Medicare Secondary Payer Questionnaire

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. Are you receiving benefits from any of the following programs?

Black Lung	☐ YES (This is Primary)	☐ NO
Research Grant	☐ YES (This is Primary)	☐ NO
Veteran Affairs	☐ YES (This is Primary)	☐ NO

2. Was illness/injury due to a work related accident/condition?

☐ YES ☐ NO

If YES, answer the following:
☐ Work related accident (Obtain date of injury and claims address)
☐ Non-work related accident (Obtain any home or auto insurance info for billing)

3. Is the patient currently employed?

☐ YES (answer next question) ☐ NO

☐ Do you have a group health plan (GHP) coverage? If yes, are there under or over 20 employees?
☐ OVER (Stop- GHP is primary) ☐ UNDER

4. Is the patient's spouse currently employed?

☐ YES (answer next question) ☐ NO

Does your spouse have a group health plan (GHP) coverage? If yes, are there under or over 20 employees?
☐ OVER (Stop- GHP is primary) ☐ UNDER

5. Is the patient entitled to Medicare benefits as a result of:
Age _______

End state Renal (Kidney) Disease? ☐ YES (Next question) ☐ NO
Are you within 30-month coordination period? ☐ YES (Stop- GHP primary) ☐ NO

Disability? ☐ YES ☐ NO

6. **Are you currently a patient in a skilled nursing facility such as a nursing home?**
(ALERT: If yes, bill SNF not Medicare.)

☐ YES ☐ NO

I confirm that the above information is correct.

Patient Printed Name: ____

Patient Signature: ____