Medicare Secondary Payer Questionnaire

Patient Account Number: _____

Patient Name: _____ **DOB:** _____/_____/_____

Are you currently being seen by a Home Health Agency?

_____ Yes _____ No

If No, continue to question 1. If Yes, they are the PRIMARY Payer and services must be authorized by the HHA.

1. Are you entitled to benefits under Black Lung Program, Department of Veteran Affairs or other Government program?

_____ Yes go to # 17 _____ No go to #2

2. Was illness/injury due to work related incident covered by a workers compensation plan?

_____ Yes go to # 17 _____ No go to #3

3. Was illness/injury due to a non work related accident?

_____ Yes go to # 4 _____ No go to #6

4. What type of accident caused illness/injury?

_____ Automobile go to #17 _____ Non-Automobile go to #5

5. Was another party responsible for this accident?

_____ Yes go to # 17 _____ No go to #6

6. Are you age 65 or older?

_____ Yes go to # 9 _____ No go to #7

7. Are you entitled to Medicare benefits based solely on End Stage Renal Disease (ESRD)?

_____ Yes go to # 11 _____ No go to #8

8. Are you a disabled Medicare beneficiary under the age of 65?

_____ Yes go to # 15 _____ No Medicare is Primary Payer

9. Are you covered under a group health plan (GHP) through your spouse?

_____ Yes go to # 10 _____ No Medicare is Primary Payer

10. Does the employer have 20 or more employees?

_____ Yes go to # 17 _____ No Medicare is Primary Payer

11. Have you received a kidney transplant or are currently undergoing renal dialysis for End Stage Renal Disease?

_____ Yes go to # 12 _____ No go to #13

12. Date of transplant or start of dialysis _____

_____ If less than 12 months go to #13 _____ If over 12 months Medicare is Primary

13. Do you have group health plan coverage through your or other family members employer?

_____ Yes go to #14 _____ No Medicare is Primary Payer

14. Are you within the 30 month coordination period?

_____ Yes go to # 17 _____ No Medicare is Primary Payer

15. Are you covered under a group health plan based on you or other family members employment?

_____ Yes go to # 16 _____ No Date of retirement _____

If No, Medicare is Primary Payer

16. Does the employer have 100 or more employees?

_____ Yes go to end _____ No Medicare is Primary Payer

17. Check the appropriate box for the primary payer.

☐ BL/VA/Gov Prog. ☐ Work Comp ☐ Auto Insurance

☐ Liability Insurance ☐ #10 GHP ☐ # 14 GHP ☐ #15 GHP

Policy or ID number _____ Contact phone number _____

Contact/Case Manager/Adjustor _____

MEDICARE IS SECONDARY PAYER TO THE ABOVE IDENTIFIED INSURER

_____ _____ _____

Patient Signature Valir Employee Signature Date