COAST SURGERY CENTER
Medicare Secondary Payer Questionnaire
(Short Form)

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

Black Lung	**____No____Yes**
Research Grant	**____No____Yes**
Veteran Affairs	**____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?
(Long form not required. ALERT: If yes, bill SNF not Medicare)

_____No _____ Yes

I confirm that the above information is correct.

Patient Signature:_____

Please Print Name:_____