Medicare Secondary Payer Questionnaire

Patient Name ______________________ Date of Birth ______________

Dear Medicare Patient:

Medicare requires that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items provided. Therefore, Three Rivers Clinic is requesting that the below information be completed so that a determination can be made if Medicare is your primary insurance, please answer all questions.

1. Is the illness/injury due to an automobile accident, liability accident, or Workman's Compensation? ❍Yes ❍No

2. Is illness covered by the Black Lung Program or Veterans Administration Program? ❍Yes ❍No

3. Are the services to be paid by a government research/ grant program? ❍Yes ❍No

4. Is the patient covered by an employer group health plan (EGHP), including Federal Employees? ❍Yes ❍No

5. Is this patient or his/her spouse actively employed by an employer of 20 or more employees? ❍Yes ❍No

6a. If under age 65, is your Medicare coverage due to disability? ❍Yes ❍No
If "yes" go to #6b, if "no", go to #7.

6b. Is the patient or his/her spouse or parent actively employed by, or is the patient considered an employee of an employer having 100 or more employees? ❍Yes ❍No

7a. Is the patient entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)? ❍Yes ❍No
If "yes", go to #7b.

7b. Has the patient completed the ESRD coordination period? ❍Yes ❍No

Patient Signature ______________________ Date of Birth ______________

Three Rivers Medical Clinic
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Please complete each question, if applicable.

Name of Primary Insurance Company: ____

Address of Primary Insurance Company ____

Name of Primary Insurance Policy Holder: ____

Primary Insurance Policy Number: ____

Name of Policy Holder's Employer: ____

Address of Policy Holder's Employer: ____

Date Benefits Began _____/____/_____

If answered 'Yes' to Question #1:

Date of Accident/Injury: _____/_____/_____

Name of attorney(s): ____

If answered 'Yes' to Question #3:

Name of Research/Grant Study: ____

____ ________________________

Patient Signature Date of Birth

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