Medicare Secondary Payer Questionnaire

Name:_____ Date:_____

Medicare law requires that we determine if your medical services might be covered under another insurer. In order to assist us in the correct billing of these services, please answer the following questions:

Please answer yes or no to each question. For yes answer, please fill in the rest of the section.

Is your spouse, parent or guardian employed? ___No, Date of Retirement, if applicable _____

____Yes, Insured's Name _____ Date of Birth: _____

Employer Name and Address:

_____

_____

Are you receiving Disability Benefits? ____ No ____Yes

Were you in a work-related accident or do you have a work-related condition?____ No ____Yes

*Name and address of worker's compensation plan:*_____

_____

Medicare ID#: _____ *Accident Date:* _____

Do you have a condition covered under the Federal Black Lung Program? ____ No ____Yes

Is your condition the result of an automobile accident? ____ No ____Yes

Name and address of Auto Insurance: _____

_____

*Adjustor:*_____ *Phone:*_____ *Fax:*_____

Claim ID#: _____*Accident Date:* _____*State where accident happened* ____

…an accident other than an automobile accident? ____ No ____Yes

Name and address of No-fault Insurer: _____

_____

*Name of Insured*_____ *Policy ID #:* _____

Accident Date: _____*Accident Location:*_____

Are you eligible for coverage under the Veteran's Administration? ____ No ____Yes

Are you employed? _____No, Date of retirement _____

___ Yes, Employer name and address: _____

_____

Do you have Employer Group Health Plan Coverage? _____ No ____Yes

Thank you for your cooperation in ensuring that your medical services will be billed to the proper insurer(s).