

Medicare Secondary Payer Questionnaire (Short Form)

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

Black Lung	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
Research Grant	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
Veteran Affairs	<input type="checkbox"/>	No	<input type="checkbox"/>	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: _____

Date: _____

Please Print Name: _____