

Medicare Secondary Payor Questionnaire

PART I:

1. Are you receiving Black Lung (BL) benefits or has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?
 Yes. Date benefits began: ___/___/___ STOP. Complete Part VII
BL or DVA is primary for these services No. Go to Question 2
2. Is this illness/injury due to a work related accident/condition (WC)?
 Yes. Date of illness/injury: ___/___/___ STOP. Complete Part VIII and IX
Workers Compensation Will Pay Primary Benefits Only For Work Related Injuries or Illness No. Go to Question 3
3. Are the services to be paid by a government *research* program?
 Yes. Complete VII STOP. No. Go to Question 4
Government Program will Pay Primary Benefits

PART II:

4. Is this illness/injury due to a non-work-related accident? (Such as a Motor Vehicle Accident)
 Yes. Date of accident: ___/___/___ Answer Next 2 Questions No. Go to Question 5

Is no-fault insurance available? (Pays for health care services resulting from injury regardless of fault)
 Yes. STOP. Complete Part VIII No. Go to Question 5
No fault/Liability Insurer Primary for Claims related to the accident

Is liability insurance available? (Pays for health care services based on negligence)
 Yes. STOP. Complete Part VIII No. Go to Question 5
No fault/Liability Insurer Primary for claims related to this accident

NO-FAULT OR LIABILITY INSURER IS PRIMARY ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT OR LIABILITY SETTLEMENT, JUDGMENT OR AWARD. GO TO PART III

PART III: Entitlements:

5. Are you entitled to Medicare based on
 Age (over 65). Go to Part IV
 Disability. Go to Part V
 End Stage Renal Disease (ESRD). Go to Part VI.

PART IV: AGE

- A. Are you , or your spouse, currently employed?
 Yes. Go To B No. STOP. Medicare is Primary
Date of your retirement ___/___/___.
Date of spouse's retirement ___/___/___.
- B. Do you have Group Health Plan (GHP) coverage based on your own, a spouse or family members current employment?
 Yes, family member Yes, self Yes, spouse. (check all that apply) No. STOP. Medicare is Primary
If yes to any go to C
- C. Does the employer that sponsors your GHP employ 20 or more employees?
 Yes. Complete Part IX and X and STOP. GHP is primary. No. STOP. Medicare is Primary

PART V : DISABILITY

- A. Do you have Group Health Plan (GHP) coverage? (Self, Spouse or other family member)
 Yes. Complete Part VIII & IX and go to B. No. STOP. Medicare is Primary
- B. Does the employer that sponsors your GHP employ 100 or more employees?
 Yes. Complete Part VIII and IX and STOP. GHP is primary. No. STOP. Medicare is Primary

PART VI: ESRD:

- A. Do you have Group Health Plan (GHP) coverage? (Self, Spouse or other family member)
 Yes. Complete Part IX and X. Go to next question No. STOP. Medicare is Primary

- B. Have you Received a kidney transplant?
 - Yes. Date of Transplant ? ____/____/____
 - No. Go to C

- C. Have you Received Maintenance Daialysis Treatments?
 - Yes. Date Dialysis began ____/____/____
 - No. Go to D.

- D. Are you within the 30-month coordination period? (*The 30-month coordination period starts the first day of the month an Individual is eligible for Medicare, (even if not yet enrolled) because of kidney failure (usually the 4th month of dialysis). If The individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period The 30-month coordination peiod starts with the first day of the month of dialysis or transplant.*)
 - Yes. Go to E
 - No. STOP. Medicare is Primary

- E. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
 - Yes. STOP. GHP Primary during 30-Month Coordination Period.
 - No. Initial Entitlement based on age or Disability. Go to next question

- F. Does the working aged or disability provision apply? (GHP already primary based on age or disability entitlement?)
 - Yes. STOP. GHP Primary during 30-Month Coordination Period.
 - No. STOP. Medicare is Primary

Part VII: BLACK LUNG, WORKMANS COMP, RESEARCH

Name and address of Black Lung Carrier, Research Program, VA Provider, or Workmans Comp Plan. _____

Policy, Identification or HIPAA Number: _____

Part VIII : NO Fault/ Liability

Name and address of No-Fault/Liability Insurer and Policy Owner: _____

Insurance Claim Number: _____

Part IX: Employer Information:

| | Patient | Spouse |
|-----------------------------|---------|--------|
| Name & Address of Employer: | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

Part X: GHP Information:

| | Patient | Spouse |
|-------------------------------|---------|--------|
| Name of Group Health Plan: | _____ | _____ |
| Address of Group Health Plan: | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| Policy ID Number: | _____ | _____ |
| Group ID Number: | _____ | _____ |
| Name of Policy Holder: | _____ | _____ |
| Relationship to Patient: | _____ | _____ |

 Representative (employee) & Date

 Witness & Date

