# MEDICARE SECONDARY PAYER QUESTIONNAIRE

Person Giving Information: _____ Relationship to Patient _____

Patient Name:

HIC Number: Patient Age: Patient Sex:

Basis for Patient Entitlement to Medicare (circle one)

Age Disability End Stage Renal Disease (ESRD)

## Group Health Plan Information

1. Is the patient or patient's spouse currently employed? **Yes** or **No**

If No: Retirement date of patient:

Retirement date of spouse:

If Yes, continue.

Is patient or spouse employed? **Yes** or **No**

Are There: _____ 1. Less than 20 employees

_____ 2. More than 100 employees

Is employee actively working? **Yes** or **No**

Insurance Company:

Policy Number: Claim Number:

Insurance Plan Name: _____

Plan ID Number:

Is the patient employed? **Yes** or **No** Full Time ___ Part Time

Employer Name:

Employer Address:

City State Zip

Employer ID Number: _____

## Automobile, No Fault, or Liability Insurance Information

2. Is the illness / injury due to an accident (auto included)? **Yes** or **No**

If Yes continue.

Type of non-work-related accident: **Auto** Other: _____

Date of Accident:

Insurance situation: **Liable** **Not Liable**

Name of Policy Holder: _____

Address of Policy Holder: _____

Policy or Claim ID Number:

Name of Insurance Company:

Address of Insurance Company: _____

Name of Patient's Legal Representative for the case, if any? _____ _____

Phone Number of Legal Representative: _____

## Workers Compensation Insurance Information

3. Was the patient involved in a work-related accident? **Yes** or **No**

If Yes, continue.

Date of Accident:

Is the patient working? (circle one) **Yes** **No** **Full Time** **Part Time**

Employer Name:

Employer Address:

City State Zip

Employer ID Number: _____

Name of Insurance Company:

Name of Person or Company Insured: _____

Insurance Company Claim or Policy Number:

Workers Compensation Claim Number: _____

Name of Workers Compensation Agency where claim is filed: _____

Address of Agency: _____

Has the case been settled? **Yes** - Date _____ **No**

Name of Patient's Legal Representative for the case, if any? _____ _____

Phone Number of Legal Representative: _____

## Veteran's Administration (VA) Authorization Information

Does the patient have a VA fee service card? (circle one) **Yes** or **No**

Has the VA issued a special authorization for these sevices? (circle one) **Yes** or **No**

Does the patient authorize you to bill the VA? (circle one) **Yes** or **No**

## Black Lung Insurance Information

Is the patient entitled to benefits under the Department of Labor's Black Lung Program? **Yes** or **No**

Are the services provided on the Department of Labor's list of approved procedures for the treatment of Black Lung Disease? **Yes** or **No**

_____

Patient Signature Date

_____

Witness Signature Date

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