

MEDICARE SECONDARY PAYER QUESTIONNAIRE



YOUR LOCAL,
NOT-FOR-PROFIT
HOSPICE
www.tidewell.org

(PLEASE PRINT)

| | | |
|----------------------|------------------------|--------------|
| PATIENT NAME: | PATIENT NUMBER: | DATE: |
|----------------------|------------------------|--------------|

1. Is this illness/injury covered by Workers' Compensation? Yes No
If yes, note employer name and address and claim number, if assigned, in # 11.
2. Is this illness/injury covered by the Black Lung Program? Yes No
If yes, note where billing should be sent in #11.
3. Is this patient a member of a Health Maintenance Organization (HMO)? Yes No
If yes, what is the name and address of the HMO? Complete #11.
4. Is this illness/injury due to an automobile accident? Yes No
If yes, what is the name of the automobile insurer responsible for coverage? Complete #11.
5. Does this patient feel that another party is responsible for this illness/injury? Yes No
Name of responsible party: _____
Name of liability insurer/attorney: _____
Address of liability insurer/attorney: _____
6. Is this patient covered by any Employer Group Health Plan (EGHP) including Federal Employee Health Benefits? Yes No
If no, move to Prior Stay Information. If yes, move to #7.
7. Is this patient age 65 or older? Yes No
If no, move to #9. If yes, move to #8.
8. Is this patient or the patient's spouse actively employed by an employer of 20 or more employees? Yes No
If yes, enter the EGHP data in #11. If no, move to Prior Stay Information.
9. Is this patient entitled to Medicare coverage solely on the basis of a disability? Yes No
If no, move to #10. If yes, is this patient or the patient's spouse or parent actively employed by an employer of 100 or more employees?
If yes, enter the Large Group Health Plan data in #11. If no, move to Prior Stay information.
10. a. Is this patient entitled to Medicare coverage solely on the basis of End Stage Renal Disease (ESRD)? Yes No
If no, move to Prior Stay Information.
b. Has this patient completed the ESRD coordination period?
If no, enter the EGHP data in #11. If yes, move to Prior Stay Information.
11. Name of Insurance Company or HMO _____
Insured's Name and Policy Number _____
Employer _____
Address of Insurance Company or HMO _____
12. Are you entitled to Veteran's Administration (VA) .benefits? Yes No