

**MEDICARE SECONDARY PAYER QUESTIONNAIRE**

Person Giving Information: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 HIC Number: \_\_\_\_\_  
 Patient Age \_\_\_\_\_ Patient Sex \_\_\_\_\_  
 Basis for Patient Entitlement to Medicare  
 \_\_\_\_\_ Age \_\_\_\_\_ Disability \_\_\_\_\_ End Stage Renal Disease (ESRD)

**Group Health Plan Information**

1. Is the patient or patient's spouse currently employed? \_\_\_\_\_ Yes \_\_\_\_\_ No

If No: Retirement date of patient: \_\_\_\_\_

Retirement date of spouse: \_\_\_\_\_

If Yes, continue.

Is patient or spouse employed?

Are there: \_\_\_\_\_

1. Less than 20 employees

2. More than 100 employees

Is employee actively working? \_\_\_\_\_ Yes \_\_\_\_\_ No

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Plan Identification Number: \_\_\_\_\_

Is the patient employed? \_\_\_\_\_ Yes \_\_\_\_\_ No Full Time? \_\_\_\_\_ Part Time? \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer Identification Number: \_\_\_\_\_

**Automobile, No Fault or Liability Insurance Information**

2. Is the illness/injury due to an accident (auto included)? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, continue.

Type of non-work-related accident: \_\_\_\_\_ Automobile \_\_\_\_\_ Other (describe) \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Insurance Situation: \_\_\_\_\_ Liable \_\_\_\_\_ Not Liable

Name of Policy Holder: \_\_\_\_\_

Address of Policy Holder: \_\_\_\_\_

Policy Number or Claim identification Number: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Name of Patient's Legal Representative for the case if any: \_\_\_\_\_

Phone Number of Legal Representative: \_\_\_\_\_

**Workers Compensation Insurance Information**

3. Was the patient involved in a work-related accident? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If Yes, continue.

Date of Accident: \_\_\_\_\_  
 Is the patient working? \_\_\_\_\_ Yes \_\_\_\_\_ No Full Time? \_\_\_\_\_ Part Time? \_\_\_\_\_  
 Employer Name: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Employer Identification Number: \_\_\_\_\_  
 Name of Insurance Company: \_\_\_\_\_  
 Name of Person or Company Insured: \_\_\_\_\_  
 Insurance Company Claim or Policy Number: \_\_\_\_\_  
 Workers Compensation Claim Number: \_\_\_\_\_  
 Name of Workers Compensation Agency where claim was filed: \_\_\_\_\_  
 Address of Agency: \_\_\_\_\_  
 Has the case been settled? \_\_\_\_\_ Yes \_\_\_\_\_ Date \_\_\_\_\_ No  
 Name of Patient's Legal Representative for the case if any: \_\_\_\_\_  
 Phone Number of Legal Representative: \_\_\_\_\_

**Veteran's Administration (VA) Authorization Information**

Does the patient have a VA fee service card? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Has the VA issued a special authorization for these services? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Does the patient authorize you to bill the VA? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Black Lung Insurance Information**

Is the patient entitled to benefits under the  
 Department of Labor's Black Lung Program? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Are the services provided on the Department of Labor's list of  
 approved procedures for the treatment of Black Lung Disease? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
 Patient Signature Date

\_\_\_\_\_  
 Witness Signature Date