Ref. _____

OMB No. 0938-0214

MEDICARE SECONDARY PAYER QUESTIONNAIRE
(TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

NAME: _____ HIC: _____

DATE OF SERVICE: _____

(If any answer to questions 1a. through 4. is yes, the corresponding section of the "Other Insurance" form must be filled out completely.)

	YES	NO
1. Is the patient a Veteran?	_____	_____
a. Did the VA refer you here for treatment?	_____	_____
b. Does the patient have a VA "fee basis ID Card?"	_____	_____
2. Do you have a Federal Black Lung card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____

If yes was it: Work Related ☐ Auto ☐ Injured in own home ☐ Other ☐

4. Is the patient covered by a health insurance plan through their own current employment or that of a family member? (Not retiree coverage) _____ _____

(Information obtained in questions 5 through 7 should be used when coding your claim for Medicare.)

5. Is the patient employed? Yes ☐ No ☐

If "no": Did you retire in the last two years? Yes ☐ No ☐
If "yes"; give retirement date. _____

6. Is the spouse employed? Yes ☐ No ☐

If "no": Did your spouse retire in the last two years? Yes ☐ No ☐
If "yes"; give retirement date. _____

7. Please check the reason the patient is Medicare eligible:

Age 65 or Over ☐ Disabled ☐ End Stage Renal Disease (ESRD) ☐
ESRD Effective Dates:
(The month kidney dialysis began)
Part A _____ Part B _____

Signature: _____