Mary Washington Healthcare

Medicare Secondary Payer Questionnaire

Yes	No	
☐	☐	Are you receiving Black Lung benefits?
		Date benefits began: _____
☐	☐	Are these services related to Black Lung?
☐	☐	Is this visit associated with a work injury / illness?
		*If patient answered **yes,** answer these following questions.*
		Date of Injury_____
		Workers Compensation Plan_____
		Policy/ID Number_____
		Employer_____
☐	☐	Is this visit associated with a non-work related accident?
		*If patient answered **yes,** answer these following questions.*
		Type of Accident: ☐ Auto or ☐ Non Auto
		Date of Accident_____
		Is No-Fault insurance available? ***Make a copy of information provided
		Is Liability insurance available? ***Make a copy of information provided
☐	☐	Are you eligible for Medicare because of age?
☐	☐	Are you eligible for Medicare because of disability?
☐	☐	Do you have group health plan coverage (GHP) based on your own or a spouse's current employment, or a family member's current employment?
☐	☐	Do you have group health plan coverage (GHP) based on your own current employment?
☐	☐	Does the employer that sponsors your group health plan employ 100 or more persons?

Name of employer_____

Address of employer_____

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☐ ☐ Do you have group health plan coverage (GHP) based on your spouse's current employment?

☐ ☐ Does the employer that sponsors your group health plan employ 100 or more persons?

Name of employer_____

Address of employer_____

☐ ☐ Are you eligible for Medicare because of end stage renal disease?

*If patient answered **yes,** answer these following questions.*

Yes	No	
☐	☐	Have you received a kidney transplant? Date of transplant: ____/____/_____
☐	☐	Have you received maintenance dialysis treatments? Date dialysis began: ____/____/_____
☐	☐	Did you participate in a self-dialysis training program? Date training began: ____/____/_____
☐	☐	Are you within the 30-month coordination period?

Name of person(s) answering this form: _____

Relationship to the patient: _____

THANK YOU FOR YOUR ASSISTANCE!!