Medicare Secondary Payer Questionnaire

PATIENT NAME: _____ . . _____ DOB: _____ DATE: 2/18/2021

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

   Black Lung ____No ____Yes Veteran Affairs ____No ____Yes

   Research Grant ____No ____Yes

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

   _____ No _____ Yes Date of injury/illness: _____

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

   _____ No _____ Yes Date of accident: _____

   What type of accident caused the illness/injury?

   _____ Automobile _____ Non-automobile

4. Are you entitled to Medicare based on:

   _____ Age _____ Disability _____ End Stage Renal Disease

5. Are you currently employed?

   _____ No _____ Yes

6. Is your spouse currently employed?

   _____ No _____ Yes

7. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?

   _____ No _____ Yes

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

   _____ No _____ Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home?

   _____No _____ Yes

10. Are you currently receiving home health care services

    _____No _____Yes

I confirm that the above information is correct.

Patient Signature:_____ Date:_____

Please Print Name:_____