McLaren

CARO REGION

401 N. HOOPER ST.
CARO, MICHIGAN 48723-0435
(989)673-3141

MEDICARE SECONDARY PAYOR QUESTIONNAIRE

Patient Name: _____ Date of Service: _____

PART 1

(Circle correct response)

1. Are you receiving Black Lung benefits? Yes No Date: _____
   Is Black Lung Primary Payer for this claim? Yes No
2. Are you receiving a Government Grant for these services? Yes No
3. Has the Department of Veterans Affairs authorized and agreed to pay for your care at this facility? Yes No
4. Department of Veterans Affairs is primary for these services? Yes No

PART 2

(Fill in Yes or No next to correct response, then enter information as instructed)

5. Auto Accident? _____ Accidental Injury? _____ Work Related? _____ Slip and Fall? _____
   Claim Date: _____ Address: _____
   Phone Number: _____ Contact Person:_____
   Claim Number: _____
   How the injury/illness occurred: _____
   _____

PART 3

(Select one)

6. Are you entitled to Medicare Based on: Age? _____ Disability? _____ End Stage Renal Disease? _____

PART 4

AGE

1. Are you employed? _____ Retirement Date: _____ Never Employed? _____
   If currently employed, name and address of current employer: Full time: _____ Part time: _____
   Name: _____ Address: _____
2. If married is spouse employed? _____ Retirement Date: _____ Never Employed? _____
   If spouse employed, name and address of current employer: Full time: _____ Part time: _____
   Name: _____ Address:_____

3. Are you or your spouse covered under Group Health Plan thru current employer? _____
4. Does the employer that sponsors your Group Health Plan employee 20 or more employees? If Yes, obtain the following:
   *Employer: _____
   *Contract #: _____ *Group #: _____
   *Policy Holder: _____

PART 5

DISABILITY

1. Are you disabled but employed? _____ Retirement Date: _____ Never Employed? _____
   Employer Name and Address: _____
2. Is spouse disabled but employed? _____ Retirement Date: _____ Never Employed? _____
   Employer Name and Address: _____
3. Are you or your spouse covered under Group Health Plan thru current employer? Yes No
   Self: ____ Spouse: ____ If you answered yes to the above question, name of Group Health Plan:_____
   Employer: _____
   Contract #: _____ Group #: _____
   Policy Holder: _____

IF NO TO QUESTIONS 1-3, MEDICARE IS PRIMARY, SKIP QUESTIONS 4&5

4. Are you disabled and employed with Group Health Plan with more than 100 employees? _____
5. Are you disabled and covered under your spouse's Group Health Plan with more than 100 employees? _____

PART 6

ESRD

1. Are you entitled to benefits only on the basis of ESRD? _____
2. Are you covered by a Group Health Plan? _____ (If answer is YES, MC may be secondary. If NO, and you're covered by a GHP with over 100 employees, then MC is secondary).
3. Have you received a kidney transplant? _____ Date of transplant? _____
4. Have you been undergoing dialysis for more than 30 months? _____
   Date of first dialysis: _____
5. Have you been entitled to Medicare for more than 30 months? _____
   If answer to questions 3 or 4 is yes, MC is primary.