Appendix 3 | Medicare Secondary Payer Questionnaire

Name:	HICN:	Date:

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

1. Is your injury/illness due to:

A. Work - related accident/condition?

- ☐ No
- ☐ Yes, Name and Address of Worker's Compensation Plan:

_____

_____

B. A condition covered under the Federal Black Lung Program?

- ☐ No
- ☐ Yes

C. An automobile accident?

- ☐ No
- ☐ Yes, Name and Address of Auto Insurance:

_____

_____

Name of Insured: _____
Policy or ID#: _____
Accident Date: _____

D. An accident other than an automobile accident?

- ☐ No
- ☐ Yes, Name and Address of No-fault Insurer:

_____

_____

Name of Insured: _____
Policy or ID#: _____
Accident Date: _____
Accident Location: _____

E. The fault of another party?

- ☐ No
- ☐ Yes, Name and Address of No-fault Insurer:

_____

_____

Name of Insured: _____
Policy or ID#: _____
Accident Date: _____
Accident Location: _____

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2. Are you eligible for coverage under the Veterans' Administration?

- ☐ No
- ☐ Yes

3. Are you employed?

- ☐ No
- ☐ Yes, Employer Name and Address: _____

_____

B. Do you have Employer Group Health Plan Coverage?

- ☐ No
- ☐ Yes, Insurer Name and Address _____

_____

4. Is your spouse employed?

- ☐ No, Date of Retirement, if applicable:
- ☐ Yes, Spouse's Name: _____

Employer Name and Address: _____

_____

B. Are you covered under your spouse's Employer Group Health Plan?

- ☐ No
- ☐ Yes, Insurer Name and Address: _____

_____

Policy #: _____ Group #: _____

5. Are you a dependent covered under a parent's/guardian's Employer Group Health Plan?

- ☐ No
- ☐ Yes, Employer Name and Address: _____

_____

Name of Insured: _____

Policy #: _____ Group #: _____

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

Addendum:

Do you have MED. PAY BENEFITS with your auto insurance? ☐ Yes ☐ No

Insurance Company Name and Address: _____

_____

Name of your Agent: _____

Phone #: _____

We must provide attorney information to MEDICARE:

Attorney Representing You: _____

Address: _____

Phone #: _____

Patient Signature: _____ **Date:** _____

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