

**McLaren Print System Order**

**Order No: 71742 Reprint Previous Order No: 5554**  
**Order Date: 2022-08-15**  
**User: Casey Coleman**  
**Phone: 5862864880**

**Ship Location: MACOMB WOMENS HEALTH**  
**37400 GARFIELD SUITE 200**  
**CLINTON TOWNSHIP, MI 48036**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 72100**  
**Dept Name: WHA CLINTON**  
**Company Number: 810**

**Order Total Price: 0.00**

**Item Number: MM-34608**  
**Item Description: Medicare Secondary Payer Questionnaire**  
**Revision Date: 8/2019**  
**Print: 1 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**Misc Info:**

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  
b. Is the patient's spouse currently employed? **YES NO**  
1. If no, date of retirement: \_\_\_\_\_  
2. If yes, please provide employer name and address  
c. Is the patient covered by a Group Health Plan? **YES NO**  
1. If yes, # of employees: \_\_\_\_\_