

Date _____

Medicare Secondary Payor Questionnaire

Name _____ Acct # _____ Hic # _____ Provider # _____

Part I

1. Are you receiving Black Lung Benefits?

___ No ___ Yes (Black Lung is prim for claims related to Black Lung)-Complete Part II

2. Are these Rehab services to be paid for by a government program or research grant?

___ No ___ Yes (Government Program will pay primary)-Complete Part II

3. Has the Dept of Veterans Affairs authorized and agreed to pay for services at this facility?

___ No ___ Yes (DVA is primary for these services)-Complete Part II

4. Was this illness/injury due to a non-work related or auto accident?

___ No ___ Yes- Complete Part II

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

___ No ___ Yes-Complete Part II

6. Are you entitled to End Stage Renal Disease (ESRD) benefits? (Medicare Secondary for 30 months)

___ No ___ Yes-Complete Part II

7. Are you under 65 and employed by an employer with health benefits that has more than 100 employees?

___ No ___ Yes - Complete Part II

Does an employer with health benefits that has more than 100 employees employ your spouse?

___ No ___ Yes - Complete Part II

8. Are you over 65 and employed by an employer with health benefits that has more than 20 employees?

___ No - Date of Retirement _____ ___ Yes - Complete Part II

Does an employer with health benefits that has more than 20 employees employ your spouse?

___ No - Date of Retirement _____ ___ Yes - Complete Part II

If all answers to the above questions are no, then Medicare is primary.

PART II

Please give details and date of illness/injury including kidney transplant date if applicable:

Provide primary insurance information due to liability or employer group health plan:

Claim/ID Number: _____

Insurance Company and Address: