Medicare Secondary Payer Questionnaire
Long Form

Were you transferred to our facility from another hospital where you are currently an inpatient?

_____**No** _____ **Yes**

If YES, STOP. You will not need to fill out the rest of the form.

PART I

1. Are you receiving Black Lung (BL) Benefits?
   _____ Yes. Date benefits began: CCYY/MM/DD _____
   BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.
   _____ No.
2. Are the services to be paid by a government program such as a research grant?
   _____ Yes. **Government program will pay primary benefits for these services.**
   _____ No.
3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?
   _____ Yes. **DVA IS PRIMARY FOR THESE SERVICES**.
   _____ No.
4. Was the illness/injury due to a work related accident/condition?
   _____ Yes. Date of injury/illness: CCYY/MM/DD _____
   Name and address of Workers' Compensation (WC) plan:
   _____
   _____
   _____
   Patient's policy or identification number _____
   Name and address of your employer:
   _____
   _____
   _____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART III.

_____ No. **GO TO PART II.**

PART II

1. Was illness/injury due to a non-work related accident?
   _____ Yes. Date of accident: CCYY/MM/DD _____
   _____ No. **GO TO PART III.**
2. What type of accident caused the illness/injury?
   _____ Automobile
   _____ Non-automobile
   Name and address of no-fault or liability insurer:
   _____
   _____
   _____
   Insurance claim number _____

Continued on next page

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

_____ Other.

3. Was another party responsible for this accident?

_____ Yes.

Name and address of any liability insurer:

_____

_____

_____

Insurance claim number _____

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

_____ No. **GO TO PART III.**

PART III

1. Are you entitled to Medicare based on:

_____ Age. **Go to Part IV.**

_____ Disability. **Go to Part V.**

_____ ESRD. **Go to Part VI.**

PART IV - Age

1. Are you currently employed?

_____ Yes.

Name and address of your employer:

_____

_____

_____

_____ No. Date of retirement: CCYY/MM/DD _____

_____ No, never employed.

2. Is your spouse currently employed?

_____ Yes.

Name and address of spouse's employer:

_____ No. Date of retirement: CCYY/MM/DD _____

_____ No, never employed.

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR PART II. DO NOT PROCEED ANY FURTHER.

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

_____ Yes.

_____ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR PART II.**

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

_____ Yes.

STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Continued on next page

Name and address of GHP:

_____
_____
_____
Policy identification number _____
Group identification number _____
Membership number_____
Name of policy holder _____
Relationship to patient _____

_____ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part V - Disability

1. Are you currently employed?

_____ Yes.
Name and address of your employer:

_____
_____
_____

_____ No. Date of retirement: CCYY/MM/DD _____
_____ No, never employed

2. If married, is your spouse currently employed?

_____ Yes.
Name and address of your spouse's employer:

_____
_____
_____

_____ No.

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

_____ Yes.
_____ No.

4. Are you covered under the group health plan of a family member other than your spouse?

_____ Yes.
Name and Address of your family members employer:

_____
_____
_____
_____ No.

IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1, 2, 3 AND 4 STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR PART II. DO NOT PROCEED ANY FURTHER.

5. Does the employer that sponsors your GHP, employ 100 or more employees?

_____ Yes.

Continued on next page

STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

_____

_____

_____

Policy identification number _____Member ID#_____

Group identification number _____

Name of policy holder _____

Relationship to patient _____

_____ No.

STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

_____ Yes.

Name and address of GHP:

_____

_____

_____

Policy identification number _____

Group identification number _____

Name of policy holder _____

Relationship to patient _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

_____ No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

_____ Yes. Date of transplant: CCYY/MM/DD _____

_____ No.

3. Have you received maintenance dialysis treatments?

_____ Yes. Date dialysis began: CCYY/MM/DD

If you participated in a self dialysis training program, provide date training started: CCYY/MM/DD _____

_____ No.

4. Are you within the 30 month coordination period?

_____ Yes.

_____ No. **STOP. MEDICARE IS PRIMARY**.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

_____ Yes. **STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

_____ No.

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

_____ Yes.

Continued on next page

STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

_____ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

_____ Yes. **GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

_____ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

Patient Signature_____

Print Patient name_____

Date_____

"FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE (SEE SECTION 142.3F.) THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR A PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS".