MEDICARE SECONDARY PAYER QUESTIONNAIRE

(TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

NAME:_____

DATE OF SERVICE:_____

(If any answer to questions 1A. thru 4. is yes, the corresponding section of the "Other Ins" form must be filled out completely.)

	YES	NO
1. Is the patient a veteran?	_____	_____
A. Did the VA refer you here for treatment?	_____	_____
B. Does the patient have a VA "Fee Basis ID Card?"	_____	_____
2. Do you have a Federal Black Lung Card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____

If "YES" was it: Work Related Auto Injured in Own Home Other

4. Is the patient covered by a Health Insurance Plan through their own CURRENT employment or that of a family member? (Not Retiree Coverage) _____ _____

(Information obtained in questions 5 thru 7 should be used when coding your claim for Medicare.)

5. Is the patient employed? YES_____ NO_____

   If "NO" did you retire in the last two years? YES_____ NO_____

   If "YES" give retirement date _____

6. Is the spouse employed? YES_____ NO_____

   If "NO" did your spouse retire in the last two years? YES_____ NO_____

   If "YES" give retirement data _____

7. Please check the reason the patient is Medicare eligible: **(PLEASE CHECK ONLY ONE)**

   Age 65 or Over_____ Disabled_____ End Stage Renal Disease (ERSD)_____
   ERSD Effective Dates:_____
   (The month Kidney Dialysis began)
   Part A_____ Part B_____

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

I understand that if my Medicare coverage is terminated due to my failure to pay premiums I am responsible for all expenses incurred.

SIGNATURE:_____ **DATE:**_____