Medicare Secondary Payer Questionnaire

Patient Name: ______________________________ DATE: __________

Patient HICN #: ______________ Date of Service From: __________ Through: __________ Provider: 9392911

Person Supplying This Information: ______________________ Relationship to Patient: ______________

NOTE: THIS QUESTIONNAIRE INFORMATION EXPIRES APPROXIMATELY 90 DAYS FROM DATE SUPPLIED

PART I

1. Are you receiving Black Lung (BL) benefits?

◯ **YES** Date when benefits began: __________ *(BL is primary only claims related to BL)*

◯ **NO**

2. Are the services to be paid by a government program such as a research grant?

◯ **YES** *(Government program will pay primary benefits for these services)*

◯ **NO**

3. Has the Deparment of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?

◯ **YES** *(DVA is primary for these services)*

◯ **NO**

4. Was the illness/injury due to a work-related accident/condition?

◯ **YES** Date of injury/illness: __________

Name & Address of WC plan: ______________________________

Policy or Identification Number: ______________________________

Name & Address of your employer: ______________________________

◯ **NO** ______________________________

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK-RELATED INJURIES OR ILLNESSES. GO TO PART III

PART II

1. Was illness/injury due to a non-work-related accident?

◯ **YES** Date of accident: __________

◯ **NO** **GO TO PART III**

2. What type of accident caused the illness/injury?

◯ **AUTOMOBILE** *(Medpay)*

◯ **NON-AUTOMOBILE** *(Medpay)*

Name & Address of no-fault *(Medpay)* or liability insurer: ______________________________

____

Insurance Claim Number: ______________________________

NO FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III

◯ **OTHER**

Part II continued on page 2

3. Was another party responsible for this accident?

◯ **YES** Name & Address of any liability insurer: ______________________

____

Insurance Claim Number: ______________________

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III

◯ **NO** **GO TO PART III**

PART III

1. Are you entitled to Medicare based on:

◯ **AGE** **GO TO PART IV**
◯ **DISABILITY** **GO TO PART V**
◯ **ESRD** **GO TO PART IV**

PART IV – AGE

1. Are you currently employed?

◯ **YES** Name & Address of your employer: ______________________

____

◯ **NO** Date of retirement: __________

2. Is your spouse currently employed?

◯ **YES** Name & Address of your employer: ______________________

____

◯ **NO** Date of retirement: __________

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 & 2, MEDICARE IS PRIMARY – UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan (GHP) coverage based on you own, or a spouse's current employment?

◯ **YES**

◯ **NO** **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR PART II.**

4. Does the employer that sponsors your GHP employ 20 or more employees?

◯ **YES** **STOP. GROUP HEALTH PLAN (GHP) IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION:**

Name & Address of GHP: ______________________

____

Policy Identification Number: ______________________

Group Identification Number: ______________________

Name of Policyholder: ______________________ Date of Birth: __________

Relationship to Patient: ______________________

◯ **NO** **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR PART II.**

Part V continued on page 3

PART V – DISABILITY

1. Are you currently employed?

◯ **YES** Name & Address of your employer: ______________________

____

◯ **NO** Date of retirement: __________

2. Is a family member currently employed?

◯ **YES** Name & Address of employer: ______________________

____

◯ **NO**

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 & 2, MEDICARE IS PRIMARY – UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan (GHP) coverage based on you own, or a family member's current employment?

◯ **YES**

◯ **NO** **STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR PART II**

4. Does the employer that sponsors your GHP employ 100 or more employees?

◯ **YES** **STOP. GROUP HEALTH PLAN (GHP) IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION:**

Name & Address of GHP: ______________________

____

Policy Identification Number: ______________________

Group Identification Number: ______________________

Name of Policyholder: ______________________ Date of Birth: __________

Relationship to Patient: ______________________

Name & Address of employer, if any, from which you received GHP coverage:

____

____

◯ **NO** **STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR PART II**

PART VI – ESRD

1. Do you have Group Health Plan(GHP) Coverage?

◯ **YES**

Name & Address of GHP: ______________________

____

Policy Identification Number: ______________________

Group Identification Number: ______________________

Name of Policyholder: ______________________ Date of Birth: __________

Relationship to Patient: ______________________

Name & Address of employer, if any, from which you received GHP coverage:

____

____

◯ **NO** **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

◯ **YES** Date of transplant: __________

◯ **NO**

Part VI continued on page 4

3. Have you received maintenance dialysis treatments?

- ◯ **YES** Date dialysis began:

  If you participated in a self-dialysis training program, provide date training started:
- ◯ **NO** **STOP. GHP IS PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

4. Are you within the 30-month coordination period?

- ◯ **YES**
- ◯ **NO** **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and Age or ESRD and Disability?

- ◯ **YES**
- ◯ **NO** **STOP. GHP IS PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

6. Was your initial entitiement to Medicare (including simultaneous entitlement) based or ESRD?

- ◯ **YES** **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
- ◯ **NO** **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the Working Aged or Disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

- ◯ **YES** **GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
- ◯ **NO** **MEDICARE CONTINUES TO PAY PRIMARY.**

IMPORTANT: PLEASE READ INFORMATION FOLLOWING ON PAGE 4 THAT WILL HELP FURTHER CLARIFY MEDICARE INFORMATION.

If the patient cannot recall his/her precise retirement date as it relates to coverage under a Group Health Plan(GHP) as a policyholder, or cannot recall the same information as it relates to his/her spouse, as applicable, the following policies are in effect:

When a Medicare patient cannot recall his/her retirement date but knows it occurred prior to his/her Medicare entitlement dates (as shown on his/her Medicare card), report his/her Medicare A entitlement date as the date of retirement. If the Medicare patient is a dependent under his/her spouse's Group Health Insurance and the spouse retired prior to the Medicare patient's Medicare Part A entitlement date, report the Medicare patient's Medicare entitlement date as his/her retirement date.

If the Medicare patient worked beyond his/her Medicare A entitlement date, has coverage under a Group Health Plan during that time, and cannot recall his/her precise date of retirement but you determined it has been at least 5 years since the Medicare patient retired, enter the retirement date as 5 years retrospective to the date of admission (that is, for example, if the date of admission is January 4, 2002, the provider should report the retirement date January 4, 1997, in the format they are currently using). As applicable, the same procedure holds for a spouse who had retired at least 5 years prior to the date of the Medicare patient's hospital admission.

If a Medicare patient's (or spouse's, as applicable) retirement date occured less than 5 years ago, providers must obtain the retirement date from appropriate informational sources: e.g., former employer or supplemental insurer.

MEDICARE DOES NOT REQUIRE A PATIENT SIGNATURE ON THIS QUESTIONNAIRE.

Notice To All Patients:
Beginning November 10, 2010, there will be a $20.00 charge billed directly to the patient for a no-show appointment. This charge will also apply to repetitive cancellations, as determined by D-MPT management.

Select location to submit form

Austintown	Kinsman
Niles	Warren