

Medicare Secondary Payer Questionnaire



Patient Account Number: _____

Patient Name: _____ DOB: ____ / ____ / ____

Are you currently being seen by a Home Health Agency? _____ Yes _____ No If No, continue to question 1. If Yes, they are the PRIMARY Payer and services must be authorized by the HHA.
1. Are you entitled to benefits under Black Lung Program, Department of Veteran Affairs or other Government program? _____ Yes go to # 17 _____ No go to #2
2. Was illness/injury due to work related incident covered by a workers compensation plan? _____ Yes go to # 17 _____ No go to #3
3. Was illness/injury due to a non work related accident? _____ Yes go to # 4 _____ No go to #6
4. What type of accident caused illness/injury? _____ Automobile go to #17 _____ Non-Automobile go to #5
5. Was another party responsible for this accident? _____ Yes go to # 17 _____ No go to #6
6. Are you age 65 or older? _____ Yes go to # 9 _____ No go to #7
7. Are you entitled to Medicare benefits based solely on End Stage Renal Disease (ESRD)? _____ Yes go to # 11 _____ No go to #8
8. Are you a disabled Medicare beneficiary under the age of 65? _____ Yes go to # 15 _____ No Medicare is Primary Payer
9. Are you covered under a group health plan (GHP) through your spouse? <input type="checkbox"/> _____ Yes go to # 10 _____ No Medicare is Primary Payer
10. Does the employer have 20 or more employees? _____ Yes go to # 17 _____ No Medicare is Primary Payer
11. Have you received a kidney transplant or are currently undergoing renal dialysis for End Stage Renal Disease? _____ Yes go to # 12 _____ No go to #13
12. Date of transplant or start of dialysis _____ _____ If less than 12 months go to #13 _____ If over 12 months Medicare is Primary
13. Do you have group health plan coverage through your or other family members employer? _____ Yes go to #14 _____ No Medicare is Primary Payer
14. Are you within the 30 month coordination period? _____ Yes go to # 17 _____ No Medicare is Primary Payer
15. Are you covered under a group health plan based on you or other family members employment? _____ Yes go to # 16 _____ No Date of retirement _____ If No, Medicare is Primary Payer
16. Does the employer have 100 or more employees? _____ Yes go to end _____ No Medicare is Primary Payer

17. Check the appropriate box for the primary payer.

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|--|------------------------------------|---|
| <input type="checkbox"/> BL/VA/Gov Prog. | <input type="checkbox"/> Work Comp | <input type="checkbox"/> Auto Insurance |
| <input type="checkbox"/> Liability Insurance | <input type="checkbox"/> #10 GHP | <input type="checkbox"/> # 14 GHP |
| | | <input type="checkbox"/> #15 GHP |

Policy or ID number _____ Contact phone number _____

Contact/Case Manager/Adjustor _____

MEDICARE IS SECONDARY PAYER TO THE ABOVE IDENTIFIED INSURER

Patient Signature

Valir Employee Signature

Date