McLaren Medical Group

Medicare Secondary Payer Questionnaire

Medicare requires providers to ask questions regarding a beneficiary's other insurance, employment, retirement, eligibility status, and potential liability information. Please answer the following questions to the best of your ability. If you need assistance please ask one of our staff members.

Patient Name**:** _____ Date of Birth: _____

Date of Service: _____

Information Provided by: _____ Relationship to Patient: _____

Form Completed by: _____ Completion Date/time: _____

1. Is the patient covered by the Federal Black Lung Program? **YES** **NO**
    a. Date Black Lung benefits began: _____

2. Is the patient entitled to benefits thru the Department of Veteran Affairs (DVA), due to having a service-related injury? **YES** **NO**
    a. If yes, has the DVA agreed to pay for the care at this facility? **YES** **NO**

3. Should the illness/injury be covered by a Worker's Compensation claim? **YES** **NO**
    a. If yes, what was the date of injury? _____. Please provide a copy of the claim information

4. Was the illness/injury due to a non-work related accident? **YES** **NO**
    a. Was the injury auto or non-auto related _____
    b. Is no-fault or liability insurance available? **YES** **NO**
        i. If yes, please provide the insurance company information and claim number
    c. Is there another party responsible for the accident or injury? **YES** **NO**
        i. If yes, please provide the name of the company, claim number and address

5. Is the patient entitled to Medicare based on:
    a. Age? **YES** **NO**
        i. Is the patient employed? **YES** **NO**
            1. If no, date of retirement: _____
            2. If yes, please provide employer's name and address
        ii. Is the patient's spouse currently employed? **YES** **NO**
            1. If no, date of retirement: _____
            2. If yes, please provide employer name and address
        iii. Is the patient covered by a Group Health Plan? **YES** **NO**
            1. If yes, # of employees _____

2. If yes, please provide the insurance name, address, policy #, name of policy holder, relationship to patient, name of the employer providing coverage, and the employer's address

b. Disability? **YES** **NO**
   i. If yes, date of disability: _____
c. End-Stage Renal Disease (ESRD)? **YES** **NO**
   i. Has the patient received a kidney transplant? **YES** **NO**
      1. If yes, date of transplant? _____
   ii. Has the patient received maintenance dialysis treatments? **YES** **NO**
      1. If yes, date of first dialysis: _____
   iii. If patient participated in self-dialysis program, provide date training started _____
   iv. Is patient within the 30-month coordination of benefits? **YES** **NO**
   v. Is the patient entitled to Medicare due to **ESRD and age** or **ESRD and disability** (circle one)
   vi. Was initial entitlement to Medicare based on ESRD? **YES** **NO**
   vii. Does the working aged or disability MSP provision apply? **YES** **NO**

6. Are services to be paid by a government program, such as a research grant? **YES** **NO**
   a. If yes, what is the name and address of the government program?
      _____
      _____
   b. What was the time span of the study by the government program?
      _____

*If the answer to any of the above questions, other than 5A is yes, Medicare will be the "Secondary Insurance carrier" and other insurance would be primary. Please give the other insurance information to the receptionist