Medicare Secondary Payer Form Questionnaire

PART I:

1. Are you receiving Black Lung (BL) Benefits?_____ If yes, date benefits began: _____
2. Has the Veterans Affairs (DVA) authorized an agreed to pay for care? _____

PART II:

1. Was the illness due to work or related accident/condition? ____ If yes, date of illness/injury:_____
2. Was Case Settled? _____ If yes, Date of Settlement (MM/DD/YY): _____
   Attorney Name:_____
   Attorney Address:_____
   Attorney Phone: _____

3. Name and Address of WC Plan

   _____

   _____

   _____

   Name and Address of Employer

   _____

   _____

   _____

   Policy/ID#: _____ Insured: _____
   WC Claim #: _____ EMP ID: _____

PART III:

1. Was the illness/injury due to a nonworking related accident? _____
   If yes, date of injury/illness (MM/DD/YY): _____
2. What type of accident caused illness/injury? ____ Auto ____Non-Auto ____Other
   If OTHER, please explain: _____

   Name/Address of Policy Holder

   _____

   _____

   _____

   Name/Address of No-Fault Liable Insurer

   _____

   _____

   _____

   INS Claim #: _____

   Attorney Name/Address:

   _____

   _____

   _____

   Responsible Party Insurance Name/Address

   _____

   _____

   _____

   INS Claim #: _____

3. Was another party responsible for this accident?
   Name/Address of Policy Holder

   _____

   _____

   _____

   Name/Address of Liable Insurer

   _____

   _____

   _____

   INS Claim #: _____

See back page

Attorney Name/Address:

_____

_____

_____

4. PRIOR STAY INFORMATION
   Has the patient been confined to a hospital or skilled facility in the last 60 days? _____
   Hospital/SNF Name/Address:

   _____ Admit Date: _____

   _____ Discharge Date: _____

   _____ Verified By: _____

   Responsibility Party Insurance Name/Address: INS Claim #: _____

   _____

   _____

   _____

   **Mark the ERSD block with one of the following for COMBINATION ENTITLEMENT: G=ERSD/Age or I=ERSD/Disable

PART IV:

1. Is MEDICARE Entitlement based of: ____ Age ____ Disability ____ ERSD

PART V:

1. Are you currently employed? _____ ____ Full Time ____ Part Time
   If NO, date of retire (MM/DD/YY)? _____
   Name/Address of your employer: _____

2. Is your spouse currently employed? _____ ____ Full Time ____ Part Time
   If NO,date of retire (MM/DD/YY)? _____
   Name/Address of spouses employer: _____

3. Do you have a group health plan (GHP) coverage on your own, or a spouse's current employment? ____

4. Does the employer that sponsors your GHP employ 20 or more employees? _____

   Name/address of GHP: Policy ID#: _____

   _____ Group ID#: _____

   _____ Policy Holder: _____

   Relationship: _____

   _____

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