McLaren Business Products

McLaren Print System Order

Order No: 78106 Reprint Previous Order No: 5554
Order Date: 2023-06-28
User: MICHELLE GALATI
Phone: 5867254604

Ship Location: McLaren Womens Health Chesterfield
51086 Fairchild Rd
Chesterfield, Michigan 48051
Forms
Quantity: 100
Paragon Dept No: 72000
Dept Name: McLaren Womens Health Chesterfield
Company Number: 810

Order Total Price: 0.00

Item Number: MM-34608
Item Description: Medicare Secondary Payer Questionnaire
Revision Date: 8/2019
Print:
Paper:
Size:
Fold:
Finish:
Drill:
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
      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 _____

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