: ______________________________
   Name of Insurance Company: _____________________________________________
   Address of Insurance Company: ___________________________________________
   Name of Patient’s Legal Representative for the case if any: _______________________
   Phone Number of Legal Representative: ______________________________________
Workers Compensation Insurance Information

3. Was the patient involved in a work-related accident? __________ Yes _______ No
   If Yes, continue.

Date of Accident: ________________________________________________

Is the patient working? ___ Yes ___ No ___ Full Time? ___ Part time?_____

Employer Name: _________________________________________________

Employer Address: _______________________________________________

City _____________________ State________ Zip Code ____________

Employer Identification Number: _________________________________

Name of Insurance Company: _______________________________________

Name of Person or Company Insured: _______________________________

Insurance Company Claim or Policy Number: ___________________________

Workers Compensation Claim Number: ________________________________

Name of Workers Compensation Agency where claim was filed: ____________

Address of Agency: _______________________________________________

Has the case been settled? ______ Yes _____ Date ________ No

Name of Patient’s Legal Representative for the case if any:_________________

Phone Number of Legal Representative: _______________________________


Veteran’s Administration (VA) Authorization Information

Does the patient have a VA fee service card? _____ Yes _____ No

Has the VA issued a special authorization for these services?_____ Yes _____ No

Does the patient authorize you to bill the VA? _____ Yes _____ No


Black Lung Insurance Information

Is the patient entitled to benefits under the
Department of Labor’s Black Lung Program? _____ Yes_____ No

Are the services provided on the Department of Labor’s list of
approved procedures for the treatment of Black Lung Disease? _____ Yes _____ No

__________________________
Patient Signature          Date

__________________________
Witness Signature          Date