Medicare Secondary Payor Questionnaire

Patient Name: _____ Clinic Name: _____

Medicare ID #: _____ Patient Account #: _____

Date: _____

1	Are you entitled to Medicare Based on	Age (65 and over)	YES	NO
		Disability	YES	NO
		End Stage Renal Disease	YES	NO
2	Do you receive Veteran's Benefits?		YES	NO
3	Are you receiving benefits under the Black Lung Program?		YES	NO
4	Was this injury due to a work-relate accident or condition?		YES	NO
	If YES, indicate accident date and complete # 10		_____	
5	Was this injury due to an automobile accident?		YES	NO
	If YES, indicate accident date and complete # 10		_____	
6	Was this injury related to an accident in which you intend to file a liability suit or litigation is pending?		YES	NO
	If YES, indicate accident date		_____	
	If YES, please provide attorney name:		_____	
	attorney address:		_____	
	attorney Phone:		_____	
7	Are you currently employed?		YES	NO
	If NO, indicate date of retirement		_____	
8	Are you currently receiving primary health coverage from current or previous employer?		YES	NO
	If YES, complete # 10			
9	Is your spouse currently employed?		YES	NO
	Do you have coverage under a group plan through spouse's employer?		YES	NO
	If YES, does the employer have more than 20 employees?		YES	NO
	If YES complete #10			

10 Insurance Name: _____

Policy ID #: _____

Phone Number: _____

Subscriber's Name _____