Family Practice Associates of Upper Dublin

Medicare Secondary Payer Questionnaire

Patient name: _____
Date of birth: _____Today's date:_____
Name of Individual Providing Responses:_____
Relationship to patient: _____
Account #_____ Medical Record #_____

Please complete **ALL** Sections:

1. Are you receiving Black Lung benefits **AND** is your treatment today related to your Black Lung?
   _____ **NO** (please continue on to question #2)
   _____ **YES**; Date benefits began (MM/DD/CCYY): _____/_____/_____ (if yes, please skip to question #5)

2. Are your services to be paid by a government research program?
   _____ **NO** (please continue on to question #3) _____ **YES** (if yes, please skip to question #5)

3. Has the Department of Veteran Affairs authorized and agreed to pay for your care?
   _____ **NO** (please continue to question #4) _____ **YES** (if yes, please skip to question #5)

4. Is your illness / injury due to a work related, automobile or other type of accident?
   _____ **NO** (please continue to question #5) _____ **YES** - Continue
   - What type of accident? - _____ Automobile? _____ Work-related? _____ Other Party?
   - Date of accident (MM/DD/CCYY): _____/_____/_____
   - If non-work-related, is no-fault insurance available? _____**YES** _____**NO**
     If YES, no-fault policy owner:_____
     (No-fault insurance pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)
   - If non-work-related, is liability insurance available? _____**YES** _____**NO**
     If YES, responsible party:_____
     (Liability insurance protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)
   - Name and address of Automobile insurance carrier, Worker's Compensation carrier or other party insurer: _____
     _____
     _____
     Claim number: _____
     Adjuster's name: _____Adjuster's phone #: (_____)_____

5. Are you entitled to Medicare based on your age? ____ **NO** (Go to question #6) _____**YES**-Continue
   Are either you or your spouse employed?
   ____**YES:** _____*Both* employed? ____*Only patient* employed? _____*Only spouse* employed?
   - Do you have group health plan coverage based on your own or a spouse's current employment? _____ **YES** _____ **NO** (Go to question #6)
   - Does the employer that sponsors your group health plan coverage employ 20 or more employees? _____ **YES** _____ **NO** (Go to question #6)
   - **Complete employment and insurance information section on the next page.**

   ____**NO**: Please provide employment information and/or retirement dates on the next page.

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6. Are you entitled to Medicare based on disability?
   _____ **NO** – (Go to question #7) _____ **YES** – Continue
   - Do you have group health plan coverage based on your own or a family member's current employment? _____ **YES** _____**NO** – (Go to question #7)
   - Does the employer that sponsors your group health plan coverage employ 100 or more employees? _____**YES** _____**NO**
   - **Complete insurance information grid at bottom of this page.**

7. Are you entitled to Medicare based on having end stage renal disease?
   _____ **NO – <u>You are done filling out this questionnaire. Thank you.</u>**
   _____ **YES** – Continue
   - Do you have group health plan coverage?
     _____ **NO – <u>You are done filling out this questionnaire. Thank you.</u>**
     _____ **YES** – Continue. Complete insurance and employment section at bottom of page.
   - Have you received a kidney transplant? _____**YES** _____**NO**
     If YES, date of transplant (MM/DD/CCYY): _____/_____/_____
   - Have you received maintenance dialysis treatments? _____**YES** _____**NO** If YES, when did dialysis start (MM/DD/CCYY)? _____/_____/_____
   - Did you participate in a self-dialysis training program? _____**YES** _____**NO** If YES, date training started (MM/DD/CCYY): _____/_____/_____
   - Are you within the 30-month coordination period?
     _____ **YES** – Coordination period start date (MM/DD/CCYY): _____/_____/_____
     _____ **NO** – You are done this questionnaire.
   - Are you entitled to Medicare on the basis of either <u>ESRD</u> <u>*and*</u> <u>age</u> OR <u>ESRD</u> <u>*and*</u> <u>disability</u>?
     _____**YES** _____**NO**
   - Was your initial entitlement to Medicare based on ESRD?
     _____ **YES** – You are done this questionnaire.
     _____ **NO** – Please make sure you answered questions #5 and #6.

PATIENT Employer Information – If not employed: Retirement date was: _____/_____/_____	
Current Employer Name:	
Employer Address:	
Employer City, State, Zip Code:	
SPOUSE Employer Information – If not employed: Retirement date was: _____/_____/_____	
Current Employer Name:	
Employer Address:	
Employer City, State, Zip Code:	

Group Health Plan / Insurance Company Information	
Group Health Plan Name:	Insurance Company Address:
Subscriber Name/Name of Insured:	Relation to Patient:
Insurance Policy ID #:	Insurance Group #:
Membership #:	